The Culture of Physician Autonomy; 1900 to the Present

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The physician of fifty years ago is barely recognizable today. Rural, autonomous, and isolated, he did everything from mending broken bones to pronouncing people dead. He was responsible for a well-circumscribed community, who came to him for all their medical needs, regardless of the hour.

Even though this physician was well on his way to extinction by the late 1940s, his image has shaped the profession's reaction to every outside attempt to influence the course of medicine. Historians have traditionally attributed doctors' zealous attacks on efforts to reform medicine to economic concerns. One noted medical writer commented, "The knowledge that public control will curtail the profession's fee privileges underlies organized medicine's position on health insurance and on every other controversial issue in the field."[1] A respected economist asserts that the American Medical Association (AMA) has an unstated goal of "maximizing the income of its members."[2] Some authors were less polite about their biases: the author of a well-respected history tracing the enactment of Medicare described the AMA's publication *AMA News* as "a weekly tabloid newspaper containing general medical information and Cadillac advertisements . . ."[3]

Economic motivations alone, however, cannot justify the ardor of organized medicine's opposition to healthcare reform efforts throughout this century. It is my contention that physicians have been motivated primarily by a desire to protect their professional autonomy, viewing reform as a threat to this autonomy. They have consistently maintained this vigilant defense of their professional sphere, *even when their political and economic interests would have dictated they act otherwise*.

The "Ideal" Physician[4]

In 1948, *Life Magazine* chronicled the professional life of Dr. Ernest Ceriani of Kremmling, a small rural community in Colorado. Dr. Ceriani was the only physician for 400 square miles. The article mentions no other doctors he consults with, except for a passing reference to an anonymous "Denver specialist." He was professionally alone, solely responsible for the health of Kremmling's 2,000 residents.

Dr. Ceriani handled all of Kremmling's medical needs, from feverish four-year-olds to industrial accidents. In the short period *Life* followed him, he diagnosed tonsillitis, amputated a gangrenous leg, treated heart disease, and repaired a dislocated elbow. (He developed the X-ray himself.)

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He dealt with no insurance companies; his patients presumably paid him directly for his services. The only "hospital bureaucracy" he faced was the nursing staff, who constantly scolded him for working too hard. Knowing the hopelessness of their admonitions, they kept a pot of coffee warm for him at all hours. As the article succinctly states, he was "his own boss."

Dr. Ceriani's practice demonstrates the major qualities of physician life during his era: autonomy, general medical knowledge (as opposed to specialty training), an unlimited time commitment to a well-defined community, and a sense of professional isolation. Over the next several decades, even as many of these qualities recede, their memory will dictate physicians' responses to outside forces attempting to influence the practice of medicine.

The Progressive Era (1912–1920)

Professional autonomy has been the highest ethic of the medical profession for much of the twentieth century. Though physicians' unyielding defense of their autonomy colors their response to many events,[5] no one issue captures this ethic more than medicine's opposition to health insurance. Doctors viewed insurance companies as threats to their autonomy, third parties coming between them and their patients. The least offensive form of insurance was indemnity, where a third party merely gave direct cash payments to the insured. The most ominous form was government-sponsored health insurance, with its threat of intrusive federal bureaucracies. It was this latter form of health insurance for which physicians reserved their most vehement attacks.

The only time doctors in this country did not actively oppose compulsory health insurance was during the Progressive Era. The first organization to advocate publicly for compulsory health insurance was the American Association for Labor Legislation (AALL), a society of liberal social scientists begun in 1906.[6] The AALL, after initial success in industrial safety legislation, turned its attention to health insurance in 1914. They proposed compulsory health insurance for industrial workers, to be paid for by contributions from employers, employees, and the state.[7]

The initial reaction of organized medicine was favorable, even enthusiastic. Dr. Frederick Green, the secretary of the AMA (which represented about half the nation's physicians in 1915), reported to the AALL that their plan, "is so entirely in line with our own that I want to be of every possible assistance."[8]

Undoubtedly, many physicians believed in the moral correctness of insuring industrial workers, who were at significantly more risk of becoming ill than the general population. An equally important reason that many physicians supported the measure, however, was simple pragmatism: health insurance resonated well with the prevailing Progressive dogma that government could improve the human condition by reforming the environment in which people lived. This sentiment became engrained in the national government with the election of President Wilson in 1912, who believed passionately in government's ability to play a positive force in people's lives. As early as 1906, a former president of the AMA declared that compulsory health insurance was inevitable.[9]

This sentiment only increased after the British health insurance system became law in 1913. Witnessing compulsory health insurance come to an English-speaking country with whom the United States had such close ties, doctors spoke of compulsory health insurance in this country as a *fait accompli*. One

physician told a gathered crowd of doctors in 1912 that, "we can either recognize the facts . . . or . . . blindly shut our eyes . . . and cry that it is unethical to attend people for a price that is within their means."[10]

Doctors also had economic reasons to support compulsory health insurance. As medicine became increasingly able to alleviate disease, it grew correspondingly more expensive. By 1915, 63% of people too sick to work did not go to a physician, largely because of cost.[11] Doctors increasingly worried about their incomes—the AMA reported in 1910 that only approximately 10% of physicians believed they were earning a comfortable living.[12] A system of compulsory health insurance, which would infuse new money from government and employers into the medical coffers, appealed greatly to them.

Their enthusiasm was bolstered by favorable reports from the British experience. Contrary to the fears of doctors in both countries, physician incomes actually increased after the British National Insurance Act became law; in some cases doctors actually doubled their earnings.[13] The specters of increased night calls and other abuses of the system also did not materialize.

Ironically, given this grand beginning, the United States came out of the Progressive Era without compulsory health insurance. Even more bewildering is that organized medicine, in the end, was implacably opposed to the measure. Perhaps physicians were swayed by the country's entry into World War I, which made any social reform seem of secondary importance; or the "Red Scare" of 1919, which effectively branded compulsory health insurance as socialist propaganda. Some urban doctors also feared their incomes would be restricted by government fee schedules.[14]

Rural doctors, however, who comprised the profession's largest proportion, held no strong opinion on the matter. A poll of state medical societies in 1916 showed that only nine of 32 societies polled had even discussed the issue, with only two societies taking a stance on its desirability.[15] Opposition to compulsory health insurance came almost exclusively from urban doctors.

This difference between rural and urban physicians at first glance seems puzzling. Shouldn't rural doctors, who made less money than their city counterparts, have been even more sympathetic to economic arguments? And rural doctors should have been equally prone to the "anti-Red" rhetoric of the day. The difference in their reactions reflects the difference in their concerns over professional autonomy.

Urban doctors had already witnessed encroachments into their professional lives. Hospitals, where a physician must succumb to policies and staffs outside his control, were becoming increasingly important participants in urban healthcare. By 1913, there were 5,000 hospitals in the United States, and they had progressed from almshouses for the poor to "center[s] of advanced medical practice and a primary instrument in the health care of all social classes."[16]

City governments were also becoming increasingly important actors in the medical sphere. City health departments, especially in New York, were rapidly evolving from institutions for disease prevention and referral of health problems to healthcare centers that administered vaccines and treated diseases. New York City established several health districts that employed physicians and other medical staff to care for a well-circumscribed city area.[17] Physicians viewed these developments with apprehension; they did not like the state crossing the line between prevention measures (i.e., sanitation) and the actual practice of medicine. Accordingly, one self-proclaimed spokesman for urban

general practitioners asked rhetorically if doctors were ready to become "cogs in the great medical machine," should compulsory health insurance come to this country.[18]

Rural practitioners, in contrast, probably felt few if any of these encroachments on their autonomy. Hospitals and specialists, even as late as Dr. Ceriani's time, were not the norm in rural America. In 1917, the average rural doctor: patient ratio was 1:991, and these patients were often spread over vast distances.[19] The life of a rural practitioner was hectic enough without worrying about peripheral matters such as health insurance. As Dr. Ceriani's wife described to the *Life* reporter:

> She has learned to accept all the problems of her husband's career except one. Even after four years of marriage, she is still unable to reconcile herself to the fact that his time is not his own. She . . . must see him at unpredictable intervals, on special occasions or simply fall asleep waiting for him to finish his work.[20]

Even as late as 1917, doctors "outside the major industrial centers" remained uninterested in the issue.[21]

The physicians most sympathetic to compulsory health insurance were doctors who belonged to organizations—hospitals, medical schools, and academia. (They were cynically referred to as "institution men" by rank-and-file physicians.)[22] One of the AALL's most influential members was the physician who expanded New York City's role in healthcare of which doctors were so leery. These doctors had essentially traded in their autonomy, preferring to work within organizations to achieve their professional goals.

Thus doctors could be categorized into three groups: rural, urban, and "institution men." Of the three groups, only the urban practitioners viewed their autonomy as both important and under fire from health insurance reform. The other two groups either were in favor of reform or had no comment. The various reasons why doctors opposed health insurance—economic, social, etc.—would have applied equally to all three groups. Only their differing view of physician autonomy distinguishes their varied response to the call for compulsory health insurance.

Despite their ultimate opposition to compulsory health insurance, organized medicine's initial response was pragmatic. Rather than reactively opposing the concept, doctors tried to work with the AALL to secure favorable terms for their profession. This pragmatism would prove to be short-lived; future efforts by reformers to enact health insurance would be met by increasingly rigid ideological positions on which organized medicine (most notably the AMA) would refuse to compromise, even in the face of public pressure and political inevitability.

The Great Depression (1929–1941)

After World War I and the resulting Red Scare of 1919, the drive for compulsory health insurance—and reform in general—abated. The issue did not dominate the country's thinking again until the Great Depression of the 1930s. With the Depression's economic upheaval reshaping public attitudes on all aspects of government's role in society, support for government involvement in healthcare was

overwhelming: 75% of Americans polled supported government assistance in the payment of medical bills in 1936, 1937, 1938, and 1942.[23]

Americans were speaking from their own personal economic plight—even historians sympathetic to organized medicine admit that "a large portion of the population . . . had incomes that left little . . . margin for meeting the expense of medical care."[24] The Depression affected doctors' livelihoods as well. The average net income of doctors in California, for example, fell from $6,700 in 1929 to $3,600 by 1933. In that same year, close to two-thirds of doctors' bills remained unpaid six months past due. Even as late as 1938, 68% of low-income and 24% of upper-income families put off seeing a doctor for economic reasons.[25]

Unmet medical need and overwhelmingly favorable public opinion, combined with doctors' tenuous incomes, should have been an ideal combination for expanded government involvement in healthcare. In 1934, the Roosevelt Administration convened a Committee on Economic Security to study, among other issues, health insurance.[26] President Roosevelt asked his Secretary of Labor, Frances Perkins, to investigate ways by which the federal government could assist paying the nation's medical bills.

The AMA's strong negative reaction, however, even to a discussion of general principles prevented Roosevelt from making the committee's report public, fearing the controversy would undermine the entire New Deal. The final Social Security Act of 1935 contains only a passing mention of healthcare, suggesting further study of the health insurance question.[27]

The AMA codified its opposition in its *Ten Principles for Medical Service*. Written in response to the expanding role of hospital insurance—and the resultant fear of insurance for doctors' services—it is essentially a declaration of professional autonomy. The document states that hospitals, "are but expansions of the equipment of the physician," that, "no third party must be permitted to come between the patient and his physician" and "the immediate cost [of medical service] should be borne by the patient if able to pay at the time. . . ."[28]

There is no mention of economic issues, especially intriguing for a document written by a financially challenged organization in the midst of the Depression. With doctors' incomes so precarious, infusions of government dollars should have been welcomed, or at least not actively opposed. Not only did the AMA resoundingly reject government initiatives for compulsory health insurance, it even admonished physicians against accepting government reimbursement for providing medical care *to the poor*, fearing the precedent it would set;[29] as an alleged advocacy organization for doctors, it urged them to swallow the cost of caring for impoverished Americans rather than risk endangering their professional autonomy.

This pattern of seeing government dollars as an allegory for loss of professional autonomy sometimes manifested itself in strange ways. The organization was "shocked" at the overly generous welfare appropriation for dependent children, seeing it, however myopically, as a harbinger for federal involvement in health insurance.[30] Government funding for medical research met with "unenthusiastic" quiescence for fear of restricting "medical freedom," though it is hard to understand how the average physician's autonomy would have been restricted.[31] The organization even opposed government funding for medical schools after World War II, despite the dire financial straits in which these institutions found themselves.[32]

The medical profession did not reject all outside involvement in healthcare; it was acceptable *provided* their autonomy was not impinged upon. The AMA, for

example, did not oppose increased government spending on medical facilities.[33] It also did not offer any significant opposition to indemnity insurance plans or plans that restricted their coverage to hospital costs (as opposed to medical insurance programs that covered physician services).[34] Even a medical insurance program where doctors themselves were in charge was a difficult pill for organized medicine to swallow: the AMA grudgingly acquiesced to the Blue Shield medical insurance program in the late 1930s, largely to circumvent the threat of more sweeping government programs.[35]

Their sworn enemy were the healthcare cooperatives, which for a set annual fee would provide medical care to all enrollees. The AMA viewed these plans as "unethical," as they turned physicians into employees rather than autonomous professionals. They also committed the sin of giving consumers a voice in how the organization was run; as distasteful as government interference, it seems, was meddling by the lay rabble.[36]

Medicine's opposition to cooperatives was intense, even ethically questionable. Doctors who belonged to health cooperatives were expelled from local medical societies, denied admitting privileges at hospitals, and threatened with license revocation.[37] The AMA's opposition was so vehement that the organization was convicted of antitrust violations in its attempt to undermine a health cooperative in Washington, D.C.[38]

Similar to the Progressive Era, rank-and-file physicians—who presumably sensed no threat to their professional autonomy—did not share the rigid views of the AMA. The AMA was troubled by a survey of 2,200 doctors in 1936 which showed that "a surprising number expressed approval of the adoption of compulsory health insurance." They also approved of government funding of medical education and public health services.[39] These doctors, who in 1916 had held no strong opinion concerning compulsory health insurance, had by 1936 embraced it as their economic salvation.

Again, this schism in views reflects the schism in doctors' working environments. The AMA, though representing approximately 65% of doctors during the 1930s, was run by a minority of its membership, the specialists.[40] Their practices, being urban and most likely connected with organizations (i.e., hospitals), were also the least autonomous. Already fearful of erosions into their professional autonomy, these doctors viewed government efforts in healthcare with the same skepticism their counterparts had 20 years before. As these physicians were also financially successful, the economic arguments that swayed rank-and-file members probably carried less weight with specialists. As one author succinctly observed: "Like men ashore urging self-reliance on their drowning companions, the wealthy doctors in the AMA were asking their poorer colleagues to hold the line against health insurance."[41]

Perhaps the most eloquent defense of their position was made by Morris Fishbein, the editor of the *Journal of the American Medical Association* (*JAMA*) and a prominent member of the AMA:

> [American doctors] see in the systems proposed the multiplication by hundreds of thousands of bureaucratic employees. They see them snooping into the intimacies of American family life, *coming between the doctor and his patient*, and waxing fat on the tax money extorted from wage earners and employers alike.[42]

Though there are other themes mentioned here, most notably the ubiquitous loathing of government bureaucrats, Dr. Fishbein's primary concern is the death of professional autonomy at the hands of federal bureaucratic hordes. Ironically, Dr. Ceriani, *Life*'s prototypical physician, probably favored the anathema his urban colleagues were fighting against in the name of *his* professional world.

Transitional Years (1945–1960)

By the late 1950s, the rural autonomous physician was largely a phenomenon of the past. Defining a "rural physician" as one working in a county with 10 or fewer total doctors, by 1959 only 3% of the nation's physicians could be described as rural practitioners. Only nine states could claim that greater than 15% of their doctors were rural, and in no state did rural physicians make up more than 35% of the total. In 14 states, less than 1% of doctors fit this description.[43]

World War II and the subsequent postwar social dislocation probably played an important role. A survey of physicians returning from the war showed that although 73% of doctors who received licensure between 1930 and 1936 planned to return to their former practices, over half the physicians who became licensed between 1937 and 1943 had decided to relocate. These younger physicians, when asked where they planned to move, restricted their choices to areas with, "adequate hospitals, diagnostic facilities, and . . . beginning subsidies."[44] These requirements, in post-war America, could only be met in urban centers.

Why were younger physicians so much more likely to settle elsewhere after the war? Perhaps younger physicians, who had not had adequate time to establish practices before being called up to serve, were not as tied to their communities as older physicians. Younger physicians would also have been more inclined to view relocation as an exciting adventure, especially after coming home from the war. Older physicians, in contrast, probably looked forward to returning to their established practices.

Physicians were also becoming increasingly specialized. By 1959, half of the nation's private physicians considered themselves specialists, a trend that would continue through the next several decades.[45,46] Again, World War II probably encouraged this trend. The armed forces favored doctors with specialty training, starting a trend that "threatened to inundate hospitals with demands for specialized residency training."[47]

Physicians were also increasingly working for organizations, resembling the "institution men" of the Progressive Era. By 1959, 65,500 of the nation's 227,000 practicing doctors (29%) worked for government medical services, for medical schools, or as employees in some other capacity.[48]

Thus several of the major qualities that represented Dr. Ceriani's medical culture were in decline as the country entered the 1960s. Physicians were no longer isolated practitioners who consulted specialists only on rare occasions. They were moving, actually stampeding, into the cities. They were specializing, restricting their medical ambits to certain body systems or parts. Finally, they were increasingly melding with organizations, sacrificing part of their autonomy in the process.

How far back does history echo? Even though Dr. Ceriani's practice was rapidly becoming an anachronism, organized medicine fought for the ideal—

the "golden age" of autonomy—with the religious zeal of a crusade. The whole process would culminate with the AMA's unyielding stance on Medicare, and the decline of medicine's societal clout that is still felt by doctors today.

Medicare (1960–1965)

Medicare was the first major defeat for organized medicine and the culture of autonomy. Enacted in 1965, it guaranteed every senior citizen government-sponsored health insurance irrespective of income or physical ailment. To its proponents, it was long overdue and a stepping stone to comprehensive national health insurance. To its detractors, most notably the AMA, it was a first blow to physician freedom with anticipated horrible consequences for doctors and the nation.

Our country has always been edgy about large government programs, and usually a great social crisis is needed to justify the largest ones. Congress passed Social Security during the Depression, for example, in part to usurp support for a more radical proposal that would have bankrupted the Treasury.[49] No similar historical circumstances existed for Medicare's inception. Though elderly Americans were badly in need of healthcare, this was a smoldering crisis, not an acute national ailment that can rally public support. The country was not in any significant economic or political danger from denying senior citizens affordable healthcare. And although the benefits to senior citizens were obvious, the nation as a whole did not have any immediate stake in Medicare.

Despite the historical improbability, however, health insurance for elderly Americans became the hot political issue of the 1960s. Although President Eisenhower remained adamantly opposed to any form of government-sponsored healthcare, public opinion in the country was accelerating rapidly in favor of the idea; as early as March 1960, Congressional mail was running in favor of medical insurance for the elderly by 30 to one.[50] Vice President Nixon, in fact, was so concerned for his party's survival in the upcoming presidential election that he tried to persuade President Eisenhower to accept some form of elderly health insurance. When Ike refused, Nixon replied that neither he nor any other Republican candidate, "could ignore sixteen million [elderly] people."[51]

The political heat stemmed from the real-life struggle of senior citizens. The elderly numbered over twelve million by 1952, or 8% of the population. These 8%, however, required a disproportionately large share of the country's medical care: elderly Americans were hospitalized twice as long and incapacitated by chronic illnesses five times as frequently as younger citizens.[52] This increased burden fell on the economic group least able to afford it: a report by the Social Security Administration in 1959 showed that four-fifths of elderly Americans had incomes of less than $2,000 per year. Furthermore, only 14% of married couples and only 9% of single elderly Americans had any of their health costs covered by insurance.[53]

As the 1960s progressed, momentum for Medicare continued to build. In the 1962 elections, no pro-Medicare member of Congress lost his seat, despite vigorous attempts by the AMA to back anti-Medicare candidates.[54] When Lyndon Johnson assumed the presidency in 1963, he immediately went on record as favoring Medicare, calling for action on "the dream of health care for the

elderly" during his first address to Congress.[55] The 1964 elections ushered in a pro-Medicare majority in both the Senate and the House of Representatives. Finally, polls during the period showed that two-thirds of American voters favored some form of guaranteed health insurance for the elderly.[56] With the President, Congress, and public solidly behind it, political observers of the day considered Medicare an inevitability.

The AMA, not surprisingly, viewed government sponsorship of elderly health insurance as anathema. As early as 1960, a Republican member of the House Ways & Means Committee (which has jurisdiction over health issues) remarked, "We might have been able to satisfy . . . Eisenhower . . . but . . . we knew those fellows out at AMA headquarters . . . wouldn't accept anything."[57]

In contrast to previous eras, this time rank-and-file physicians agreed with their leadership. A poll of private practitioners in 1961 found less than 20% favored elderly health insurance provided by the government.[58] The AMA inundated doctors' offices with literature, sent speakers to talk to community groups, organized letter-writing campaigns, and urged doctors to persuade their patients to vote against Medicare.[59] One overzealous physician actually threatened to stop caring for his patients if they voted for a pro-Medicare congressman.[60]

No issue, not even their patients' health, was more important to physicians than stopping Medicare. The Surgeon General's report on the hazards of cigarette smoke was released in January 1964. In the following month, the Federal Trade Commission ordered that cigarette packages carry a warning of smoking's possible health risks. The AMA, surprisingly, opposed the order, claiming that Americans were already aware of the dangers of smoking. In protesting the order, the AMA noted that "the economic lives of tobacco growers, processors, and merchants are entwined in the industry; . . . governments are the recipients of . . . millions of dollars of tax revenue."[61]

Why would the principal organization representing doctors take such a seemingly antihealth stance? Although a warning label might have prevented the ills of smoking, tobacco state congressmen were in key positions to thwart the Medicare effort, the greatest ill of all. A congressman from Kentucky, for example, was one of three Democrats opposed to Medicare on the important House Ways & Means Committee. One pro-Medicare congressman summed up the situation succinctly: "The AMA has made a deal with the tobacco industry . . . to get tobacco-state Congressmen to vote against Medicare."[62]

The conventional wisdom of the period held that organized medicine opposed Medicare for fear of physician incomes being curtailed by government fee schedules. Economic motivations alone, however, are hard pressed to explain this degree of vehemence and rigidity. The AMA was savvy enough politically to foresee the inevitability of Medicare. There were several moments in the debate when, had their principal motivation been the dollar, organized medicine could have capitulated and tried to negotiate the most favorable terms they could under the new program.[63] Instead, physicians maintained their bitter opposition to Medicare throughout the period; even as late as March 1965—three months before Medicare's enactment—only 38% of doctors favored the measure.[64]

It is even questionable if economic motives played any significant role among physicians. A survey of doctors taken in early 1966 showed only 12% believed they would earn less money under Medicare.[65] *JAMA*, the primary publication

of the AMA, contains no articles addressing the financial implications of Medicare for physicians in 1964 or 1965.[66] In fact, Medicare ultimately increased physician incomes, infusing government money into the healthcare system with little or no regulation of how physicians spent it.

Physicians viewed Medicare as an attack not on their wallets *but rather on their professional autonomy*. The argument was eloquently made by Dr. Donovan Ward, the president of the AMA during 1964 and 1965. In both of his presidential addresses to the House of Delegates (the AMA's governing body), he blasts Medicare as an affront to medicine's historic legacy:

> Now we are the trustees of our profession's noble heritage. We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind. I say [Medicare] ignores the lessons of history and the record of scientific progress which we and our forbears have written in *an atmosphere of freedom*.[67]

This is not a rational call to resist Medicare for fear of lost income. Indeed, Dr. Ward does not discuss economic concerns in either speech. He is issuing a call to arms to protect the physician culture of professional freedom, of autonomy. His entire speech continues in this same vein, likening the struggle against Medicare to a religious crusade.

By 1965, at the end of his tenure, Dr. Ward must acknowledge that government intervention in healthcare has become a reality on his watch. He concludes his final address:

> As St. Paul wrote to his son Timothy: 'I have fought a good fight. I have finished my course. I have kept the faith'.[68]

To what "faith" does Dr. Ward refer? He is acknowledging the legacy of physician autonomy, seeing Medicare as an invasion of the doctor's world. He echoes, in this sense, Dr. Fishbein several decades before who warned of medicine's demise at the hands of faceless government bureaucrats. Dr. Ward, and the organization he heads, looks back nostalgically to an era when no outside influence clouded the physician's role, no one meddled in doctors' livelihoods. He longs for Dr. Ceriani's world, a world gone but certainly not forgotten.

1970s and the Demise of Autonomy

Physician autonomy came under fire from a variety of directions in the 1970s. Financially, medicine was becoming an increasingly important part of the national economy. Per capita spending on healthcare jumped 136% from 1960 to 1970. As these costs escalated, government's share of the burden increased concomitantly: federal and state governmental expenditures on healthcare rose 20.8% annually from 1960 to 1970. As more money, especially publicly visible tax money, poured into the medical system, government officials became increasingly critical of doctors' medical decisions.[69]

Social movements of the 1970s also whittled away at physician autonomy. The women's movement viewed the medical establishment as paternalistic, and demanded an equal voice for women in medical decision-making.[70] Patient rights court cases, decided in the 1970s, made informed consent mandatory,

giving patients more control over their medical treatment. Similar movements sprang up for mentally ill patients, human clinical subjects, and disabled patients. None of these movements overtly challenged physician dominance; however, taken together they implied that doctors should not be the sole authority in medicine.[71]

Ironically, as physician autonomy was being challenged on so many fronts, organized medicine was becoming increasingly marginal. The seeds for this diminution are evident as far back as 1960. In that year, an AMA membership study revealed that although 75% of all private practice physicians were members, only 35% of all salaried physicians belonged to the organization.[72] Salaried physicians were more likely than physicians in private practice to be connected with larger organizations, either as clinicians or in a teaching, research, or administrative capacity. Like the "institution men" of the Progressive Era, they were probably not as interested in the autonomy-inspired goals of the AMA. "The goals of the AMA back then were to keep physicians in power in every way and to keep medicine from changing. And it wasn't a popular thing," says an academic pediatric neurologist who graduated from medical school in 1971.[73] The only difference was that unlike the Progressive Era, salaried physicians were an increasing segment of the profession.[74]

Perhaps even private physicians' zeal for professional autonomy was beginning to wane. The role of the hospital in medical care was increasing steadily: average annual hospital admissions per physician rose from 61.4 to 111.5 between 1940 and 1959. This trend forced physicians to share their decisionmaking authority with outside entities such as hospital boards, subspecialists, and insurance companies. As a *JAMA* article concluded in 1964, there was now "an *interdependency* among patient, physician, hospital, and other third parties."[75]

Despite these changes in physician character, the message of the AMA remained one of unflagging commitment to professional autonomy. Dr. Russell Roth, president of the AMA in 1971, strikes historical chords very similar to Dr. Ward during the Medicare debate and to Dr. Fishbein during the Depression:

> many physicians feel that if our fundamental ethical principles are to prevail, we must fight for the preservation of the system which maintains the physician as a responsible professional rather than as a hired technician.[76]

These words reflected the beliefs of the AMA membership: AMA members were more likely to disapprove of autonomy-related issues such as group practice, peer review, and physician extenders (i.e., nurse practitioners) than were nonmembers.[77,78] Surrounded by change, the organization stayed its historical ground. It remained the voice of professional autonomy.

In 1971, AMA membership—for the first time since early in the century—dropped to 50% of practicing physicians. The doctors choosing not to join were primarily the younger ones.[79] This trend was consistent, even controlling for type of practice (salaried versus private), main professional activity, and socioeconomic background.[80] Younger physicians—solely by virtue of their age—were not as interested in the AMA's stewardship as were their older colleagues.

What was different about these physicians? Younger doctors, when compared to their older counterparts, *were not as ideologically committed to professional autonomy*. A 1973 study of physicians found that 55% of doctors under 35 years of age were in favor of peer review, where doctors submit their practice

of medicine to the scrutiny of their colleagues. Older doctors were progressively less inclined to allow even fellow physicians to invade their autonomy: only 20% of physicians over 65 favored such a measure. The study found a similar trend for other autonomy-related issues such as the delegation of traditional physician tasks to other medical professionals (i.e., nurse practitioners, physician assistants) and the desirability of group practice.[81]

The study concluded that these differences were a true *generational* divide, not explained by differing stages of doctors' respective careers.[82] For example, in 1955 29% of physicians under the age of 39 felt solo practice was the most desirable career; by 1973, that proportion had dropped to 6%.[83] In other words, younger doctors believed differently because their views had been shaped by experiences other than those that had guided the profession in the past. The goals of the AMA did not appeal to them in the way they had motivated their predecessors. These younger doctors, forced to work increasingly with larger organizations, were less dogmatic, and the zealotry of the AMA must have sounded hollow, even anachronistic, to them.[84]

For decades, physicians had engrained in each new class the importance of professional autonomy. What happened in the 1970s that broke the chain? How did the message become garbled? Almost three decades after *Life* interviewed him, Dr. Ceriani's world was long forgotten. Modern doctors, trained in large urban teaching centers, were coming of age in an era of insurance companies, Medicare, and organizations. These young physicians, without their elders' historical baggage, adapted to the new medical culture, sacrificing the profession's legacy of autonomy in the process.

Young doctors today are even less concerned with their professional autonomy.[85] Recently, a first-year medical student succinctly expressed his generation's position:

> It's like when people say baseball isn't what it used to be, now that there are three divisions instead of two. That may be true. But this is the only game we know.[86]

Epilogue: Implications for the Future

Though the legacy of professional autonomy is dim, echoes of it remain even today. A veteran state legislator recently described her confrontation with the doctors in her state when she attempted to draft legislation requiring surgeons to inform patients of lumpectomy as an option in the treatment of breast cancer.[87] She met with fierce opposition from the state medical society:

> I was a naive first-term legislator with what I thought was a simple, straightforward bill which only required doctors to hand patients a brochure explaining all the options. . . . In spite of the fact that doctors were not required to favor any of the options, the entire medical community exploded. *Who was I to tell them what to tell their patients*?[88]

Even a flimsy pamphlet remains a strong enough fuse to ignite doctors' defense of their autonomy.

The ideological rigidity with which physicians have defended the ethic of autonomy precluded them from participating in the national debate on healthcare reform; participation implies capitulation, which would ultimately lead to

the takeover of medicine by outside interests, by nondoctors. The 1970s and 1980s saw the replacement of physician leadership by a corporate structure that today seems permanently engrained in the medical landscape. Physicians increasingly work for hospital networks, managed care organizations, and university centers. Almost 80 years after they first voiced concern during the Progressive Era, doctors have become "cogs in the great medical machine" rather than leaders of it. Insurance companies dictate the course of medicine today, with doctors increasingly relegated to spectator-status.

Perhaps nowhere was this diminution of physician authority over the course of medicine more evident than during President Clinton's first term. Hillary Clinton assembled a panel of healthcare experts to debate the course of healthcare reform. When it came to including doctors, however, the consensus of the Clinton Administration was that organized medicine represented an "interest group," and thus was denied a seat on the panel. The AMA's societal clout was at an all-time low; the organization even agreed with the White House's assessment of their status.[89]

It was a curious spectacle—the deliberate exclusion from the healthcare reform process of the profession most intimately familiar with the healthcare system. After decades of refusing to participate in constructive dialogue, reformers have come to view organized medicine as a reactive naysayer, rather than a partner in healthcare reform. The public evidently has accepted this role for the medical profession, as there was no significant outcry at the exclusion of doctors from the panel.

There are, however, hopeful signs for the future. Doctors coming of age today, unhampered by the ideological legacy of past generations, are increasingly willing participants in the healthcare system. Physicians are forming their own organizations to negotiate with managed care organizations; in some cases they are circumventing insurance companies altogether and offering their own plans to employers directly.[90]

The current president of a physician-owned medical group values his autonomy much as physician leaders of the past did:

> I think ultimately only physician-driven groups . . . are going to succeed. Really, the physician is the only one who has to communicate with the patient, do the right thing, and be responsible. All the other entities out there are simply capital [and] tool providers [assisting the physician.][91]

However, acknowledging the realities of medicine today, he realizes he must interact with the healthcare system, rather than reactively oppose it:

> Right now the insurance companies have the hammer. But as [doctors] consolidate, whether it's presciently or [by force], they're going to wake up in 3 or 4 years and . . . it won't be as easy to pick us off.[92]

Working *within* the system, modern doctors are attempting to recapture their professional autonomy. The irony is that these doctors, who in earlier decades would have been denounced as heretics, will probably attain greater professional freedom than their more zealous predecessors. In the end, this will prove promising for medicine, as the professionals most familiar with the healthcare system return to a position of influence in its administration.

Notes

1. Harris R. *A Sacred Trust*. New York: New American Library, Inc., 1966:16.
2. Colombotos J, et al. *Physicians and Social Change*. New York: Oxford University Press, 1986:21.
3. See note 1, Harris 1966:124.
4. Smith WE. Country doctor. *Life* 1948; September 20:115–25.
5. Richard Carter, for example, in his book *The Gentle Legions*, describes physician indifference—and occasional hostility—to the rise of volunteer lay health associations (i.e., the March of Dimes). Physicians "had never . . . accepted laymen as equals in voluntary warfare against disease . . . [and believed] . . . the role of the lay volunteer was merely to do the physician's bidding." Carter R. *The Gentle Legions*. Garden City, NY: Doubleday, 1961.
6. Numbers RL. *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912–1920*. Baltimore: The Johns Hopkins University Press, 1978:15.
7. See note 6, Numbers 1978:25.
8. See note 6, Numbers 1978:34.
9. See note 6, Numbers 1978:30.
10. See note 6, Numbers 1978:31.
11. See note 6, Numbers 1978:2.
12. See note 6, Numbers 1978:9.
13. See note 6, Numbers 1978:32.
14. See note 6, Numbers 1978:89.
15. See note 6, Numbers 1978:50, 51.
16. See note 6, Numbers 1978:5.
17. See note 6, Numbers 1978:8, 9.
18. See note 6, Numbers 1978:43.
19. See note 6, Numbers 1978:4.
20. See note 4, Smith 1948:124.
21. See note 6, Numbers 1978:73, 74. Illinois physicians, for example, devoted "more energy to combating compulsory health insurance than the doctors of [almost] any other state . . ." Yet when the state's county societies were polled on the subject of compulsory health insurance, only 17 of 101 bothered to respond.
22. See note 6, Numbers 1978:57.
23. Starr P. *The Social Transformation of American Medicine*. New York: Harper Collins, 1982:278.
24. Burrow J. *AMA: Voice of American Medicine*. Baltimore: The Johns Hopkins University Press, 1963:212.
25. See note 23, Starr 1982:270.
26. See note 23, Starr 1982:267.
27. See note 23, Starr 1982:269.
28. See note 23, Starr 1982:299, 300.
29. See note 23, Starr 1982:271. The AMA Judicial Council warned in 1934: "One of the strongest holds of the profession on public . . . support has been the . . . ideal of medical service to all, whether able to pay or not. . . . The abandonment of that ideal and the adoption of a principle of service only when paid for would be the greatest step toward socialized medicine . . . which the medical profession could take."
30. See note 24, Burrow 1963:197, 198.
31. See note 24, Burrow 1963:323.
32. See note 24, Burrow 1963:319–22.
33. See note 24, Burrow 1963:194.
34. See note 23, Starr 1982:299. See also note 24, Burrow 1963:218.
35. See note 23, Starr 1982:308.
36. See note 23, Starr 1982:302, 303.
37. See note 23, Starr 1982:303.
38. See note 23, Starr 1982:305.
39. See note 24, Burrow 1963:200, 201.
40. See note 23, Starr 1982:273.
41. See note 23, Starr 1982:271.
42. See note 24, Burrow 1963:203 (emphasis added).
43. American Medical Association. *Distribution and Characteristics of Physicians in the United States*. Chicago: American Medical Association, 1959. Adding up the total number of doctors in counties that have 10 or fewer and then dividing by the total for each state gives individual state

percentages of "rural" physicians. The average state percentage of rural doctors was 7.7%. The highest percentage was S. Dakota, where 168 of 480 doctors (35%) worked in rural locales.
44. See note 24, Burrow 1963:303, 304.
45. See note 43, American Medical Association 1959:3, 4.
46. American Medical Association. *Distribution and Characteristics of Physicians in the United States*. Chicago: American Medical Association, 1972. By 1971, of the nation's approximately 290,000 physicians, 232,000 (81%) would specialize.
47. See note 24, Burrow, 1963:308.
48. See note 43, American Medical Association 1959:3, 4. Of the 227,000 active physicians in the United States, 40,000 worked full time in nonfederal hospitals, 8,000 were involved in teaching or administration, and 17,500 worked for government-related medical services.
49. See note 23, Starr 1982:266, 267.
50. See note 1, Harris 1966:103.
51. See note 1, Harris 1966:102.
52. See note 1, Harris 1966:62.
53. See note 1, Harris 1966:89.
54. See note 1, Harris 1966:149.
55. See note 1, Harris 1966:157.
56. See note 1, Harris 1966:178.
57. See note 1, Harris 1966:102, 103.
58. See note 2, Colombotos 1986:134 (endnote).
59. Marmor T. *The Politics of Medicare*. Chicago: Aldine Publishing Company, 1970:49, 50.
60. See note 1, Harris 1966:151.
61. See note 1, Harris 1966:159, 160. The AMA's opposition to this health initiative prompted one Senator to respond, "I find myself growing somewhat apprehensive about the concern of the AMA for the economic well-being of the tobacco industry rather than the physical well-being of smokers."
62. See note 1, Harris 1966:160.
63. See note 1, Harris 1966:180. The only constructive attempt on the part of the AMA to affect the course of elderly health insurance was "Eldercare," a proposal whereby states would help pay insurance premiums for senior citizens based on income. The proposal was introduced late in the course of debate and was never given much attention on Capitol Hill; one congressman went as far as to call the proposal "nonsense."
64. See note 2, Colombotos 1986:143.
65. See note 2, Colombotos 1986:145.
66. There is one article describing the British National Health Service that comments on the relatively lower incomes of British physicians as compared to their American counterparts. The author, however, at no point draws any analogies to the Medicare debate.
67. Ward MD, Donovan F. President's Address to the House of Delegates. *JAMA* 1964;190:110 (emphasis added).
68. Ward MD, Donovan F. Remarks of the President. *JAMA* 1965;193:113.
69. See note 23, Starr 1982:384.
70. See note 23, Starr 1982:391.
71. See note 23, Starr 1982:389. Starr notes that "few other developments so well illustrate the decline of professional sovereignty in the 1970s as the increased tendency of the courts to view the doctor-patient relationship as a partnership in decision making rather than a doctors' monopoly."
72. American Medical Association Council on Medical Service. Physician-hospital relations. *JAMA* 1964;190:75.
73. Personal interview with S. Coker, MD. 11 February 1996.
74. See note 72, AMA Council on Medical Service 1964:75. The authors note that the number of salaried physicians had "probably doubled in the past three decades . . . nearly one in every sixteen physicians receive full- or part-time hospital salaries."
75. See note 72, AMA Council on Medical Service 1964:76 (emphasis added).
76. Roth MD, Russell B. Medicine's ethical responsibilities. *JAMA* 1971;215:1958.
77. See note 2, Colombotos 1986:173 (Table). All comparisons are significant at the $p = 0.01$ level.
78. Asked whether the government should mandate the use of a clearly superior drug, an AMA member of the 1970s said, "We didn't get to be the best medical care in the world by having the government mandate [the practice of medicine]." Personal interview with J. Raettig, MD. 22 February 1996.

79. See note 23, Starr 1982:398.
80. See note 2, Colombotos 1986:169.
81. See note 2, Colombotos 1986:123 (Table). Pearson's *r* coefficients for these questions were 0.2, 0.2, and 0.17 respectively.
82. See note 2, Colombotos 1986:127.
83. See note 2, Colombotos 1986:128 (Table).
84. "Some of the words and thoughts that strike fear into the older physicians [are] a fact of life for the younger physicians—words like HMO, capitation, managed care. When you're used to acting in one way for 25 years, it's hard to accept change. In newer physicians, it's a fact of life." Personal interview with James Dan, MD. President, Mid-America Medical Group, Chicago, Illinois, 7 May 1997.
85. Older doctors are concerned about this trend. "There's a lot more bureaucracy in medicine [today]. People are willing to put in their forty hours a week and go home. I don't think there's a work ethic. . . . It's kind of like a job. It's no longer a profession." Personal interview with J. Raettig, MD. 22 February 1996.
86. Rosenthal E. HMOs, lower wages don't deter would-be doctors. *Denver Post* 1995; October 15:17A. Robert Pratt, a first-year medical student at Columbia College of Physicians and Surgeons, is the medical student quoted. The article also notes that "in dozens of interviews across the country . . . medical students say they do not share their colleagues' nostalgia for a world where doctors reigned supreme, a world of small practices and big incomes, a world they view as history."
87. A lumpectomy is a surgical procedure that removes only part of a woman's breast that is cancerous, sparing the rest of the breast tissue.
88. Berman M. *The Only Boobs in the House Are Men*. Troy, Mich.: Momentum Books, 1994:9 (emphasis added).
89. Cawley J. AMA not miffed over health panel. *Chicago Tribune* 1993; March 5:14. An AMA spokesperson said of the decision: "We haven't asked for a seat at the table. . . . We understand they're not giving special interests a seat on the task force."
90. Church G. Backlash against HMOs: doctors, patients, unions, legislators are fed up and say they won't take it anymore. *Time* 1997; April 14:32–9.
91. See note 84, Dan interview 1997.
92. See note 84, Dan interview 1997.

Commentary

Allen I. Goldberg

No political, economic, or cultural segment of society has escaped the universal impact of recent cataclysmic change. Physicians were no exception. During the 20th century, *all* members of society, including physicians, have experienced change of enormous speed and magnitude. Futurist Alvin Toffler noted that global societal transformation has created a "future shock" of personal malaise that poses difficulty for both individual and group adaptation.[1] Toffler further described current change as a fundamental shift and conflict in *all* aspects of civilization (how we live, work, and relate to each other).[2] Toffler also noted major alterations in the basis for distribution of societal power (who controls what, why, and how).[3] One manifestation of recent change directly affecting all members of society, *including physicians*, has been the social transformation of medicine that has been a power shift from the individual physicians to control by organizations and management.[4]

Dr. Pont's brilliant essay provides a chronicle and analysis of change faced by physicians during the current century. He has defended his thesis, that physicians value autonomy over all other considerations, including even

economic self-interest, with well-documented supportive evidence during multiple eras this century, defined by social issues (Progressive Era), economic events (the Depression), and political activity (Medicare), each of which have affected healthcare public policy, health system organization, and healthcare finance. He has carefully made the distinction between perspectives of physicians who differ in geographic location (rural/urban), practice setting and type (generalist/specialist, solo/group, office-based/institutional), and preference for "organized medicine" (AMA/non-AMA). Despite these distinctions, Dr. Pont describes physician autonomy as an enduring "culture," thriving across dimensions of time and changing social values.

Culture affects every individual, group, and organization in society, *including physicians*. Cultural determinants reflect history and tradition, while cultural expectations are forged by group/peer education and individual/group/organizational learning and living experiences. Culture provides physicians with core values, shared beliefs, common attitudes, and accepted norms of behavior. These cultural elements must be acknowledged *by physicians* and understood by others if members of our society are to work together and integrate all participants, including physicians, into the fabric of social transformation expected to continue at a rapid pace into the new millennium.

Autonomy represents a core cultural value, as well as a fundamental ethical principle that drives physicians as well as their patients. Dr. Pont has defended physician autonomy as a cultural driver of behavior during the early 20th century when *individual autonomy* was a reason to become a doctor and an expectation of what it would be like to practice medicine. He has also described how physician autonomy survived more recently in the 20th century with *group autonomy* as a determinant of current trends in physician practice type and organization. If physicians so strongly value their autonomy, we may need to ask why. If there is no "third party" (insurance company, managed care organization, governmental agency, corporate management) that gets between physicians and their patients, physicians have more freedom to make decisions that they believe will do good for their patients that they can justify by their knowledge and experience. Physicians might also value autonomy to be "in control" of the patient–physician relationship, whence they believe that physicians are best fit to determine "medical necessity."

Individuals become physicians for different reasons at different times in history, influenced by mythology, tradition, experience, and learning *before* formal medical education.[5,6] Physicians enter professional education affected in some degree by fundamental ethical principles that include *autonomy* (desire to make decisions and take actions justified by informed expert opinion based upon education and extensive experience). Admission interviews of new entrants into the medical profession and actions of experienced veterans both provide evidence that physicians are affected by other essential ethical principles as well. These include *beneficence* (desire to make judgments and take actions that will do good for individual patients) and *social justice/equity* (desire to affect social policy and practice that will do good for the community health, the natural environment, and universal humankind). Dr. Pont has provided excellent documentation of these ethical drivers; recent examples include physicians' groups for social responsibility such as health reform/policy, gun control, nuclear ban, and abolition of land mines.

While in medical school, residency training, and early practice, the developing physician becomes strongly influenced by "the medical culture" and integrates cultural elements (attitudes, beliefs, values, norms of behavior) that are mutually understood to facilitate functional activities among peers. However, physicians may also reflect "subcultures" that also exist within "the medical culture" (e.g., physicians versus surgeons). These "subcultures" can lead to cultural misunderstandings and conflicts that limit peer functionality. In a similar way, cultural conflicts can exist among those educated, trained, and experienced in other cultures (e.g., medical versus management), which can limit the functional interdependence and synergistic teamwork needed to adapt to changing environmental realities. *Awareness of the impact of culture is critical for physicians and others if they are to work together and be integrated with all essential participants involved with change processes currently underway*. It is only by such integration that physicians can influence future societal transformation that will recognize and support their core values and ethical principles, rather than being affected and limited by the values and principles of others that will be imposed upon them.

If physicians are to regain autonomy and their *essential* role in health system evolution, they will have to evaluate trends, predict future change, and proactively adapt. Guild mentality and behavior matched societal norms during the transition from an agrarian to an industrial society during the early industrial revolution, but our modern, postindustrial, information age civilization will require physicians to think and act in new ways. Dr. Pont gives us a sense of such adaptation in his "Epilogue and Implications for the Future" with his physician interview and evidence of newer physician-designed organizations (group practice, physician-directed managed care). "Power shifts" today require political resources, economic wealth, and/or control of information. To position themselves for a future scenario whereby they "regain control," physicians must make projections based on current universal trends and provide leadership with effective skills in culture and change management.

Several trends must be considered by physicians in order to determine a future vision in which they might retain their autonomy AND play a visionary/servant leadership role:

1) *Healthcare Organization (Integrated Health Networks)*
   Healthcare will continue to be a "local business" with more direct community involvement. Healthcare will be organized as integrated health systems across the entire care continuum (acute, subacute, long-term) in a variety of institutional settings (hospitals, subacute and long-term care facilities). Healthcare entities will network with other community-based organizations meeting social, educational, and other health-related needs to achieve individual, family, and community health. Working together synergistically, organizations can provide more comprehensive shared services with cost and operational efficiencies that leverage restricted revenues from increasingly constrained budgets. Such networks will require executive leadership provided by local physicians committed to serving their communities.
2) *Healthcare Finance (Global Health and Social Budgets)*
   Healthcare will continue to be financed by contractual arrangements, with a variety of ap-

proaches including discounted payment for targeted and/or comprehensive services, partial to full capitation, and global health and social budgets. The growth of public and private healthcare financial obligations will require a limit in the incremental and universal growth of healthcare expenditures. In the United States, the Balanced Budget Act of 1997 will have a huge constraining impact on healthcare organizations and physician practices. Statutory, regulatory, and/or contractual financial arrangements will require new ways for physicians to think, act, and organize their services since they will be paid by their achieving certain health outcomes and well-being of patients and populations, not by what they do or how they do it. Physicians in leadership must be involved in designing, implementing, and evaluating these financial arrangements to assure they provide access, enhance quality, and manage cost.

3) *Health Systems Management (Integrated Information Networks)*
Community health networks will be managed with integrated information systems that will provide all users (providers, managers, funders, and consumers) with information they require to make decisions and take actions. All users will be empowered with information that will facilitate clinical diagnosis, and management as well as system administration and control. Informed interaction will become easier for all end-users—doctors, administrators, payers, patients and families. This will encourage more patient/provider/payer partnerships in system planning and individual care management. Physicians will be essential collaborators as servant leaders who share community health visions with other members. Physician executives must be involved with the leadership and management of these community information networks.
4) *Applications of Medical and Telecommunication Technologies*
Health will be promoted in multiple sites, including the home and other community-based settings as well as traditional facilities (hospitals, nursing homes). Medical devices will continue to be adapted and developed that can be safely applied by physicians and used by patients wherever they are dependent on medical necessity and preference. Interactive telecommunication will provide text, data, audio, video, and image transmission that will make it easier for physicians to make diagnoses and modify clinical treatment in care settings where the impact of the environment on health will be considered/evaluated. Physicians will be using telephone, cable, and internet technologies for communication for both patient care management and continuous professional learning. It will become easier to take care of patients and obtain essential information wherever the physician and patient may be. Physicians must help design these telecommunication systems that will provide them information as essential participants.
5) *Power and Influence of Informed Consumers (Consumer Choice/Preference)*
Healthcare consumers (direct users, such as patients, families, self-employed small businesses) and others who pay for health plans used by others (employ-

ers, labor unions) will become more informed decisionmakers. Patient and family choice will become more prominent as more of the burden of the cost of care is shifted to them (by self-pay, higher deductibles, increased copayments). They will have access to information about traditional as well as alternative and complementary approaches to health. Physicians must become more aware of the impact of consumer choice and adapt practices to acknowledge newer options because consumers will *demand* them.

Dr. Pont's essay reflects the theme that the physician value of autonomy has driven individual and group physician behavior during the past century and has adapted to current environmental changes and realities. He has documented how physician practice, location, and situation as well as political, economic, and social forces have modified physician opinion/preferences while maintaining commitment to culture. These demonstrations of the pervasive influence of culture must be acknowledged by all concerned. The future world order will require cultural respect for the core values of *all* social participants including physicians. If physicians are to play their essential future leadership role *and* maintain their professional autonomy, they, as all members of society, must become both more sensitive to the impact of culture *and* more responsive to cultures of others with whom they must work synergistically to improve the health of their patients, families, and communities. It is critical that the culture of the physician, the manager, and the patient be respected and understood by each and all parties if they are to work together. Leadership from all societal sectors and participant groups must incorporate cultural sensitivity into future change management.

Notes

1. Toffler A. *Future Shock*. New York: Random House, 1970.
2. Toffler A. *The Third Wave*. New York: William Morrow and Company, 1980.
3. Toffler A. *Power Shift*. New York: Bantam Books, 1990.
4. Starr P. *The Social Transformation of American Medicine*. New York: Harper Collins, 1982.
5. Hoeber, PB. *The Horse and Buggy Doctor*. Garden City, N.Y.: Blue Ribbon Books, 1941.
6. Hawkins CF. *Buggies, Blizzards, and Babies*. Ames, Iowa: The Iowa State University Press, 1971.

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Commentary[1]

Henry S. Perkins

Many people see high income as the primary motivation of today's American physicians. But in "The Culture of Physician Autonomy, 1900 to Present," Dr. Pont offers a provocative new idea: that preserving professional autonomy has been a far more powerful motivation through this century.

Dr. Pont argues for his idea on two levels—that of organized medicine and that of individual physicians. On the level of organized medicine, Dr. Pont argues that since about 1920 the American Medical Association (AMA) has viewed government proposals for healthcare reform as direct threats to physicians' autonomy. As a result, the AMA has resisted vigorously many important reform proposals and lost political and economic advantage in the process. Dr. Pont supports this belief by citing the AMA's opposition to federal health insurance in the 1930s,

to federal funding for medical schools in the late 1940s, to the surgeon general's report on smoking in 1964, and to Medicare legislation in the mid-1960s. Obviously appealing to its main constituency of independent practitioners, the AMA persistently raised the specter of government intrusion into the physician–patient relationship. For example, Dr. Morris Fishbein, editor of the *Journal of American Medical Association*, warned about "the multiplication . . . of bureaucratic employees . . . snooping into the intimacies of American life, coming between the doctor and his patient, . . ."[2] Because such zealous attempts to preserve professional autonomy stymied many needed healthcare reforms in the past, Dr. Pont concludes, the AMA has lost its leadership role in shaping today's healthcare.

On the level of individual physicians, Dr. Pont shows the importance of professional autonomy over income in the life of one "ideal" American physician, Dr. Ernest Ceriani. Dr. Ceriani—the only physician in tiny Kremmling, Colorado—was the subject of a *Life* magazine feature in September 1948.[3] Following graduation from Chicago's Loyola School of Medicine and service in the Navy, Dr. Ceriani took a job as assistant to a prominent surgeon in Denver but tolerated the job only two months. Dr. Ceriani "could not manage the proper subservience; often he felt he could not exercise his own judgment or capacities. He also rebelled against the rigid protocol (and) . . . politics" of big-city practice.[4] Therefore, Dr. Ceriani moved his family to Kremmling and began a solo general practice. Despite the long hours and significantly reduced income, he enjoyed being his own boss. Dr. Ceriani felt the esteem of the townspeople and especially his newfound professional autonomy compensated him adequately.

The Ceriani illustration prompted me to examine my own motivations as a practicing physician. In my senior year of college, I quit physics for premedical studies after I realized that people are more interesting to me than equations, and that I could use my science to fight disease, an exciting prospect. Perhaps less nobly, I also realized that medicine promised a comfortable income, social respectability, and professional autonomy.

Twenty-five years of training and practice have significantly changed my primary professional motivations. I have gravitated to care for the indigent—first at the Free Clinic in Berkeley, California; then at a mission hospital in Kenya; and now at the county hospital in San Antonio. In my current role as an "institution man," service to the disadvantaged has given me the greatest, most enduring satisfaction of my professional life. For patients and physicians alike, America's public healthcare system presents many frustrations, especially inefficiency, depersonalization, and unresponsiveness to individual patients' needs. However, the chronic, severe shortage of staff convinces me that the most meaningful contribution I can make as a practicing physician is in the public system.

Other powerful motivations for working in that system come from sources I never anticipated as a medical student or resident. I now enjoy the satisfaction that, though total strangers to me, these indigent patients invite me into their lives at critical times, confide in me some of their deepest secrets, and trust me to do my best for their health. I also enjoy the realization that I can provide simple services that may do these patients more good than can sophisticated medical science. For example, in recent clinics I have reassured a young man that his chest pain was not a heart attack, supported a lung cancer patient as she made the difficult decision to stop chemotherapy, listened to a middle-aged

housewife describe her family problems, and persuaded a despairing former race car driver who had neglected his diabetes to accept retinal laser treatments and hemodialysis. Nothing momentous. No fame or glory. No prizes. Just the satisfaction of knowing that these simple services may have helped the patients.

The person who has most influenced my professional ethic is Dr. Albert Schweitzer, himself the subject of a *Life* magazine feature in July 1949.[5] Born in 1875 in Alsace, Dr. Schweitzer had earned worldwide fame by age 30 for his writings in ethics, theology, and music and for his performances of Bach's organ works. Despite his fame Dr. Schweitzer gave up a promising academic career to study medicine. He became a medical missionary to Gabon and established a hospital at Lambarene, where he lived and worked until his death in 1965. Dr. Schweitzer lived by two moral principles.[6,7] "Reverence for life," the more famous principle, challenges people to embrace all life with awe and compassion. "Opportunity obligates," the lesser known principle, challenges the advantaged to serve the disadvantaged. In retrospect, I realize that both of these principles have guided my most important career decisions.

Dr. Schweitzer understood the importance of serving others. He once observed, "If affirmation of life is genuine, it will demand from all that they sacrifice a portion of their lives for others".[7] As a young physician, I was unaware of this lesson, but now I see its importance daily: service to others—not income or professional autonomy—can motivate, sustain, and even inspire physicians over the long haul.

Notes

1. Susan Bagby made helpful suggestions about earlier drafts of this commentary.
2. Burrow J. *AMA: Voice of American Medicine*. Baltimore: The Johns Hopkins University Press, 1963:203.
3. Smith WE. Country doctor. *Life* 1948;September 20:115–25.
4. See note 2, Smith 1948.
5. Sargeant W. Albert Schweitzer. *Life* 1949;July 25:74–80.
6. See note 4, Sargeant 1949.
7. Cousins N. What matters about Schweitzer. *Saturday Review* 1965;September 25:30–2.
8. See note 6, Cousins 1965.