Physician Discontent: Dissent or Co-optation in Response to Capitalist Initiatives?

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Abstract

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The medical profession in the U.S. has witnessed the erosion of its empowered status and professional dominance during the past quarter century. Structural changes in the health care industry, such as the inception of managed care programs, have subjected physicians to cost containment strategies and other forms of external accountability. Technological advances have enabled allied healthcare occupations to perform work that was previously the sole domain of physicians, and accessibility to medical information has resulted in better educated patients who are more likely to challenge the authority of physicians.

Physicians have responded to these initiatives in a number of ways. Some have traded in solo practices and joined large medical groups while others have joined the salaried ranks as employees of health maintenance organizations. Increasingly, medical professionals are returning to school to obtain advanced degrees in business and law. Yet others have looked to unionization to stem the loss of autonomy from regulatory forces and corporate profit objectives.

The question addressed in this paper is whether the rejoinders of medical professionals represent forms of dissent by active agents seeking to circumvent the subjugation of their professional dominance, or if these responses reflect a profession that has been coopted by the imperatives of capitalism.

I swear in the presence of the Almighty and before my family, my teachers and my peers that according to my ability and judgment I will keep this Oath and Stipulation:

To reckon all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart a knowledge of the art of medicine to others. I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient.

I will follow that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform act or omission with direct intent deliberately to end a human life. I will maintain the utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life.

With purity, holiness and beneficence I will practice my art. Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient.

 Whatever in connection with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not be spoken abroad, I will not divulge, reckoning that all such should be kept secret.

While I continue to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the art and science of medicine with the blessing of the Almighty and respected by my peers and society, but should I trespass and violate this Oath, may the reverse be my lot. (Hippocratic Oath, Modern Version)[i]

The medical profession has long enjoyed a position of privilege and status. Physicians are regarded by some in the sociological literature as an archetype for defining the essence of a profession (e.g., Friedson, 1970; 1980; 1993). Medicine has, however, experienced a shift in its dominant position in recent years. The reasons for this change have been the subject of considerable debate and speculation (Anderson, 1992; Hafferty and Light, 1995; Schlesinger, 2002; Scott, Ruef, Mendel and Caronna, 2000) as have the interpretive schema used to explain its current status (Derber, 1983; Derber, Schwartz and Magrass, 1990; Hafferty and Wolinksy, 1991; Haug, 1973; Light and Levine, 1988; McKinlay and Arches, 1985). Structural forces that encompass cultural, economic and political elements have been linked to assessments of a profession that is deprofessionalized (Haug, 1973; 1975), proletarianized (McKinlay and Arches, 1985) and corporatized (Montgomery, 1992; see also Light and Levine, 1988). Historical accounts, however, fashion an alternative view of medicine and the social position of physicians. They dismiss the notion of a golden era of medicine and the unfettered dominance

of the medical profession (Light and Levine, 1988; Starr, 1982). Viewed in a historical context, medicine is said to be experiencing the push of countervailing power by institutional purchasers of healthcare who have challenged the unrestrained expenditures of physicians through techniques of rationalization and who were themselves at one time the subject of struggle from physicians (Light, 1991).

Of particular interest in this essay are the actions engaged by physicians in response to structural changes in healthcare. Although much of the literature has explored what has happened *to* the medical profession in an effort to explain its current standing, less attention has been directed at understanding physician agency. Yet, in order to more fully appreciate the present day status of the medical profession, research must extend beyond macro level explanations by examining the micro politics of physicians as active agents (Hoff, 1999). The question explored in this paper concerns the nature of the initiatives engaged by physicians in the U.S. and whether the rejoinders of physicians represent forms of dissent that are intended to circumvent the subjugation of their professional dominance and restore the profession to its status of a quarter century past, or, if these responses reflect a profession that has been coopted by the imperatives of capitalism.

I begin with a description of some of the contextual changes in the U.S. in which doctors perform their work and follow this with the dialogue and debate that has predominated in the sociological literature on the status of medical professionals. Thereafter, I describe some of the mechanisms adopted by physicians during the last quarter century. The goal is to better inform our understanding of physicians as active agents, and to explore whether the adaptations in which they have engaged symbolize acts of resistance or acquiescence to the realities of capitalism and the corporate enterprise.

Changing Structural Context of Medical Work

The institutional structure of medical care throughout time has been fluid and variable, owing in large part to the state of the political economy. As organizational arrangements have undergone change from an era of domestic production to a predominately cottage industry in medicine, and more recently, bureaucratization into the post-industrial era, so too have observations of the professional standing of physicians. The current era of managed care has profoundly altered the nature of healthcare, giving rise to new systems of delivery, new actors, new organizational arrangements and questions about the social place of physicians within the healthcare environment. Starr's (1982) work on the social transformation of American medicine has been widely cited for tracing the evolution of medicine's journey from its pre-scientific roots and lowly status to its emergence as a profession legitimized by scientifically-based medical advances. He is credited with having envisaged correctly that healthcare would experience a transformation resulting from the rising influence of corporations and the insurgence of profit-making firms in the healthcare domain. He predicted that professional and voluntaristic ideals would be replaced with a market mentality and a corporate ethos, and that the independent conditions of work for medical practitioners would give way to the rationalization of medicine, and consequently, a waning autonomy for physicians.

During the past half century, the governance structure and the cultural framework of medicine have indeed witnessed a metamorphosis toward a market ideology in the U.S. The precursor which presaged the shift from the professional dominance of physicians during the first half of the 20th century to the ascendancy of a corporate ethos in medicine, however, was the state's decision to allocate public funds toward healthcare assistance for the elderly and indigent segments of the population (Scott et al., 2000; Starr, 1982). Beginning in the mid 1960's, the inception of government sponsored healthcare legislation in the form of Medicare for the elderly and Medicaid insurance for the destitute created an opportunity for state influence. Although governmental interest initially emphasized equity of access to healthcare for the

underprivileged segments of society, as the single largest purchaser of healthcare services, cost containment increasingly assumed prominence on the state's agenda and, in the process, paved the way to the demise of physicians' unfettered dominance. Physicians continued to prioritize the quality of patients' medical care as their foremost objective (Fennell and Alexander, 1993; Scott et al., 2000), and failed to preemptively address rising concerns about escalating healthcare expenditures as the government initiated prospective reimbursement systems. They took such forms as diagnosis related groups (DRG's), which aggregated patterns of treatment for similar health conditions and established payment structures on the basis of medical diagnoses instead of the type of treatment provided. Another was resource-based relative value scales, used to evaluate the costs and value associated with different medical procedures (Hafferty and Light, 1995). These initiatives were instrumental to the development of a belief system that medical care could be and should be subject to quantification and measurement. Moreover, they laid the foundation for additional performance and outcome-based measures of medical treatment such as the assessment of physician error rates and compliance with standardized treatment protocols.

State initiatives were supplanted by private sector involvement in healthcare signaled by the introduction of a mosaic of delivery systems along with additional third party payers of health services. Among the more consequential structural changes to have emerged is managed care. New organizational arrangements include health maintenance organizations (HMO's), which emphasize preventive medical practices, and preferred provider organizations (PPO's), which mediate the relationship between patients and physicians through contractual arrangements between doctors and healthcare entities. The stated benefit of such networks for the medical community is the assurance of a steady base of patients for physicians in exchange for a predetermined stream of income (Scott et al., 2000; Starr, 1982). However, they have also had the effect of altering the conditions under which physicians practice by closely monitoring physicians' treatment protocols and instituting reimbursement contingencies that require physicians to seek prior authorization by the managed care organization, thereby constricting the authority to which they were previously accustomed.

Some argue that more has been affected than merely the conditions of work; that the rationalization of medicine has insinuated itself into the technical core of medical work as well with the imposition of drug formularies and tighter time constraints with more patients scheduled into each work day (Hafferty and Light, 1995; Leicht and Fennell, 1997). For some physicians, such as those who practice in a staff model HMO, autonomy is lost as they enter the salaried ranks of full time employment. Physician report cards and other assessment tools have been instituted along with clinical practice guidelines that direct and evaluate the quality of medical treatment in order to reduce variability in treatment modalities. In other words, doctors have been subjected to a host of surveillance mechanisms to ensure that corporate financial and productivity objectives are realized.

Additional market influences observed with the intensification of healthcare privatization include the diminishment of free standing community hospitals which have given way to hospital chains and multisystem conglomerates through horizontal and vertical integration (Anderson, 1992; Hafferty and Light, 1995; Starr, 1982). Illustrative of this trend is the emergence of new organizational forms such as: home health care services, sports medicine clinics, ambulatory surgery centers, substance abuse centers, nursing homes, and psychiatric hospitals (Anderson, 1992). These new arrangements signal the appropriation of corporate influence in healthcare and over the context in which the medical profession performs its work.

External measures of accountability do not, however, arise solely from the corporate purchasers of healthcare. The sources of countervailing power include, for instance, providers of medical aids such as pharmaceuticals manufacturers, medical equipment suppliers, and ancillary healthcare providers such as chiropractors, physical therapists and nurse practitioners (Hafferty and Light, 1995). Organizations, as employers, have inserted themselves into the

healthcare arena with economically-motivated interests predicated upon their role as purchasers of healthcare for employees. Similarly, relationships between physicians and patients have changed, becoming more transaction-based and less trusting, as patients have grown accustomed to profiting from the ready accessibility of computer-based medical information to challenge medical judgments and hold physicians accountable for treatment outcomes (Anderson, 1992; Haug, 1973, 1975).

This brief review illustrates the incursions made by broad structural health care changes into the practice of medicine. It is intended to provide a backdrop to the ensuing debates among medical sociologists who have been keen to develop theoretical explanations of the consequences of these institutional shifts for the medical profession.and its status within the capitalist political economy.

The Professional Status of Physicians

The Hippocratic Oath offers a telling glimpse of how the social standing of physicians today is rooted in the ethics of Greek antiquity. The oath depicts medicine as a guild whose members were guided by the ideals of patient welfare, integrity, and the obligation to train new members. Modern day characterizations of the professions, and physicians in particular, recount similar ideals. As the most ardent proponent of the professional dominance thesis in medicine, Friedson (1970; 1980; 1993) points to several criteria as evidence of the continued dominance of the medical profession. Most fundamental is the autonomy that physicians have over their sphere of work. A profession is considered dominant to the extent that it is self-directed in carrying out its work rather than dependent for direction either by the open market or functionaries of the state. Its monopoly over specialized knowledge grants it the authority to define the entrance criteria to the profession. It is exclusively entitled to regulate, by means of peer mechanisms, the performance of its members and it is called ethically to ensure that members either maintain their competence or be removed from practice (Cruess, Johnston and Cruess, 2002). Moreover, a dominant profession is characterized by the authority to control the work of others. In the case of medicine, this implies the ability to direct allied health care occupations. Although self-direction is a necessary condition, it is an insufficient criterion upon which to establish professional dominance. This occurs when autonomy is conferred politically and economically from the public's recognition and acceptance of a profession's service ethic and moral code. Members of a profession are expected to guard the trust instilled in them by the public by subordinating personal interests to those of individual patients and society at large (Cruess et al., 2002). To the degree that a profession is capable of successfully manipulating public opinion so that altruism and service ideals remain intact, the profession will maintain its dominant stronghold (Wolinsky, 1993).

Numerous explanations of the status of physicians have been advanced that are in contraposition to the thesis of professional dominance. Each betrays the dismal sentiments of medical sociologists who have come to believe that medicine has lost its hegemonic position to the overreaching forces of capitalism. One of these is the deprofessionalization hypothesis which is defined as a loss among professional occupations of their unique qualities (Haug, 1973; 1975). Chief among these losses is a profession's monopoly over an esoteric body of knowledge that is otherwise not easily accessible to the public. The deprofessionalization perspective argues that the knowledge monopoly of physicians is being challenged on several fronts. For one, computer technology has made it possible to codify and retrieve information previously unavailable to the public. It is now possible to incorporate the rapidly growing findings from medical research into computerized databases, which are able to store, synthesize and recall massive amounts of information with ease. Computerization is able to manage emerging medical information more quickly and more accurately than is possible for the individual practitioner. There is, as well, an increasing sophistication among a better educated

public, one that is more willing to challenge the authority of physicians. Health information is readily available in various forms such as books, magazine articles, television segments and by computers, and is consumed by an inquisitive public. Moreover, the rise of allied healthcare occupations has provided the public with alternative outlets to the exclusive reliance upon physicians.

The proposition that medicine may be moving in the direction of deprofessionalization is also argued on the basis of its tarnished humanitarian image. The ethical credo, 'first, do no harm' has come under fire from a skeptical public who have questioned the altruistic ideals and trustworthiness of medical professionals. Physicians are being called to account for the increasing costs of healthcare services and are routinely confronted with malpractice lawsuits from a disaffected public (Haug, 1975). These trends, it is suggested, signal the loss of consumer confidence in the service commitment of physicians, and raise questions about the prevalence of their self-serving tendencies. Indeed, the logic of capitalism has been used to explain the drive to seek out new markets and to create a demand for services that some submit, reveals less a humanitarian concern and one driven more so by self-interest – the rising prevalence of cosmetic surgery being one noteworthy example (Light and Levine, 1988). If the proposition is correct that professional dominance may only be sustained so long as autonomy is conferred by an accepting public, then dominance will diminish when the public believes a commitment to service and the avowed promises made by the medical profession have been broken (Wolinsky, 1993). That the medical profession is aware of its tenuous position is reflected in the American Medical Association's campaign emphasizing physician stewardship, proposals for national health insurance, or, what have otherwise been described as attempts to manipulate public opinion (Wolinsky, 1993). Indeed, it is argued that the social consequences incurred by the deprofessionalization of medicine include ethical tensions among practitioners who are caught between competing objectives, the desire to provide technically competent patient care on the one hand, and the financial incentives generated by rationalizing practices that lead to shorter hospital stays with earlier discharges of sick patients and turning away the uninsured, on the other (Anderson, 1992).

McKinlay and his colleagues (1989; McKinlay and Arches, 1985; McKinlay and Marceau, 2002; McKinlay and Stoeckle, 1988; see also Chernomas, 1986) provide a counterpoint to the deprofessionalization hypothesis with an alternative interpretation of how rationalizing practices adopted in the health care sector have impacted medicine. They assert that the medical profession has moved toward proletarianization which they define as such, "the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism" (McKinlay and Arches, 1985, p. 161). They point to several trends in defense of their stance. One of these is the increasing dependence that professionals have on capitalists as the result of technology. As medical advances have become associated with sophisticated, technically-driven equipment, physicians have become reliant upon the corporate sector to purchase this new technology, and in the process have relinquished some of their power to shape production. Moreover, the growing specialization in medicine has been likened to the deskilling process experienced by 19th century craftsmen (Mckinlay and Arches, 1985; McKinlay and Stoeckle, 1988). As medical knowledge has expanded and physicians have apportioned information into discrete areas of specialization, it risks vulnerability to potential rationalizing practices incited jointly by bureaucratic structures and computerization. This creates the possibility of extracting surplus value while concurrently, dividing up the tasks among other actors such as allied healthcare occupations. Physicians may, therefore, become akin to 'technobureaucratic scientist-technicians' who, through computerization, may see their technical functions usurped, and thus, render their professional function unnecessary (McKinlay and Arches, 1985).

The prospects of physician proletarianization are said to be manifested also by physicians' increasing presence in bureaucratic organizations as salaried employees, where regulatory norms overtake the earlier socialization experiences and the ideals transmitted during medical training. As McKinlay and Arches (1985, p. 172) describe the process, "once physicians succumb to bureaucratization, they become enslaved to a process over which they have very little control and contribute, albeit indirectly, to an ideology and activity (exploitive capital accumulation) for which they may indeed have little sympathy". They assert that professionals in bureaucratic environments eventually develop a loyalty to the interests of the organization, in part, stemming from a desire to advance their personal self-interests, which cannot be achieved separate from the interests of the organization.

However compelling this assessment of the medical profession's present day status may be to some, it has nonetheless been challenged on several fronts. In brief, there are those who argue that the relationships between capitalists and professionals such as physicians cannot easily be explained within a classical Marxist framework and that a new and different theoretical category is necessary. Among the dissenters are those who prefer to view professions as members of a professional-managerial class (e.g., Ehrenreich and Ehrenreich,1976; Navarro, 1988) whereas others suggest that the relationship between capitalism and professionalism may be described as a form of sponsorship that refers to the ability of professionals to dissociate themselves from institutional goals while simultaneously adhering to the belief that controlling the techniques or means of work remains steadfast (Derber, 1983; Derber et al, 1990). This less constricted perspective of the relationship between medicine and capitalism – sponsorship - characterizes the social relations as one of offsetting interdependencies (Derber, 1983). Doctors, it is contended, are in a unique relationship to capitalists in that they enjoy a monopoly over specialized knowledge which may be used as a cultural and economic resource. The form of sponsorship that exists between the parties dictates the ensuing balance of power. Under a proprietary sponsorship, hospitals provide fixed capital for doctors via hospital beds and costly medical equipment, while physicians accept responsibility for marketing themselves and their services to (prospective) patients. Moreover, hospitals maintain a degree of dependence on physicians upon whom they rely for inpatient hospital admissions and other medical services. However, when relations are that of market sponsorship, such as that between a physician and a third party payer, the payer functions as a mediator between provider and patient/consumer. Under this arrangement, third parties (such as an HMO) may generate business for physicians by including them in their referral network. Relations of control and dependency, therefore, are a function of the form of sponsorship, hence, they preclude classifying social relations between medical professionals and capital interests as unidirectional.

The concept of a professional-managerial class, alternatively, theorizes the relationship between physicians and capitalists altogether differently (Ehrenreich and Ehrenreich, 1976). Those who are self-employed within solo- or small-group practices are characterized as petit bourgeoise in that, unlike the proletarian class, they are largely irrelevant to the process of capital accumulation. However, those who accept positions within a bureaucratic structure, such as physician administrators or medical directors, succumb to the ideological imperatives of rationalization and are prone to identify more closely with capitalist values instead of those of the medical profession. They are salaried workers who owe their allegiance to the capitalist enterprise, and who seek to reproduce capitalist social relations. Members of the professional-managerial class have elsewhere been described as the new elite, physician administrators who proclaim their allegiance to the institutional framework in which they are employed rather than the medical profession (Hafferty and Light, 1995; Montgomery, 1992). This assessment is particularly intriguing since those who have examined the developmental experiences of professionals such as physicians find that the intensity of the socialization process to which they are exposed instills an deeply rooted ideology of social welfare and concern for the individual patient as foremost, in contrast to the development of managerial identities, with interests that

emphasize institutional objectives and fiscal criteria, and which are not typically so firmly inclulcated (Golden, Dukerich and Fabian, 2000). Hence, it appears that the social identities of physicians who transition into managerialist roles shift away from their professional indoctrination and align with capitalist interests.

The discussion to this point has been concerned with describing the structural modifications made to health care in the U.S. under advanced capitalism and examining the sociological explanations that have attempted to make sense of how these changes have affected the social position of physicians. However, it remains that the conditions experienced by the medical profession are not wholly deterministic. Physicians are also subjective beings who engage with and act upon their objective conditions and should therefore be seen as active agents in relation to corporate and state practices (Hoff and MCCaffrey, 1996). What is not clear, though, is if the practices undertaken by physicians are better understood as forms of resistance and deliberate attempts to crush the encroachment of corporatization into their professional dominance, or, if they are better read as symbolic of a pervasive false consciousness.

Physician Agency

Much has been written about the moral contract with society to which physicians are bound in exchange for the autonomy they have been granted (e.g., Cruess and Cruess, 2000; Hernes, 2001; Sullivan, 2000). The consignment of autonomy and the trust which accompanies it require that professionals adhere to an ethos of altruism and service. Paradoxically, the asymmetrical relationship between physicians and patients presents a tension that economists refer to as the principal – agent problem. As agents for their patients, physicians, who possess the expertise to diagnose medical conditions, prescribe appropriate treatment and determine the monetary value of the services they render, are expected to act in the best interest of the patient. The market mentality meanwhile, creates temptations to insert personal interests into the exchange relationship (Hernes, 2001). That this tension is widely recognized, and that it has figured into the loss of faith and trust in medicine has not gone unnoticed by the profession or the state (Schlesinger, 2002). Evidence of the state's suspicions is manifested by a recent decision to extend a moratorium on the creation of physician-owned specialty hospitals due to concerns over potential conflicting interests (Pearlstein, 2005). This is, of course, merely one recent example of state efforts to curtail physician dominance in healthcare, other state and corporate initiatives having previously been discussed.

The profession of medicine, however, has also recognized both the shift in public sentiment and the effects of macro-structural forces on its elite status. Physicians have engaged in a myriad of actions intended to quell negative perceptions and to reassert their elite location. These efforts have occurred at a collective level involving the profession in the aggregate, and they have taken place also at the local level by individual practitioners.

Among the collective initiatives enacted by the medical profession is a public reassertion of its long standing ethical principles in the form of a document titled, "Charter on Medical Professionalism" (Sox, 2002). Said to be the product of joint efforts by several European and U.S. medical associations, the charter was conceived of frustration by physicians due to the accelerated pace of changes in health care delivery and concern over the universal endangerment of the medical profession (Blank et al., 2003; Miles, 2002). Its fundamental principles and commitments are analogous to the Hippocratic Oath, as they call for physicians to assert the primacy of patient welfare, patient autonomy and social justice, and to commit themselves to professional competence, scientific knowledge, patient confidentiality, and quality and access to care. The charter is neither a binding document nor a pledge that physicians are sworn to uphold. Hence, its value appears largely symbolic. Given its discourse of universality, the charter may be intended as a call to organize physicians into collective action to engage in a

countervailing response against the rationalizing forces of state and corporate tendencies. The prospect of such a feat does not appear likely, however, on several grounds. Most fundamentally, the experiences of physicians across national and continental divides are not universal. There are unique challenges faced by the medical profession in third world countries that are not encountered among industrialized nations, such as access to medical equipment and practice under oppressive political regimes. Moreover, subjective experiences of physicians within a nation's borders are heterogeneous. The changing demographic composition of practitioners in the U.S. exhibits signs of stratification within the ranks. The sentiments of older physicians who have been personally affected by the structural changes they have encountered during the course of their careers are likely different from those of new entrants to the profession who have only ever known a profession within the managed care environment (Hoff, 2001). In addition, physician administrators, those in the medical profession who cross over into managerial ranks do not necessarily share equivalent priorities with practitioners, in that they emphasize capitalist objectives of efficiency and fiscal responsibility first, and so are apt to experience the 'professional crisis' in medicine quite differently than their practitioner colleagues, many of whom report to them (Hafferty and Light, 1995; Hoff, 1999; Montgomery, 1992).

To be sure, the mobilization of collective interests among physicians is far from unprecedented. To wit, numerous professional associations and societies exist to represent the concerns of physicians. Some, such as the American Medical Association (AMA), seek to coalesce the objectives of all members of the profession. Others exist on behalf of the needs of specific medical subspecialties, examples being the American College of Surgeons, American Academy of Pediatrics, and American College of Cardiologists. The differentiation of professional associations on the basis of particularized interests also carries the seeds of fragmentation for the profession. Members are divided and segmented into narrow areas of specialization, which diminishes the possibilities for a unified voice. This is not meant to suggest that professional associations originated to engage in active protest. However, the decentralization of professional affiliations along the lines of medical specialization has narrowed the scope of power and potential political influence of medical professionals to shape a coordinated agenda. The AMA was at one time regarded as a formidable entity capable of lobbying successfully to shape proposed legislative reforms as they related to the system of healthcare, but has since lost much of its influence as its membership has dwindled and physicians have aligned with specialty associations instead (McKinlay and Marceau, 2002). And while many of the professional organizations to which physicians subscribe involve advocacy, the absence of support for a centralized entity appears to have diminished the influence of physicians as a profession. Instead, professional associations are splintered by opposing views on issues such as physician ownership of diagnostic facilities and work hour limits for residents (Hafferty and Light, 1995).

Although professional societies and associations are not considered unions in the legal sense of the term - since those who choose to affiliate do so more for expressive reasons than for instrumental objectives - they have nonetheless offered advantages similar to legally recognized unions (McKinlay and Arches, 1985),. For one, they have permitted individuals with common occupational interests and similar ideals to forge a united social identity and to satisfy the socio-emotional needs of individual members. Likewise, they provide their memberships with continuing education opportunities, which is necessary both for recertification and to maintain licensure, and they provide advocacy on issues that are similarly important to members. In light of the decline in the professional dominance of physicians, the benefits derived from decentralization by professional specialty seem rather hollow.

The collective interests of the profession have also been represented by the inception of legally sanctioned unions. Some physician unions, such as the Union of Amercian Physicians and Dentists, have been in place for approximately three decades (Budrys, 1997), while others

have more recently come into existence. The American Medical Association attempted to rejuvenate its power with the introduction of an association-sponsored union referred to as, 'Physicians for Responsible Negotiation' in 1999 (AMA, 2001). The rhetoric on its website referred to PRN as such:

> "Physicians for Responsible Negotiation (PRN) is a new breed of labor organization. PRN is a national negotiating organization for employed physicians and eligible medical residents aimed at giving you the collective voice you need to advocate aggressively for you and your patients in today's changing health care environment…. PRN is the only national, independent labor organization created specifically for physicians. PRN understands the shared values of the physician community and is committed to protecting medicine's high standards of ethics and professionalism. Physician who choose to join PRN agree not to strike or withhold essential medical services. PRN can restore the integrity of the patient-physician relationship. It can ensure the quality and integrity of patient care, reinforce physicians' historic role as patient advocate, and make it economically viable for physicians to practice quality medicine". [ii]

Physicians for Responsible Negotiation has since merged into a partnership with the Service Employees International Union (SEIU), a labor organization specializing in the interests of multiple health care occupations. At the time of the partnership, PRN reported a membership of 20,000; its affiliation with SEIU accompanied that of two other medical profession unions – the Committee of Interns and Residents and the Doctors Council. The former was founded in NYC to protest what medical residents in the New York City area perceived as exploitative working conditions. Today, it collectively bargains on behalf of a membership of 12,000 located in the Northeastern U.S., Washington, DC, and other locations, to establish contractually, limitations to residents' on-call schedules, maximum permissible work hours and other traditional bread and butter issues. [iii] The Doctors Council, by comparison, is comprised of salaried physicians, dentists and veterinarians who are employed by hospitals, private healthcare facilities, and other agencies.

At one time, the notion of unionization was perceived as antithetical to the very essence of professionalism (McKinlay and Arches, 1985). Sentiments have changed somewhat, however, not only among those in medicine and other healthcare occupations, but more broadly among white collar occupations where the rate of successful organizing efforts now surpasses that of blue collar occupations (McKinlay and Arches, 1985; Oppenheimer, 1975). Although self-employed physicians remain prohibited by law from affiliating with unions, the fact that increasing numbers of physicians do so supports the data documenting a trend toward salaried employment and away from self-employment among doctors in the current era (an estimated 40% of physicians are salaried employees, Hoff, 2001). That so many are willing to do so symbolizes the gravity felt by physicians of their diminishing status. Whether it signifies a profession that is attempting to circumvent the logic of capitalism is another question however. More likely, as McKinlay and colleagues (McKinlay and Arches, 1985; McKinlay and Marceau, 2000) have asserted, the ability to recognize the effects of corporatization are difficult in the absence of a historical lens since it has been both gradual and insidious. Hence, members of the medical profession have been slow to acknowledge the invidious threats to their elite status and attribute them to state-sponsored and corporate initiatives.

One additional collective response that has been enacted by physicians is the trend toward group practice settings. Approximately one third of licensed physicians in the U.S. work within a single – or multi-specialty group practice, a reported increase in excess of 350% since 1965 (Hoff, 2001). This tendency is motivated by several factors. One is the desire to enhance negotiating leverage with health care insurers and managed care providers, and to minimize

encroachment upon physicians' clinical autonomy and financial interests. Another is related to the ability to minimize the financial risks associated with medical practices by pooling resources to purchase malpractice insurance and medical equipment. Moreover, group practice arrangements afford an opportunity for some physicians to avoid the drudgery associated with the business elements of managing a practice and to focus on their core interest of practicing medicine. These efforts, while applicable to physicians on a smaller scale than unionization and professional association membership, may be perceived as local attempts to assert countervailing power against corporatization (Light, 1991).

The large scale collective actions engaged by medical professionals, as discussed here, whether in the form of public proclamations of the profession's values, or the efforts to mobilize the profession into unions, have heretofore been unsuccessful in swaying the socio-political environment away from the corporate agenda. And, the prospects of doing so are rather dismal. For one, the profession has been complicit in creating its current conditions through fragmentation from within according to specialized interests and by adapting to a medley of work arrangements (e.g., salaried doctors, physician administrators, group practitioners) that engender ideological differences. In addition, as the AMA has fallen out of favor with doctors, with many who align instead with specialty associations, its capacity to sway the actions of the state through intensive lobbying efforts has eroded. Hence, although the rejoinders of the medical profession as a collective appear to signify attempts at circumventing their lost dominance to bureaucratic and corporate hegemony, they have not been able to reverse the decline.

An understanding of how physicians have responded to their changing status is partial and incomplete without examining the localized practices of individual physicians (Hoff, 1999; 2003; Hoff and McCaffrey, 1996). Hoff has addressed this question by examining how physicians construct meaning and identity through their work arrangements. He found that among salaried physicians of an HMO, most had accepted their status as employees and rationalized their position by emphasizing the positive features of employee status such as the insularity from business pressures (Hoff, 2003). Although he asserts that the physicians do not perceive themselves as victims of deskilling, the description he presents in fact suggests a loss of autonomy over the conditions of work and a mindset characteristic of false consciousness among the practitioners. Further evidence of this assessment may be found in another study by Hoff (Hoff and McCaffrey, 1996) which was conducted with primary care physicians practicing within two distinct work arrangements. Acts of resistance were more apparent among self-employed physicians in solo and group practices than among the salaried physicians of a staff model HMO. Self-employed physicians were shown to resist the incursions made to their economic circumstances by actively negotiating with insurers over the terms of their contractual arrangements. They also devised methods to circumvent structural constraints by adopting creative methods of financing when medical procedures were denied by insurers. These active forms of adaptation were less evident among the salaried primary care doctors. Instead, they were more passive in their relations with their HMO employer, although they acknowledged experiencing tension by the mechanisms of control and surveillance to which they were subjected.

These findings underscore the complexity of the profession and reveal the importance of refraining from applying overly simplistic characterizations to the profession as a whole. Physicians may be considered as both active agents and passive dupes. Inasmuch as the nature of the work arrangement may be informative in explaining which physicians are prone to actively resist the tendencies toward exploitation and control by state and corporate imperatives and which ones are not, clearly, this does not establish how some doctors acquiesce to their circumstances ideologically.

One other endeavor appears to be gaining prominence among medical professionals, this being a tendency toward the pursuit of advanced degrees in areas such as business and

law. The popularity of integrated MD-MBA and MD-JD programs is evident from the number of universities that have introduced joint programs of study in recent years. An estimated 46 universities in the U.S. and Canada offer blended arrangements between their medical and business schools whereas 19 do so with their law schools. [iv] Yet other academic institutions provide advanced business degree programs custom tailored to licensed physicians in formats that are arranged to accommodate their clinical practice schedules. It is perhaps a safe assumption to suggest that the interest in these arrangements, particularly the pursuit of an advanced business degree, does not symbolize active resistance among physicians who wish to reverse the hegemonic influence of the corporate ethos under advanced capitalism. Rather, and more likely, it reflects the subservience of values associated with medicine as a profession to those of the business enterprise.

Conclusion

The medical profession has been subjected to sweeping structural changes during the second half of the 20th century and especially in the past three decades. These changes have derived from state-sponsored initiatives and they have been a product of corporate usurpation of the health care system. These structural incursions have been the impetus for spirited debates in the sociological literature among academics who have attempted to both explain and predict the impact of these macro forces on the status of the profession. There is no longer a question of whether the profession has lost its hegemonic position in healthcare. Although physicians as a profession may continue to enjoy privileges and status relative to other healthcare occupations, the dominant stronghold they possessed during the 1960's has weakened.

The question posed in this paper is how physicians have responded to their changing circumstances and whether their responses are indicative of a profession that has been actively resisting its diminished status and seeking to reassert its position of power and privilege, or, whether it is a profession that has been subjugated to the imperatives of capitalism and a corporate – bureaucratic ethos. The evidence presented does not offer a definitive assessment – as there are localized pockets of resistance practiced by individual physicians and collective efforts directed at broad change concurrent with and alongside ideological shifts that favor the imperatives of capitalism. It is fair to say, however, that medicine has neither demonstrated the capacity to reverse its fortunes nor shown a determined collective desire to do so. Should the medical profession wish to reestablish its dominance, it will be necessary to regain the lost trust of its patients with credible assertions of its foremost commitment to social welfare. It will also be necessary to once again generate the support of the state such that physicians are granted unfettered autonomy over both the conditions of their work and its technical core. Neither seems a likely possibility anytime soon.

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i **This is a modern version of the original Oath attributed to the Greek physician, Hippocrates. Other variants may be recited by physicians as they prepare to embark on the practice of medicine depending on the institution where the medical degree is earned. Some new medical graduates, for instance, recite the Prayer of Moses Maimonides, another historic document that is believed to have been written in 1793. The American Medical Association provides its members with a set of nine ethical principles that address physicians' obligations to their patients and public health. In 2001, the AMA Council on Ethical and Judicial**

Affairs developed a pledge titled, Declaration of Professional Responsibility: Medicine's Social Contract with Humanity.

ii This information was retrieved from the website of the American Medication Association in 2001. http://www.ama-assn.org/ama/pub/category/2554.html .

iii Information on the Committee of Interns and Residents may be located at www.cirseiu.org and Doctors Council information is located at www.doctorscouncil.com.

iv Information on universities which offer medical degrees in combination with other graduate programs is available from the Association of American Medical Colleges.