Professionalism

THE END OF THE GOLDEN AGE OF DOCTORING

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Eight interrelated reasons for the decline of the golden age of doctoring are discussed in this article. Major *extrinsic factors* (generally outside the control of the profession) include (1) the changing nature of the state and loss of its partisan support for doctoring, (2) the bureaucratization (corporatization) of doctoring; (3) the emerging competitive threat from other health care workers; (4) the consequences of globalization and the information revolution; (5) the epidemiologic transition and changes in the public conception of the body; and (6) changes in the doctor-patient relationship and the erosion of patient trust. Major *intrinsic factors* are (7) the weakening of physicians' labor market position through oversupply; and (8) the fragmentation or weakening of the physicians, union (AMA). Despite the recent sociopolitical transformation of modern U.S. medicine, our thinking remains wedded to a now inadequate theoretical approach. A future sociology of the professions can no longer overlook now pervasive macrostructural influences on provider behavior (corporate dominance). Until these influences are appropriately recognized and incorporated in social analyses, most policies designed to restore the professional ideal have little chance of success.

If we want things to stay as they are, things will have to change.
Giuseppe di Lampedusa (1)

There are striking similarities between the rise and fall of religious monasticism during the Middle Ages and the rise and still continuing decline of professionalism around the turn of the 21st century. During the medieval period, groups of monks (religious orders) clustered together in functionally dependent units (monasteries), eschewed worldly interests (commerce), and professed through values, beliefs, and actions their adherence to another world. Monks considered themselves "called" to their special vocation and embarked on a period of sacrifice and training as novices, during which they learned appropriate forms of behavior and

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an unquestioning deference to a special body of revealed knowledge. Secrecy, elaborate rituals, special costumes, and an exclusive brotherly devotion to others in their religious order (the brotherhood) insulated them from surrounding worldly corruption. They occupied a special position in the social order and enjoyed a protected status as moral arbiters of all that was good and evil. Civilian authorities (wealthy landowners, royalty, or local governments) generally left them to their own devices or used them to legitimate worldly activities (e.g., unfair taxation, repression, exploitation).

Viewed simplistically as a contest between two competing worldviews (monasticism versus civilian authorities) it is now clear who won. Macroeconomic forces transforming the surrounding society made monasteries increasingly untenable economic units. Increasingly considered anachronistic and out of touch, the once powerful monasteries eventually declined. While a few continued to cling to the traditional order, most were swept away with social and economic change. Rigid adherence to an idealized worldview precluded strategic economic and political alliances that might have halted or forestalled their inexorable decline. From our historical vantage point at the beginning of the 21st century, sociologists of religion can look back and examine the rise and fall of medieval monasticism: with appropriate intellectual distance, we can now understand how religious orders acquired and maintained their special position in society, the functions they performed for other established elites, and how their insulated existence eventually led to their decline.

Present-day observers are just too close to late 20th and early 21st century changes in U.S. medical care to enjoy the vantage point of, say, a contemporary historian reviewing medieval societal changes. Not enough time has elapsed for the full social consequences of the late capitalist transformation of U.S. health care to completely unfold. Still, there are remarkable parallels between the rise and fall of monasticism and the rise and continuing fall of professionalism. Inevitably, modern-day commentators are prisoners of the proximate—being so involved in the phenomenon of interest, it is difficult to assume the distance necessary to appreciate the underlying causes and likely consequences of the subject of our inquiry. To understand the consequences of the industrial revolution as it finally caught up with medicine, we can observe effects produced by its earlier impact on other industrial sectors (like farming, banking, and transportation).

Over a decade ago, the first author and a colleague (Dr. John Stoeckle) argued that the corporatization of medical care was transforming the U.S. medical workplace and profoundly altering the everyday work of the doctor (2). We questioned the adequacy of the prevailing view of professionalism (Freidson's notion of professional dominance) and proposed an alternative view more informed by current developments in the U.S. medical care marketplace (2–4). Our work explicitly repudiated "doctor bashing," a popular sport among social scientists at the time, in favor of a theoretically grounded political-economic explanation (historic changes in the mode of medical care production) of the demise of

doctoring. It produced a fierce reaction among many physicians and some medical sociologists. We probably added fuel to the flames by initially employing the Marxist notion of proletarianization—a term eventually abandoned in favor of a less threatening term like "corporatization." That much of the reaction resulted from the term "proletarianization" is evident from the fact that nothing else in the paper was changed—not one argument or datum. While strenuously rejecting the claim that doctors were being slowly "proletarianized," many agreed that doctors were indeed being "corporatized." Apparently it was the word "proletarianized" and what it implied that was objectionable, not our underlying thesis. In our view, it was important that the thesis not be dismissed because of a single word (5–7).

While some could not accept the notion of corporatization (or proletarianization) back in the 1980s, there is hardly an objection today (8). In just 25 years, U.S. health care has been historically transformed—from a predominantly fee-for-service system controlled by dominant professionals to a corporatized system dominated by increasingly concentrated and globalized financial and industrial interests (9). Dudley and Luft (10) believe U.S. health care has experienced "a sea change in the past two decades—not just in the financing of health insurance, but also in the way medicine is practiced." With the golden age of medicine now almost behind us, doctors are huddling in their monasteries (hospitals and medical centers) powerlessly awaiting the next corporate onslaught. One unanticipated consequence of the Clinton administration's failed attempt at health care reform in 1994 was to further dissipate the power of doctors and coalesce opposing economic interests (especially the private insurance, pharmaceutical, and hospital sectors) against progressive change.

Professionalism can be defined as a system of values and beliefs and behavior (concerning how things ought to be done) resulting from dedicated commitment usually following a prolonged period of training. Adherents to this system (professionals) have enjoyed a privileged position and status in society, and their activities have typically been protected or sanctioned by the state. Professional activities were often insulated from observability by secrecy, protective subordinates, and impregnable institutions (11). An ethos of professional collegiality and confidentiality (the brotherhood) was hardly conducive to public scrutiny. From such a viewpoint and for much of the 20th century, professionalism was a powerful social force—it encouraged adherents to behave "ethically" and promoted unquestioning trust among the public (*credat emptor*); it institutionalized the conflict within organizations, between bureaucratic authority (based on tenure in a position in a hierarchy) and professional authority (based on a body of knowledge and technical expertise) and worked against dialectical change; it allowed rapacious interests to disguise their activities in good intentions and a transparent beneficence.

The recent (late 20th and early 21st century) decline of the medical profession and of professionalism as a social force undoubtedly results from many different social influences—at least eight of varying importance are discussed in this article.

For convenience we organize them into extrinsic factors (which appear outside the control of the profession) and intrinsic factors (which may be amenable to change by the profession itself). Major *extrinsic factors* are (*a*) the changing nature of the state and loss of its partisan support for doctoring; (*b*) the bureaucratization (corporatization) of doctoring; (*c*) the emerging competitive threat from other health care workers; (*d*) the consequences of globalization and the information revolution; (*e*) the epidemiologic transition and changes in public conceptions of the body; and (*f*) changes in the doctor-patient relationship and the erosion of patient trust. Major *intrinsic factors* are (*g*) the weakening of physicians' or market position through oversupply; and (*h*) the fragmentation of the physicians' union (the American Medical Association, AMA).

SHIFTING ALLEGIANCE OF THE STATE

Various studies have described the important role of the state (local and national government structures) as a sponsor for professionalism generally and as a protector of doctoring in particular. The rise of the medical profession during the 20th century was powerfully reinforced by government action (9, 12–16). The state served a legitimating function for many professional activities, accorded select groups (e.g., physicians and attorneys) a monopolistic position and privileged status, and served as a guarantor of their profits (through programs like Medicare and Medicaid). Hardly neutral with respect to the medical profession, the state has through political and legal means unabashedly advanced professional interests and disposed of perceived threats to professional dominance (13, 17, 18). For its rise during the 20th century, the medical profession (among other privileged interest groups) achieved much for which the state can be thanked. Figure 1 depicts principal sources of support for the medical profession in the United States during much of the 20th century (with government and the AMA as mainstay institutional supports).

While there is extensive discussion in the social sciences around the changing structure, functioning, and power of the state, this has yet to feature prominently in the major theories of professionalism or in the debate on the decline of professionalism, despite the state's recognized influence on all health-related activities (the nature and financing of our health care system, the power of medical professionals, the legitimation of competing interests, and the level of support for social policies affecting doctoring). The future of the medical profession and the nature of doctoring in the 21st century will depend on, more than any other influence, the changing nature and support of the state (19, 20). We devote more emphasis to this than any other factor.

The "state" can be viewed organizationally as the "apparatus of government in its broadest sense: that is, as that set of institutions that are recognizably 'public' in that they are responsible for the collective organization of social existence and are funded at the public's expense" (21, p. 84). Most observers

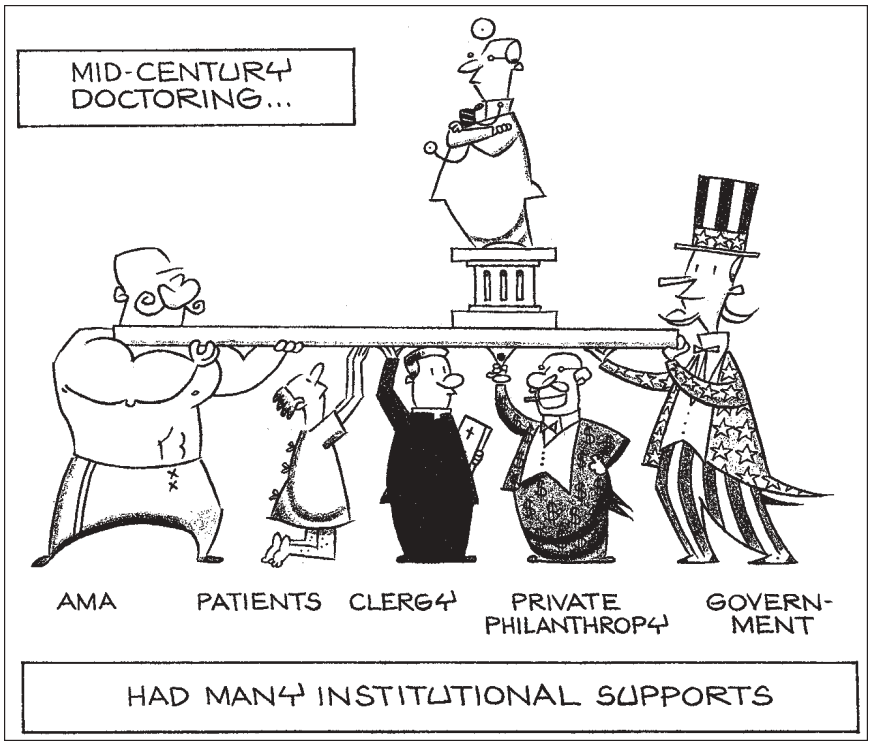

Figure 1. Sources of support for doctoring in the middle of the 20th century.

view the state as consisting of a wide range of institutions, including the government or legislature (which passes laws), the bureaucracy or civil service (which implements government decisions), the courts and police (which are responsible for law enforcement), and the armed forces (whose job it is to protect the state from external threats). Included under this broad definition are such institutions as welfare services, the education system, and the health care establishment (22).

As far as the United States is concerned—as evidenced by the attempt at health care reform in 1994 (23), the defeat of anti-tobacco legislation (24), and the rapid evolution of managed care—the state appears to have lost some of its ability, or willingness, to act on behalf of and protect the profession's interests. Figure 2 depicts the way in which, in the United States during the last decades of the 20th century, the state shifted its primary allegiance from the profession's interests to often conflicting private interests. Such a shift will shape the content and socio-political context of doctoring during the new millennium (25).

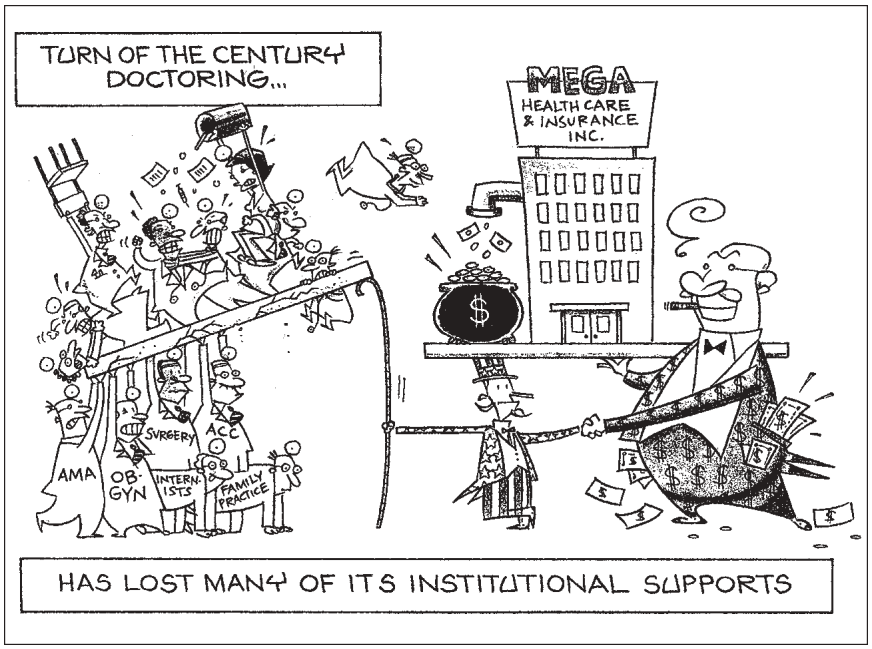

Figure 2. Sources of support for doctoring in the early 21st century.

While there are numerous theories of the state, for the purpose of this discussion of the decline of professionalism and the medical profession, it may be useful to distinguish just three general viewpoints.

1. The *Marxist perspective,* which has never been predominant in the United States, views the state as partisan—maintaining the class system by either subordinating certain groups (e.g., racial and ethnic minorities and women) or dissipating class conflict. According to this view, the state cannot be understood separately from the prevailing economic structure of society. Here we have a clear alternative to the popular pluralist view of the state as neutral arbiter or umpire of competing countervailing interests. The Marxist theory of the state has undergone considerable debate and revision, especially with contributions from Gramsci (26), Mosca (27), Miliband (28), Poulantzas (29), Mills (30), and more recently Jessop (31). Neomarxists, while attempting to remain faithful to the classical ideas of Marx, have generally abandoned the idea that the state is merely a reflection of the class system. The original two-class model is now recognized as simplistic, and Poulantzas (29) has identified significant divisions within the ruling elite (e.g., between financial and industrial (manufacturing) capital). Neomarxists have also tried to provide an alternative to the mechanistic and simplistic views of traditional Marxism (often incurring the wrath of the orthodox in the process) and to move

beyond crude economic determinism. Jessop (32), for example, views the state not as an instrument wielded by a dominant group but as "the crystallization of political strategies," a dynamic entity that reflects the balance of power within society at any given time, and thus reflects the outcome of an ongoing hegemonic struggle. Current developments with respect to globalization (the subordination of national governments to supranational organizations and agencies) appear to give the Marxist theory of the state increasing currency.

2. The *pluralist perspective,* with origins traceable to the 17th century liberalism of Thomas Hobbes and John Locke and more recently the work of John Rawls (33), views the state as a neutral body that arbitrates between competing interests in society. There is an often unacknowledged assumption of neutrality—the government sets the rules and acts as an umpire or referee in society. It is viewed as acting in the interest of *all* citizens and therefore as representing the common good or public interest. Many pluralists embrace a constant sum concept of power (there is a fixed amount of power that is widely and evenly dispersed) and view the state as having no interest of its own that is separate from society. Heywood (21) identifies two assumptions underlying the pluralist theory of the state: (*a*) the state is effectively subordinated to government (nonelected state bodies such as the civil service are strictly impartial and subject to the legitimate authority of their political masters); and (*b*) the democratic process is effective and meaningful (party competition and interest-group activity ensure the government remains responsive to public will). With the work of Dahl (34), Lindblom (35), Marsh (36), and Galbraith (37), among others, it is now recognized that the traditional pluralist theory of the state requires some revision, especially to take account of modernizing trends such as globalization and the emergence of postindustrial society. Neopluralists view Western democracies as "deformed polyarchies," in which major multinational corporations and globalized interests now exert disproportionate influence (21). The medical profession thrived during the latter half of the 20th century under a pluralist state (it was a dominant interest group with widespread public support). The theory of countervailing powers advanced by Mechanic (38) and Light (39) in their discussion of the medical profession appears to rest on a now outmoded pluralist view of the state. Historical developments have left these theories (and especially Freidson's notion (40) of professional dominance) with little explanatory currency. Professional powers appear, incidentally, to have countervailed little in the context of changes in the National Health Service in Britain (41).

3. The *New Right perspective* is a recent powerful reaction against the view of the state as "leviathan"—a self-serving monster intent on its own expansion and aggrandizement (21). The two perspectives discussed so far (pluralist and Marxist) have been termed "society centered"—the state and its actions are shaped by external forces in society as a whole. Pluralism views the state's actions as determined by the democratic will of the people; Marxist theory sees its actions as shaped by the interests of an increasingly concentrated cluster of powerful

institutions and individuals. Clearly, society can and does influence the structure and functioning of the state, but obviously the reverse can also occur. This possibility has given rise to what are termed "state-centered" approaches to the theory of power in modern society (22). These approaches (and the New Right is but one of them) view the state as acting independently, or autonomously, to shape social behavior. Nordlinger (42) suggests the state itself has acquired three forms of autonomy: (*a*) when the state has preferences that differ from those of major groups in society and implements its preferred policies despite pressure for it not to do so; (*b*) when the state is able to persuade opponents of its policies to change their mind and support the government; and (*c*) when the state follows policies that are supported, or at least not opposed, by the public or powerful interest groups in society (22).

The New Right perspective, which appears to be on the ascendance in the United States, is distinguished by its strong laissez-faire attitude and antipathy toward state intervention in economic and social life (even medical care). Its proponents argue that the state should retreat from responsibility for medical care (and protection of doctoring) and let market forces prevail. Rooted in a radical form of individualism and exemplified in the writings of Robert Nozick (43), the New Right considers the state a parasitic growth that threatens individual liberty and even economic development. The New Right perspective has been described as follows (21, p. 91):

> In this view, the state, instead of being as pluralists suggest, an impartial umpire or arbiter, is an overbearing "nanny," desperate to interfere or meddle in every aspect of human existence. . . . [The] state pursues interests that are separate from those of society (setting it apart from Marxism), and . . . those interests demand an unrelenting growth in the role or responsibilities of the state itself. . . . [The] twentieth century tendency towards state intervention reflects not popular pressure for economic and social security, or the need to stabilize capitalism by ameliorating class tensions, but rather the internal dynamics of the state.

Figure 3 summarizes the three perspectives on the modern state.

To most political scientists, the three perspectives identified and discussed here will be a gross simplification of the complex debate occurring over several decades. Since each viewpoint has its own philosophical tradition, efforts to integrate them creatively so as to achieve some overall theoretical synthesis will remain an elusive task. The appropriateness of any theory of the state probably varies *among* countries, although with globalization this may be changing. The role of the state may also change over time *within* a particular country: *in the United States we are witnessing a move from a pluralist to a New Right state.* New society programs (e.g., Medicare and Medicaid) were formulated and implemented during a more liberal pluralist era—the nature of the state then made them

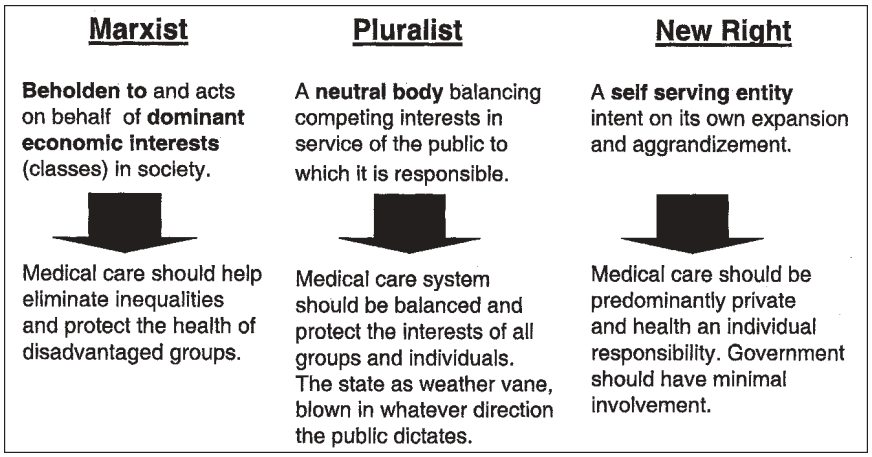

Figure 3. Theories of the modern state.

possible. Efforts at health care reform in the United States failed in large part because of a well-orchestrated assault on the leviathan state (as Big Government, increased taxation, public dependency, and curtailed freedoms) (23). Likewise, the ability of the New Right (in combination with the business community) to portray physicians as greedy and willing participants in fraud (overbilling for services) has implications for regulation and public trust. The encroachment of the state even on the once-sacred physician-patient relationship (through "gag rules" and court opinions) is discussed below.

The medical profession thrived during the era of the pluralist state: as a major public interest group with considerable public support, the umpire invariably ruled in its favor. Writing in the context of Britain, but with application to the U.S. scene, Klein (44) describes "the politics of the double bed," referring to the way doctors in the United Kingdom were directly involved in policy decisions affecting their activities. While the state (government) is often viewed as an unchanging entity, it is now clear that a subtle change occurred during the last decades of the 20th century: the state is transitioning from a pluralist to an antileviathan New Right viewpoint. Commentators have discussed the transition from a Fordist to a post-Fordist state and what this portends for the medical profession (45–48). Farrell's recent biography (49) of U.S. House Speaker Tip O'Neill describes the nature and focus of government during the late 20th century, ending with a presidential declaration during a State of the Union address that "the era of big government is over." This now dominant New Right perspective has resulted in an important shift in the primary allegiance of the state—from protecting the interests of the medical profession to advancing the interests of the financial and industrial owners of an ever more corporatized U.S. health care system. Figure 2 depicts the

changes in institutional support for doctoring, with the state shifting its principal allegiance to other interests.

A recent discussion of the implications of the 2000 election for health care in the United States concludes that (50):

> the election of Bush as president has brought a different focus and tone to health policy. . . . Clinton advocated a larger federal role. . . . President Bush has a very different view of the government's role in health care. He emphasizes individual responsibility in making decisions about health care and paying for it, as well as the positive role of the private market place. Bush also believes that local charities should be encouraged to provide needed health care services, that state governments should assume the primary role in many areas of health care policy, and that the federal role should be smaller.

Partisan protection of professional prerogatives now appears secondary to the advancement of global corporate interests. Whereas previously, the state enacted legislation designed to protect physicians, nowadays the New Right state's protective cloak is first used to cover the corporate interests that now determine the structure and content of U.S. health care. Rather than setting the rules and acting as a neutral umpire as Light (51) envisages it, the emerging New Right state is now on the side of and in the service of multinational financial and industrial interests. The gradual shift in the state's principal allegiance (from the medical profession to the corporation and especially its owners) has fostered the erosion of professionalism, leaving the medical profession with little more than ostensible support (see Figure 3). Just as the state was important in the earlier rise of the medical profession, so too has its recent protection of corporate interests left the medical profession without a significant source of support, thereby threatening the profession's special position and status. Zola (52) traced the origins of the earlier, special position of physicians as agents of social control to the sponsorship they derived from the state (see also 14). Much of this is now eroding as the state comes increasingly under the control of new global masters. While the decline of the medical profession appears to be a global phenomenon, there is presently no universal explanation for this, but many complex reasons that differ from country to country (53).

BUREAUCRATIZATION (CORPORATIZATION) OF DOCTORING

Using data from the AMA's Socioeconomic Monitoring System (a series of periodic nationally representative samples of the entire U.S. physician population), Kletke and his colleagues (54, 55) report dramatic changes in the nature of physician employment (type of work arrangement) from 1983 to 1997. Between these years, the proportion of patient-care physicians working as employees (with no ownership interest in their practice) rose from 24 to 43 percent, an increase of

19 percentage points (Figure 4). Also during this period, the proportion of physician's in *self-employed solo practices* (one-physician practices with an ownership interest) fell from 40 to 26 percent. The proportion of physicians in *self-employed group practices* (multiple-physician practices with an ownership interest) fell from 35 to 31 percent. Kletke and colleagues (54, 55) note that these trends are accelerating—most of them occurring during the latter part of the study period. Moreover, these trends are especially evident among younger physicians (Figure 5). Among newly practicing doctors (0 to 5 years in practice), the proportion who were salaried employees increased from 37 to 66 percent between 1983 and 1997. The authors conclude: "These trends are pervasive throughout the patient care physician population, occurring for both male and female physicians, for U.S. medical graduates and international medical graduates, for all specialty groups, and in most parts of the country. . . . That these changes have been especially pronounced among younger physicians suggests that their impact on the delivery of medical care will continue long into the future" (55, p. 559).

Under late 20th century bureaucratized medicine, physicians are *required* (there are now few practice options) to participate in assembly-line medicine. Stoeckle (56) described "working on the factory floor with an M.D. degree." Speed-up of the medical care production process (physicians are "permitted" six to eight minutes with a patient) occurs continuously under the guise of efficiency, or even clinical appropriateness. A report recently suggested that the length of the doctor-patient encounter has not shortened under managed care (57), but its methodology has limitations and its findings differ from the everyday experience

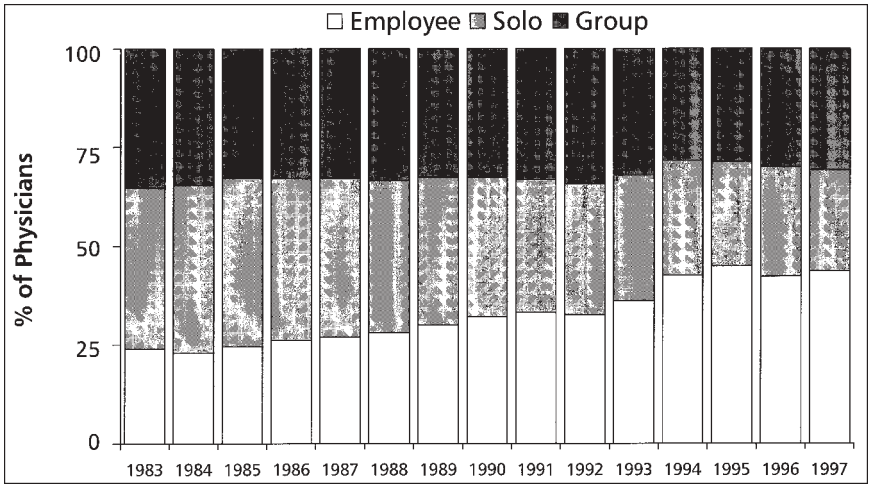

Figure 4. Distribution of physicians by type of practice, United States, 1983–1997. *Source:* Kletke et al. (54) and personal communication, 1998.

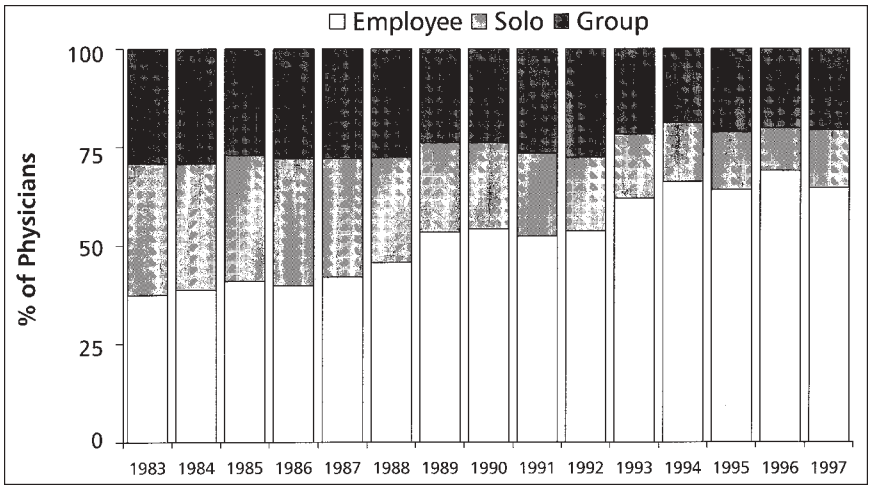

Figure 5. Distribution of young physicians (five or fewer years of practice) by type of practice, United States, 1983–1997. *Source:* Kletke et al. (54).

of many practicing doctors on the medical care production line. While originally motivated by concern over the quality of care, clinical practice guidelines are welcomed by corporatized medicine and serve to curtail extraneous and costly procedures and to streamline the production process (58). The reward structure for physicians is increasingly tied to exemplary performance of the bureaucratic employee role (the number and types of diagnoses, referrals to other specialties, throughput of patients per practice session). Toward the end of the 20th century, Taylorism appears to have finally caught up with American medical care (59, 60).

Of special concern to some "old-time" doctors is the absence of any real professional resistance to worrisome bureaucratic encroachments. The loss of administrative and economic autonomy is understandable and even tolerable; but for many physicians, the loss of clinical autonomy is especially troubling (61, 62). Where they should actually practice (selective contracting) and how much they should be paid are now largely determined by others; but having others determine *how* they should practice (the technical content of care) is just too much (63–65). Sophisticated data-management systems can now track the minutest aspects of care; these systems appear to exist as much to monitor the productivity and costs incurred by providers as to monitor any beneficial clinical outcomes (66). Increasingly, the treatment regimen is formulated before a live case actually presents for medical care. Prior approval is often required from a non–medically qualified reviewer at some geographically distant corporate headquarters before a final decision can be made. The choice of treatment (e.g., which medication can be prescribed) is often determined by what is allowed by a patient's health

insurance or by the physician's employer. All clinical actions are scrutinized on a regular basis, and deviant practice behavior is highlighted and corrective steps taken to ensure future conformity with overall practice norms. Older recalcitrant or unproductive practitioners can easily be replaced with younger physicians (oversupply is discussed later) or replaced by less expensive nonphysician clinicians (also described below). As one chief of medicine recently remarked to us, "I listen to all these complaints from the doctors and ask myself, 'But where are they going to go?'" In order to get along under corporatized medicine, it appears that most physicians, for understandable reasons, must be willing to go along.

AN INCREASINGLY CROWDED PLAYING FIELD

During much of the 20th century, physicians gained a privileged position as the principal providers of medical services in the U.S.: the term "monopoly" has been used to characterize their unique situation and behavior (13). Of the many factors that contributed to the emergence of "the golden age" of doctoring, clearly the most influential was the highly supportive action taken by a generally partisan pluralist state described above (9, 12–14, 40). First, early in the century the legitimacy of the medical profession was established through *state licensing and regulations*—no other group of health care providers could legitimately perform certain tasks. If there were exceptions for particular groups, they had to work under the direct supervision of physicians. Second, during the middle of the 20th century, *third-party reimbursement* enhanced the economic position of the medical profession—they could bill for almost anything and solely determined what was appropriate treatment. Through programs like Medicaid and Medicare (which reimbursed a physician's full costs), the state acted as both an underwriter and a guarantor of professional profits. Third, with considerable support for medical education from government, the medical profession strengthened its position by *training new physicians* in numbers that eclipsed other medically related disciplines.

Physicians had the medical playing field to themselves for most of the 20th century, but the last several decades witnessed the arrival of a group of ever more powerful and legitimate new players who are threatening the physician's traditional game. Nonphysician clinicians (NPCs) are responsible for increasing amounts of the medical care that was previously provided almost exclusively by physicians (9, 67–73). With increasing numbers and improvement of their position, NPCs appear to be using the same political game plan that physicians used to secure this special status so successfully in earlier times (70, 74–77).

Cooper and his colleagues (72, 74) have projected the future likely workforce of NPCs and what their rapid increase portends for physicians. Most NPCs are within ten different medical and surgical specialties, which can be classified into three broad groups: (*a*) *the traditional disciplines*—nurse practitioners (NPs), certified nurse-midwives (CNMs), and physician assistants (PAs);

(*b*) *the alternative or complementary providers*—chiropractors, naturopaths, acupuncturists, and practitioners of herbal medicine; and (*c*) *specialty disciplines*—optometrists, podiatrists, certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs).

Through statutes and regulations, states have granted extensive practice prerogatives to *all* the NPCs listed above. The most important of these prerogatives is licensure, which has established the right of these disciplines to practice (although it does not yet assure their autonomy as providers). There are marked differences in the practice prerogatives that states grant to NPCs in the various disciplines. For most disciplines, the magnitude of the prerogative correlates with the number of NPCs in each state. In some states, "practice prerogatives [have] authorized a high degree of autonomy and a broad range of authority to provide discrete levels of uncomplicated primary and specialty care" (72, p. 795).

Late 20th century changes in the organization and financing of health care (especially the emergence of profit-driven corporatized care) enhanced the labor market position of NPCs. For a profit-driven organization, the growth of NPCs offers an opportunity to hire appropriate replacements for a physician. Studies comparing the performance of NPCs and physicians show that there are few differences in any clinical outcome, but NPCs are considerably less expensive and patients often prefer the quality of care they offer. Lower costs and customer satisfaction are imperatives in the new medical marketplace.

With respect to the likely magnitude of the threat to physicians posed by NPCs, the aggregate number of NPCs graduating annually in the ten disciplines listed above doubled between 1992 and 1997, and a further increment of 20 percent is projected for 2001 (72). The supply of NPCs is expected to grow from 228,000 in 1995 to 384,000 in 2005, and is likely to continue to expand at a similar rate thereafter. Figures 6, 7, and 8 (pp. 393–395) depict the projected increase in the three broad groups of competing medical care providers.

Competition on the medical playing field is likely to become increasingly intense, especially given the existing oversupply of physicians combined with the national desire to contain health care costs. The size of the overall pie is unlikely to increase, and larger numbers of ever more powerful disciplines are competing for a piece of it. Grumbach and Coffman consider the emerging situation as subject to "Evans Law of Economic Identity" (78), which they describe as follows (79, pp. 825–826):

> . . . total expenditures on professional health care services are by definition equal to the total number of services provided multiplied by the price of each service, which are in turn equal to the total number of persons earning incomes in health care multiplied by the income of each person. If the supply of health care workers increases and income per worker remains constant, then health expenditures also will increase. To increase the supply of workers without increasing overall costs, either incomes per worker must diminish or new

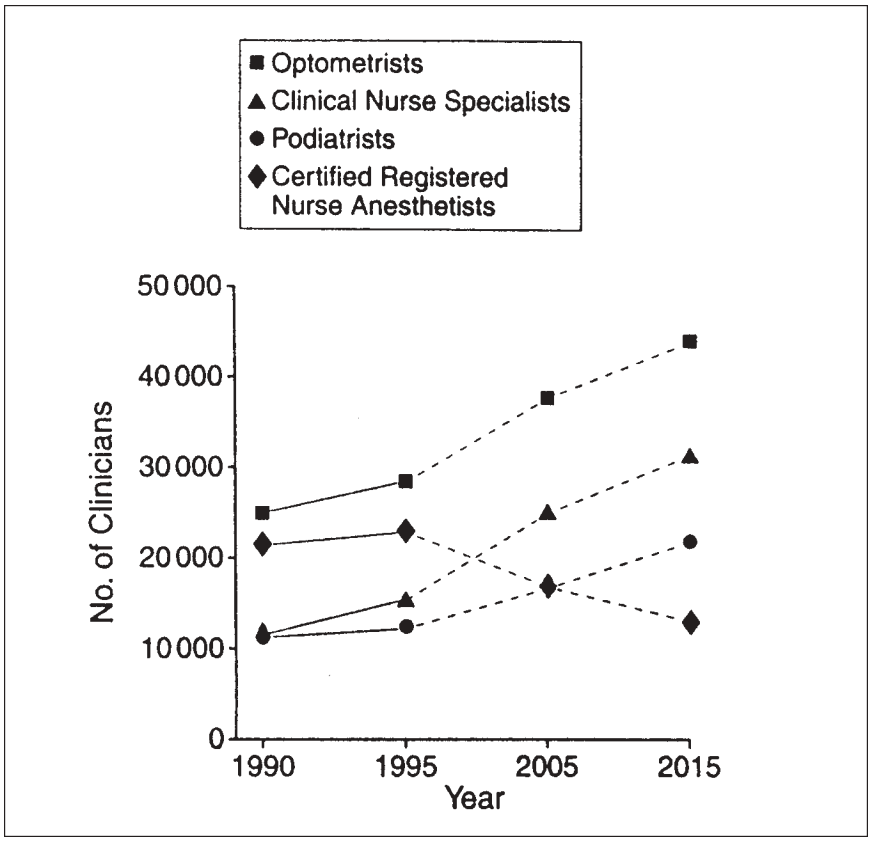

Figure 6. Supply of specialty nonphysician clinicians, United States, 1990–2015. *Source:* Cooper et al. (72).

> workers must displace other workers. . . . [This] implies either a substantial growth in expenditures for payment of these practitioners or rivalry among physicians and NPCs to protect incomes and jobs in a financially constrained system.

Commenting on the growth of NPCs in relation to the likely supply of physicians over the next decade, Cooper observes (69, p. 1542):

> When assessed in terms of physician equivalent effort, the number of NPCs will increase from 51 per 100,000 in 1994, a level equal to 25 percent of patient care physicians, to 84 per 100,000 in 2010, which is equal to 34 percent of the physician workforce in 2010. The incremental increase of NPCs

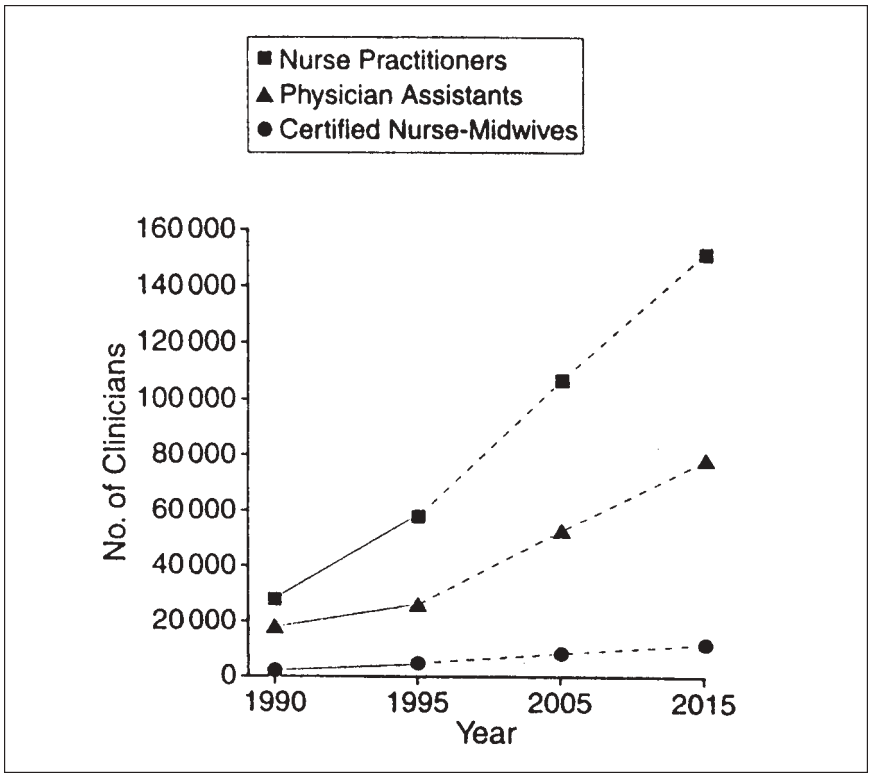

Figure 7. Supply of traditional nonphysician clinicians, United States, 1990–2015. *Source:* Cooper et al. (72).

> between 1994 and 2010, expressed as physician equivalents, is 33 percent, which is identical to the increment of physician supply that is projected during the same period. . . . [The] the order of magnitude of the projected growth in their numbers is large in proportion to any estimate of physician surpluses. Moreover, there does not appear to be the capacity to absorb both the increased numbers of physicians that have been projected and a parallel workforce of NPCs of this magnitude.

The recent rapid increase in the number of physicians and other health workers is already creating intradisciplinary (between physicians) and interdisciplinary (between physician and nonphysician clinicians) rivalries. Several observers have noted a decline of intradisciplinary courtesy and reciprocity. Some doctors are barely hanging on, while others are reported to be abandoning a sinking ship (Figure 9). All of this is to emphasize that much of the debate over medical

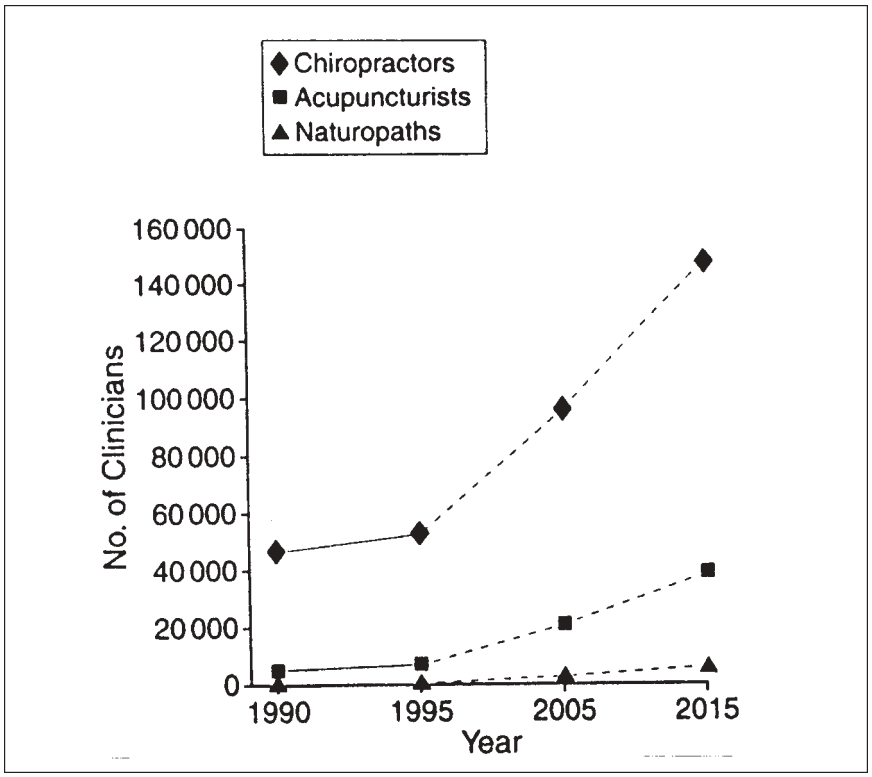

Figure 8. Supply of alternative or complementary nonphysician clinicians, United States, 1990–2015. *Source:* Cooper et al. (72).

workforce trends (oversupply versus undersupply) and their likely consequences appears to be without (political or economic) context or background (80). Discussion of the intrinsic threat to doctoring resulting from statistical oversupply appears myopic and overlooks the even more significant extrinsic threats presented by macroeconomic changes in the surrounding society (e.g., corporatization and the trend to employee status, the changing nature and shifting allegiance of the state, and the erosion of patients' trust). Beneath the threat to doctoring that accompanies statistical oversupply and competition lie even more significant social trends that are undermining the position of physicians in the division of medical labor and the status of doctoring in the surrounding society.

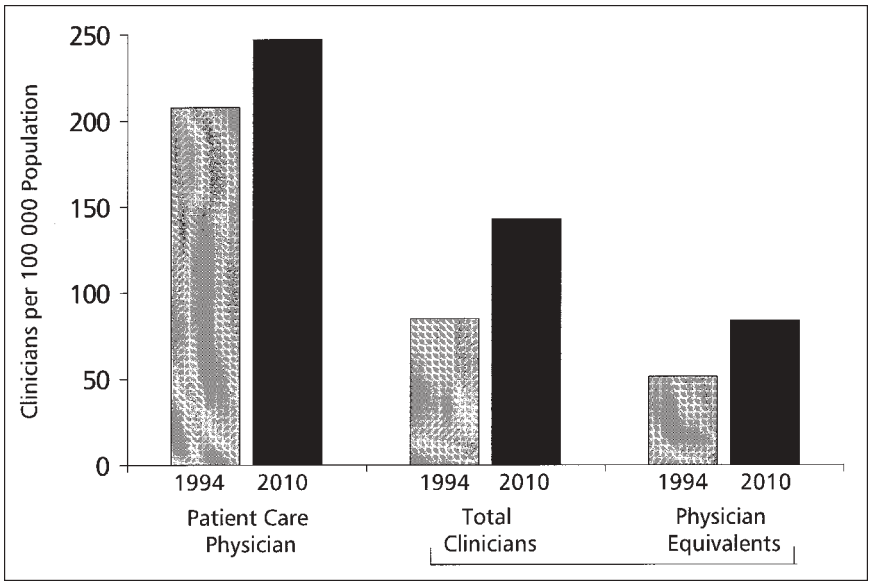

Figure 9. Increase in supply of nonphysician clinicians, United States, 1994–2010.

GLOBALIZATION AND THE INFORMATION REVOLUTION

Globalization and the information revolution are also phenomena with potential to alter the social position of doctors worldwide. While globalization may appear only to concern abstract phenomena at the level of nation states and macro-economics that have little bearing on behavior at the local level (e.g., currency and market fluctuations in one geographic region can force governments in far-off regions to dramatically change local economic policy), nothing could be further from the truth: "it is the very dynamic of globalization that its dimensions operate *both* at the global and local level *at the same time*" (81, p. 55). Giddens observes: "It is wrong to think of globalization as just concerning the big system, like the world financial order. Globalization isn't only about what is 'out there,' remote and far away from the individual. It is an 'in here' phenomena too, influencing intimate and personal aspects of our lives" (82, p. 30). The implications of globalization and the information revolution at the local level for the organization and delivery of health care, for the social position of doctors, and for the content of medical work (doctoring) have received little attention and remain poorly understood.

The term "globalization" refers to the emerging consciousness of the world as a single place and the accompanying process whereby geographically disparate

social systems are becoming linked so as to assume a worldwide scale. Modern electronic communications (especially the Internet) provide the lifeblood for emerging global bodies. Globalization is being institutionalized through the activities of transnational corporations and the formation of supranational agencies like the World Bank, the World Trade Organization, and the World Health Organization. Regional affiliations between countries (e.g., the North American Free Trade Agreement and the European Union), which may be termed "intermediate globalization," may eventually result in the formation of worldwide structures. There are several ways in which their activities affect the social position of doctors and the everyday value of doctoring.

Much of the power and position of the medical profession has been traced to the protective activities of professional associations (the doctors' union), often manifest through locally powerful medical societies. As described elsewhere, professional associations like the AMA in the United States and the British Medical Association in Great Britain have exerted considerable influence on the state, shaping legislation affecting their prerogatives. Policies promulgated by supranational organizations and agreements between governments are marginalizing once powerful national and local professional associations, limiting their ability to control licensure and training and shape legislation so as to benefit their constituency. NAFTA is a reciprocal agreement between the United States of America, Mexico, and Canada that provides for the free-trade movement of physicians and other professionals between these three countries. It is expected that other countries will be added to NAFTA in the near future. Similarly, the interests of professional associations in the member countries of the European Union are now subordinated to legislation emanating from Brussels. Despite the local training and licensing requirement of local medical interests, employment mobility of physicians between countries linked through global structures is increasingly common. Illustrative are perhaps the recent reports of South African doctors being lured to work in Canada. South Africa's foreign minister and its ambassador to Canada have said it is unethical for the West to lure doctors from the developing world, which already has too few doctors and struggles to provide medical care for millions of impoverished people and to cope with epidemics such as AIDS and tuberculosis. According to some estimates, 1,500 South African doctors are now working in Canada. Apparently, the president of the Saskatchewan Medical Association (a South African) was able to stand before a group at the association's annual golf tournament last year and tell a joke in Afrikaans (83).

Increasingly widespread use of the Internet, while empowering patients by providing valuable health information, also may have the unanticipated consequence of undermining key aspects of physician authority. For much of the 20th century, the medical profession seemed to exemplify the adage "knowledge is power." Possession of a body of purportedly scientific knowledge about the human body and various methods to possibly prolong life, avoid death, and

alleviate suffering contributed to the privileged position of doctors in the social order (described below). Acquisition of technical expertise through prolonged training (professional socialization) was considered a defining characteristic (attribute) of any profession (84). Public access to this highly valued and authoritative medical knowledge was possible only through consultation, usually face-to-face, with a certified (licensed) physician. Any other source of health information was considered suspect and lacking in scientific legitimacy. The ready availability of sophisticated medical information to anyone with Internet access is increasing levels of public medical knowledge, interposing a lay electronic help-seeking system, and changing the structure and content of the doctor-patient relationship.

In contrast with earlier times, newly empowered patients now enter the doctor-patient encounter with (*a*) considerable *up-to-date information* concerning a medical condition and possible types of diagnoses and (*b*) industry-generated *requests* for specific tests or treatments ("ask your doctor about . . .") and expectations concerning what ought to occur during the encounter. And (*c*), subsequent to the encounter, patients now use the Internet to *informally evaluate* the appropriateness of particular treatments and procedures received. The timing of a Web search appears to depend on the person for whom health information is being sought: if for someone else, it usually occurs after a doctor's visit; if for oneself, it tends to occur before a doctor's visit, presumably to see what the diagnosis might be (85).

Physician behavior around the mid-20th century was described as "insulated from observability" (11). Doctors tended to act as independent agents, free from administrative oversight with little formal accountability. As professionals, and again with the acquiescence of the state, doctors acquired a legally sanctioned privilege accorded few occupations—self-regulation. Probably because doctors could "bury their mistakes," professional misconduct appeared to be a rare event, and whenever oversight or investigation was required, it was conducted in closed-door sessions involving only selected members of the profession. With the changes in physician employment described in this article (corporatization), the computerization of medical records, and the on-line availability of data on the comparative performance of medical facilities and particular practitioners, the everyday work situation of doctors is changing dramatically.

Computerized information systems can now capture minute aspects of the clinical encounter (e.g., length of visit, tests ordered, referrals made, prescriptions written, clinical outcomes, patient satisfaction, and costs incurred). Particular providers are now easily compared with each other in terms of patient throughput, productivity, and patient satisfaction, and their performance assessed against officially agreed upon standards of care (practice guidelines). Legal actions against providers for alleged malpractice were once largely based on the testimony (memory) of the parties involved, or required plaintiffs to find a doctor willing to testify against one of their own. Nowadays, the computerized medical record

provides an independent contemporaneous record of everything that is done (or not done) during a doctor-patient encounter, and it constitutes evidence thought to be superior to the memory of self-interested parties. Anyone can now go on-line to acquire previously private information on particular providers: their age, educational background, employment history, and the frequency and success of any legal actions. Through the use of the Web, patients today can enter the doctor-patient relationship with up-to-date information on any medical condition, informed expectations about what constitutes appropriate practice, and considerable information on the personal biography of their provider.

Globalization is also having more subtle effects on the position of doctors and the work of doctoring around the world. During the 18th and 19th centuries, British imperialism involved more than only the export of industrial production and products through colonization. Anglo-Saxon culture was also exported. So, too, globalization involves more than just the production, distribution, and exchange of tangible commodities on a worldwide scale. It also involves the development of a worldwide common culture of values, images, and assumptions as to what is modern, stylish, right or wrong, and ideal. For example, a multibillion-dollar diet industry in the United States produces and distributes both pills and diet supplements *and* a demand-producing image of the ideal body (the so-called "tyranny of thinness"). New electronic forms of communication (especially films, television, and the Internet) are greatly facilitating this process.

Transnational corporations involved in the globalization of medicine (pharmaceuticals, services, medical insurance, and biotechnology) generate local demand for services, which indigenous systems are simply unable or unprepared to meet, often widening existing health disparities. In most countries it is usually those who can afford to pay, those who have access to private health care facilities, who receive the benefits of globalized medicine. For the medical profession, being "up to date" or "cutting edge" is highly valued around the world. This usually entails using the latest Western approaches and equipment. In developing countries, scarce resources are often consumed by the latest high-tech equipment and specialties, diverting resources from equipment that is culturally more appropriate, disfiguring indigenous health systems, and disrupting local patterns of medical care. The field of international health is replete with examples of the often unanticipated disfiguring consequences for indigenous systems of globalized health care.

The globalization of medical culture also fosters division within local health care systems. Patients may prefer providers who appear more cosmopolitan, who have "been abroad" and studied at prestigious Western (usually U.S.) medical institutions. Many academic centers now offer distance learning courses for providers in the developing world. The work and status of traditional and indigenous providers, whose orientation is more toward local culture and medical needs, is therefore devalued. Social status within the profession often derives from how Westernized a provider is (educational background, linkage to overseas

institutions, regular participation in international symposia), not from the esteem that derives from effectively managing local medical problems. Local medical care systems and the social position of doctors around the world are being insidiously eroded as much by the globalization of Western medical culture as by the globalization of medical care production (manufactured goods and services).

THE EPIDEMIOLOGIC TRANSITION AND CHANGING CONCEPTS OF THE BODY

Sociologists have been engaged for decades in a lively debate on the conceptualization and measurement of occupational status or prestige, and much appears to depend upon the theoretical framework employed (this determines which criteria are given priority) and the purpose for which an occupational classification is developed (the interests of academic researchers and government officials are sometimes at odds). A large body of sociological work on the profession can be reduced to two main schools of thought (although most purists would reject any such simplification): one view (advanced by functionalists) emphasizes the value of "the" professions to society; the other view (advanced by critical theorists and social constructionists) emphasizes the power and self-interest of the professions and the value of their activities to the advancement of their own social position. Both viewpoints may contribute to understanding the changing social position of any occupation. The prestige of any occupation depends to some extent on its contribution to what is valued in any society (e.g., health, the prolongation of life, and the reduction of suffering). There have been changes over time in both the nature of disease and the ability of medical care providers to beneficially alter the natural course of illnesses. Little attention has been devoted to how such epidemiologic changes relate to the changing social position of doctors.

Patterns of mortality, morbidity, and disability obviously change over time: just as each historical epoch has its own predominant form of production (agricultural, industrial, informational), so too does it have its own predominant form of illness (86). Omran (87) suggested that changes in patterns of disease and death can be characterized as moving through three distinct phases. The *age of pestilence and famine* characterizes premodern and pre-industrial societies. It was characterized by high mortality associated with environmental exposure and accidents and conflict. Total life expectancy was only 20 to 40 years. During the *age of receding pandemics,* improvements in housing, sanitation, and nutrition and public health activities resulted in a decline in deaths from infectious and parasitic diseases. Specific medical measures contributed little to the decline in the diseases (88–91). People began to survive into older age, when they were more likely to die from chronic degenerative diseases. Life expectancy increased to about 50 years. Equilibrium in mortality characterizes the *age of degenerative and human-made diseases.* Overall mortality rates continued to drop and life expectancy increased

to about 70 years. A small number of chronic conditions (heart disease, cancer, and stroke) were major contributors to mortality, and (with the exception of cancer) these began an unexpected rapid decline beginning in the mid-1960s. It is common to attribute these improvements to secular changes in lifestyles and improvements in medical care, although the evidence for this remains somewhat inconclusive.

Olshansky and Ault (92) propose a fourth stage of epidemiologic transition, which they term the *age of delayed degenerative diseases.* During this stage the major causes of death remained unchanged, but they became more concentrated in the older age groups. There is evidence that while people may be living longer, they are experiencing increasing periods of disability (93). Palliative care has become an important component of modern medical practice. A fifth stage now appears to be emerging, which can be termed the *age of globalized health threats.* This stage is characterized by (*a*) the emergence of new infectious diseases and the reemergence of old (but newly resistant) foes (e.g., TB and malaria); and (*b*) the emergence of worldwide environmental threats (e.g., pollution, ozone depletion, bioterrorism) (94–96). While these threats have similarities with those of earlier stages, they differ in at least two respects: their global impact and the rapidity of their transmission. With respect to TB for example, the WHO estimates that *Mycobacterium tuberculosis* now infects some two billion people: one in every three worldwide. Approximately 10 percent of these carriers develop the disease and become infectious to an average of 10 to 15 other people. Globally, TB is now the fifth largest cause of death and the major cause of death for women. It is estimated that by 2020 there will be one billion new cases and around 70 million deaths. This new globalized threat of (often drug-resistant) TB obviously requires a globalized public health response—like the Global Alliance for TB Drug Development, involving governments, supranational agencies, transnational corporations, and major philanthropic organizations. Similarly, these emerging worldwide environmental threats will require new forms of sociopolitical intervention as part of a global public health strategy for the 21st century. It is clear that one-on-one curative interventions by health providers (e.g., physicians) will have little impact during the Age of Globalized Health Threats.

The social position of healer in society, only recently termed "the doctor," appears to have changed as the nature of the threat to health has changed over time. Although the evidence is fragmentary, it appears there was little role for a healer during the age of pestilence and famine. During and following the industrial revolution, with its air, water, food, and vector borne diseases, the afflicted either died (in accordance with the will of God) or quickly recovered (as a result of the intervention of a physician). In other words, doctors were perceived to be effective when people survived; failure was attributed to the will of God. Doctoring reached its zenith during the age of degenerative and human-made diseases, when pharmaceuticals and surgery were considered effective cures against the major conditions (heart disease, cancer, and stroke) of the modern era. Curing appears to have been supplanted by caring and palliative measures during the age of delayed

degenerative diseases. Much of the focus of doctoring has now shifted to regular monitoring of presently incurable conditions (diabetes, hypertension, asthma, arthritis, cancer) and to improving the quality of life. Curing is commonly thought to be a more glamorous and valued activity than caring. Moreover, caring may be more appropriately performed by the many other providers (discussed above) now considered to be equal partners with physicians on the health care team. The emerging threats to health that accompany globalization will likely require entirely different types of interventions, of a more sociopolitical nature.

Several other cultural phenomena have contributed to the erosion of the doctor's social position in the United States. First, increased public access to medical knowledge has resulted in some demystification of the body. The understanding of illness and disease has moved from the metaphysically inexplicable (which once gave providers almost priestly functions) and been reduced to biophysiologic functions. Second, the body is increasingly viewed as a machine that requires regular calibration (weight and diet control) and preventive maintenance (annual physicals). Defective parts like hearts, liver, kidneys, knees, or hips that deteriorate through excessive mileage (aging) are now able to be replaced. Doctoring now shares many similarities with the work of skilled car mechanics. Third, responsibility for personal health has shifted from paternalistic medical care providers: people are now viewed as personally responsible for their own health. Self-care (weight, exercise, diet, stress, self-examination) is beginning to assume the status of a moral obligation. Diagnoses of many medical conditions (diabetes, hypertension, pregnancy, some cancers) can now be made at the kitchen table. Computer-assisted diagnosis and the filling of prescriptions is now possible via the Internet, often rendering a face-to-face encounter with a doctor unnecessary. While such phenomena are increasingly marginalizing the doctor and are a source of some concern for the medical profession, they are often viewed by physician employers as welcome developments likely to reduce costs.

FROM RELATIONSHIP TO ENCOUNTER— THE EROSION OF PATIENTS' TRUST

Macrolevel changes in the content and organization of doctoring and the accompanying decline in the social position and status of doctors bring microlevel changes to the doctor-patient relationship. A measure of the change in this relationship lies in the words now used to describe it: "doctor" has become "provider," the "patient" has become a "client," and the "relationship" is now an "encounter." Recognizing that profound changes are occurring, we have suggested elsewhere the need for new, third-generation studies of the doctor-patient relationship (97). First-generation studies focused on the influence of patients' attributes (age, race, social class, gender, physical attractiveness, and so forth) on the doctor-patient relationship and clinical decision-making. Second-generation studies brought a shift in focus to the characteristics of physicians/providers (age

or clinical experience, gender, race/ethnicity, medical specialty). These two types of study tend to employ a closed-system model of the doctor-patient encounter—the exchange is viewed as occurring in a sociological vacuum (a patient interacting with a physician). Our proposed third-generation studies recognize the increasing intrusion of social, economic, and organizational influences on the structure and content of the encounter. Table 1 summarizes some differences in the doctor-patient relationship from the mid-20th century to the early 21st century.

Table 1

Some differences in the doctor-patient relationship from mid to late 20th century

	Mid 20th century	Late 20th century
Terminology	Doctor-patient relationship	Client-provider encounter
The state (government) and insurance companies	Recognizes sanctity of "the" relationship	Intrudes on the encounter (e.g., gag rules)
Ownership	Patient is "owned" by the doctor	Client is "owned" by provider's employer
Reference group	Independent physician works for the patient (sole practitioner)	Salaried provider works for an employer
Duration of relationship	Continuity of care (often over many years)	Discontinuity of care (changes with employer and medical staff)
Length of encounter	15–20 minutes	6–8 minutes
Power	Doctor in control (patient has few options)	Client more in control (able to "shop around")
Trust	*Credat emptor*	*Caveat emptor*
Treatment options	Physician does what the patient requests/needs	Provider does what organizational policy permits
Reimbursement	Physician rewarded for doing more (fee-for-service)	Provider rewarded for doing less (salaried employee)
Confidentiality	Held to be inviolable	Threatened by the number of parties involved and computerized medical records.

During the middle years of the 20th century, physicians acquired a widely discussed position of professional dominance (12, 40), and the doctor-patient relationship was depicted as "asymmetric." While commentators questioned the role of physicians as "medical imperialists" and "agents of social control," still doctors were generally considered to be on the patient's side. There was a coincidence of interest between physicians (who, through autonomous practice on behalf of patients, maximized their income) and patients (who cooperated with their doctor in order to get well). *Credat emptor* was considered an appropriate motto and a necessary condition for an effective encounter (98, 99).

Even the once cherished privacy of the physician-patient relationship is under attack. State encroachment on the relationship is evident in the "gag rule" prohibiting doctors in federally funded clinics from speaking about abortion with their patients. This rule, and the supporting Supreme Court opinion in *Rust v. Sullivan,* permitted increased governmental control over physicians' speech (100, 101). Testifying before Congress, an AMA representative considered the gag rule would "denigrate the integrity of the doctor-patient relationship and force health care professionals to violate established standards of medical care and professional ethics" (102).

With the phenomenal growth of corporatized medical care the average physician's administrative, economic, and even clinical autonomy has been challenged. Professional dominance has been supplanted by bureaucratic dominance, with the resulting appearance of a conflict of interest for physicians. Physicians now find themselves between a rock and a hard place: there is evidence that many must employ manipulative "covert advocacy" tactics so that patients can receive care that physicians perceive as essential (103). Essentially they must do the wrong thing (lie) to achieve the right outcome (their preferred medical treatment). It is not unreasonable to ask whether physicians are still able to serve the interests of their patients or are required to advance the interests of their employers (104). Physicians have even been referred to as "double agents" (105). Profound changes in the structure and content of late 20th century medical care appear to be eroding the trust that is thought to be a crucial ingredient in the doctor-patient relationship (106–110). Kao and colleagues (104) show that the method of physician payment is related to the level of patients trust. While usually confined to other market transactions (like auto repair, insurance, and the purchase of real estate), the motto *caveat emptor* is now increasingly invoked in the context of the corporate provider-client encounter.

WEAKENING OF MARKET POSITION THROUGH OVERSUPPLY

Much of the decline of modern doctoring can be attributed to influences outside the control of the profession: such *extrinsic factors,* as discussed above, include the bureaucratization of medical care and the decline in public trust, profit-driven

corporatization, the erosion of state sponsorship, and the competition presented by other health workers. There are, however, factors *intrinsic* to the medical profession (and certainly under its control) that also are undermining its privileged social position. Of the intrinsic factors, the most important is almost certainly the weakening of physicians' own labor market position by physician oversupply and unwillingness to curtail the overproduction of new medical graduates.

For several decades numerous reports have warned of a looming physician surplus; these worrisome projections are now a reality for the medical profession (111–117). More than 20 years ago (in 1976) it was predicted that by 1990 there would be a surplus of 70,000 active physicians (a 13 percent surplus) and that by 2000 this would increase to 145,000 (22 percent surplus) (111). Weiner (77) projected a surplus of 165,000 physicians (28 percent of practicing physicians) by 2000. He subsequently revised his projected surplus to an oversupply of 270,000 physicians (39 percent of all patient-care physicians) by 2000 (118). These and numerous other projections (and the devil is in the assumptions on which they are based) are the subject of intense debate (119). Despite some disagreement over whether a *national* physician surplus exists there is little doubt that oversupply presents a serious problem in some geographic areas (112, 120–126). The Boston–Washington corridor, for example, accounts for much of the projected surplus (20 percent). One commentator thinks that a decrease of 25,000 physicians (40 percent) and 16,000 residents (40 percent) is necessary to bring this region to the national norm: "it is unlikely that in the near term this region could absorb more physicians per capita than now exist" (69, p. 1541). In the context of national oversupply, there are of course other areas of the country with alarming health inequalities that continue to be severely underdoctored. The most valuable national data on physician supply and demand and their likely consequences for modern doctoring are presented by Cooper (69), who suggests that supply may exceed demand by up to 62,000 physicians (8 percent) through 2010. Cooper predicts that a small deficit may occur by 2020, when the growth rate of physicians is projected to be less than the growth rate of the U.S. population (Figure 10).

The debate over likely trends will no doubt continue, with different constituencies presenting different scenarios. Practicing physicians are already feeling the squeeze and suggesting that the production of medical graduates should be carefully monitored. But the medical education establishment is required to increase the production of medical graduates to justify earlier massive investments in institutional development. No medical school is likely to close its doors in the foreseeable future (the supply of student applicants will continue to exceed the number of available places). If oversupply is a likely scenario, then the medical profession appears to be on a self-destructive course. In our view there is clearly an overproduction of physicians. But current proposals to address the problem, like encouraging specialty and geographic redistribution and some constraints on international medical graduates, appear inadequate and are unlikely to be effective (127, 128). One high-level meeting on this subject (the Trilateral Physician

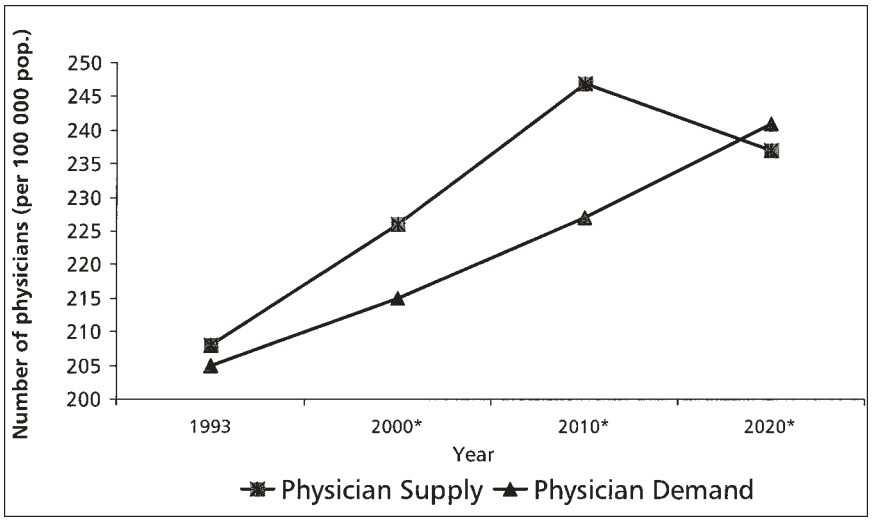

Figure 10. Resident-adjusted physician supply and demand, United States, 1993–2020. *Source:* Cooper (69).

Workforce Conference, held in 1996) concluded that the difficulty of translating the results of workforce research into public policy is more pronounced in the United States than elsewhere (e.g., Canada and the United Kingdom) and that the situation in the United States suffers from "paralysis by analysis" (129).

Until quite recently, a medical degree guaranteed full employment immediately upon graduation from a reputable medical school. Physician unemployment is still rare, but *under*employment appears to be quite common (more than other occupations, physicians are able to supplement their income with non-patient-care activities). Miller and her colleagues (126) reported that one-quarter of newly trained physicians experienced difficulty finding appropriate employment; 67 percent obtained clinical practice positions in their specialties.

Through an inability to even acknowledge let alone control their own worrisome overproduction, physicians appear determined to continue along the path of their own demise—very much like lemmings inexplicably self-destructing into the Arctic Ocean. This erosion of labor market position is, of course, exacerbated by trends in the growth of other health workers as described earlier.

THE DOCTORS' UNION—DIVIDE AND CONQUER

During much of the 20th century, the special position of physicians and the state-supported prerogatives they acquired were engineered and advanced by an ever more powerful union—the American Medical Association. During

midcentury, the support or opposition of the AMA determined the success or failure of major national legislation. There was no greater prize for aspiring politicians than some form of support or even endorsement from the AMA. Medical specialization, however, splintered the once unified posture of the AMA; specialty-based societies (unions) replaced the increasingly distant AMA as the primary reference group of many physicians. For example, cardiologists joined the American College of Cardiology and internists joined the Society for General Internal Medicine. These memberships were instead of rather than in addition to membership in the AMA. While the AMA was a dominant institutional force around the middle of the 20th century, probably as influential as the state itself in advancing the prerogatives of "the" profession (Figure 1), its influence today is shared with often rival specialist medical societies (Figure 2). Its power now appears no greater than that exerted by competing state or specialist societies, and a coincidence of interests cannot be assumed.

Membership in the AMA was never compulsory, but during the middle of the 20th century nearly all physicians joined and paid their dues. It is safe to assume that most physicians still belong to some professional association (or union), but nowadays membership in the AMA is deemed unnecessary by more than half of U.S. physicians. Figure 11 shows that at the turn of the 20th century the United States had an estimated 800,000 active physicians, but membership in the AMA had slipped to well under 300,000 (only 40 percent of the nation's doctors).

Particularly disturbing for the AMA is the tendency for younger physicians or new medical graduates not to become members. In other words, the current membership is declining and aging. Previously unheard of divisions within the AMA are now also apparent: an upstart challenge (by Raymond Scaletter) to the usually well-choreographed installation of an heir apparent (Thomas Reardon) reflected discontent within this once unified pressure group (130). A decision by the AMA in 1997 to enter into an exclusive trademark licensing agreement with Sunbeam Products, Inc., created turmoil within the organization over the relationship of business and professionalism and particularly disturbed the leadership because it became public: it caused "wrenching public adversity" and "horrendous and well publicized difficulty" (131–133).

The AMA's declining influence on national public policy was evident during the 1994 debate over health care reform—its submission at one early point was given no more time or weight than those of other labor unions and public interest groups. Through its political arm, the American Medical Political Action Committee (AMPAC), the AMA is obviously still a powerful professional interest group—it remains one of the highest-spending lobbying group in the United States (100). Its positions on major issues such as smoking, domestic violence, teen pregnancies, handguns, and the distorting influences of commercialism on medical care are consonant with a majority of public opinion. But the influence of the AMA does appear to have diminished; nowhere is this more evident than in its inability to withstand the movement toward managed care and the corrosive

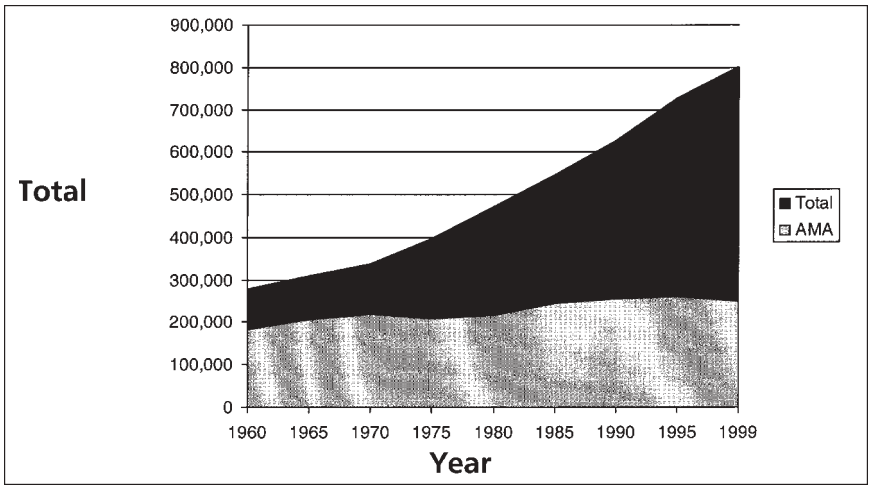

Figure 11. Physicians in the United States and membership in the AMA, 1960–1999. *Source:* AMA Physician Masterfile 2000.

effect of commercialism on professional behavior. Fragmentation of physicians into specialist societies and internal dissention within the AMA itself have created a divide-and-conquer opportunity for both private business interests and the state. Groups of physicians with particular specialty interests can be pitted against each other to achieve an outcome that is sometimes not in the overall or long-term interest of the profession.

CONCLUSION

We have argued in this article that late capitalist changes in the ownership and organization of U.S. health care are eroding the ethos of professionalism, reducing the social status of doctors, and transforming the nature of everyday medical work (doctoring). To underscore the historic magnitude of these changes, we draw parallels with the rise and fall of religious monasticism during the Middle Ages. In just 25 years, U.S. medical care has been transformed from a mainly fee-for-service system controlled by dominant professionals to a corporatized system dominated by increasingly concentrated and globalized financial and industrial interests. Present-day observers are, however, too close to late 20th and early 21st century changes in U.S. medical care to enjoy the vantage point of, say, a modern-day historian studying medieval monasticism. Recognizing the increasing threat to professionalism and doctoring, some commentators have recommended what may be termed intermediate solutions (e.g., more emphasis on a new professional ethic during an already overcrowded medical school curriculum,

interventions to increase patients' trust, unionization of discontented doctors, and even a patients' bill of rights). In the context of the global macroeconomic forces now transforming U.S. medical care, such proposals, while well intentioned, appear unfortunately naive.

Freidson (134) has recently made revisions to his earlier work on professional dominance. While recognizing profound changes, he continues to look *inside medicine* to understand the changing status of doctors (training, specialized knowledge, and "the soul of professionalism") rather than *outside medicine,* at more influential surrounding macroeconomic circumstances. He misinterprets and dismisses attempts to look at these latter factors as ideologically inspired attacks and simply shibboleths rather than efforts to understand the more fundamental reasons for the historical decline of doctoring.

We argue that the recent (late 20th century and early 21st century) erosion of professionalism and decline of the medical profession result from many different social influences—at least eight of varying importance are discussed in this article. For convenience we organized these into *extrinsic factors* (six of which appear to be outside the control of the profession) and *intrinsic factors* (two of which may be amenable to change by the medical profession itself). The major extrinsic factors are:

- The changing nature of the U.S. state (from pluralist to New Right) and loss of historically important institutional support for doctoring.
- The bureaucratization (corporatization) of doctoring and consequent loss of professional autonomy.
- The emerging competitive threat from other health care workers who provide an opportunity for profit-driven owners to replace doctors with appropriately trained workers at cheaper labor rates.
- Globalization and the information revolution, which are subordinating national and local medical societies, stripping doctors of their monopoly on medical knowledge, and permitting the monitoring of the minutest aspects of the doctor's everyday behavior.
- The epidemiologic transition (to palliative care and global health threats), changing concepts of the body (a well-maintained machine), and routinization of the doctor's charisma as an agent of life or death.
- Changes in the nature of the doctor-patient relationship and the erosion of patients' trust, which are corroding the esteem in which the profession is held.

Two intrinsic factors are:

- The weakening of physicians' labor market position through oversupply.
- The continuing fragmentation of the once powerful physicians' union (AMA) through specialty and subspecialty differentiation.

This article is *not* an attempt to assess the strengths and weaknesses of the competing theories of professionalism (dominance, corporatization, deprofessionalism). Its purpose, rather, is to describe the historic magnitude of the changes in the financing and organization of U.S. medical care and their implications for professionalism, the social position of doctors, and the everyday work of doctoring. Just as medieval monks were considered increasingly anachronistic and out of touch, hoping that macroeconomic secular changes in the surrounding society would pass them by, so too do some contemporary observers of medicine cling to the hope that things will eventually get better. With the golden age of medicine now almost behind us, doctors are huddling in their monasteries (hospitals and medical centers) powerlessly awaiting the next corporate onslaught. It is unlikely that the laity (the public) will rise up and save the church (hospital organizations) and the monks (the doctors). In other words, it is unlikely that any actions taken by the institution of medicine—health care organizations, the training and mobilization of doctors—or public protest will have any major effects, given the momentum already in motion. Our only hope probably lies in some form of government action (some fundamental reorganization of the health system to protect the profession and the public). Given the shift in the state's allegiance to the interests that are behind the recent changes in U.S. medical care, whose consequences for doctors we wish to mitigate, that unfortunately must be considered false hope.

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