THE CENTRALITY OF PROFESSIONALISM TO HEALTH CARE

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ABSTRACT

This article begins by noting that some policies designed to lead the physician to be more economical in providing and ordering services contain within them conflicting and incompatible assumptions. Those assumptions can be clarified by reducing them to three logically or ideal-typical "pure" and mutually exclusive methods of organizing, motivating, and controlling the performance of work: the free market, the bureaucratic market, and the professional market. The author argues that the critical question for the future lies in choosing one of them as the central focus for policy support, and using the others solely as supplements. Arguing that a desirable health care system must be based on trust in professional workers who are free to exercise discretionary judgment, the author concludes that policy should aim at strengthening professionalism and employ elements of the other models—especially those of the free market—with great caution.

I. THE CONFLICTING ASSUMPTIONS OF COST CONTROL POLICIES

The crisis in health care continues. The percentage of the Gross National Product that the United States spends on health care is well above that of any other nation,[1] and the cost unacceptably high. In the absence of control exercised over institutional budgets and physicians' prices, as is done in Quebec

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[1]For a recent tally of cost, *see* Fuchs, *The Health Sector's Share of the Gross National Product*, 247 SCIENCE 534–38 (1990).

and Germany, the key to controlling cost is the physician, because it is the physician who authorizes or "orders" the use of most other services and health-related goods. Therefore, many efforts at controlling costs in the United States have been aimed, directly or indirectly, at influencing the physician's practice patterns. But few, if any, have been unequivocal successes. Taken together these financial mechanisms and administrative procedures make a number of contradictory assumptions about the way practice patterns are influenced. This becomes apparent when we take as an example the use of Diagnosis Related Groups (DRGs) as the basis for reimbursing hospitals and the review framework by which it is administered.

A. The Diagnosis Related Group

The use of the Diagnosis Related Group methodology involves reimbursing hospitals a flat sum for each patient they care for.[2] It is based not on the cost incurred by the hospital for each patient no matter what the diagnosis, nor on the individual diagnosis, nor on the number of days individuals actually occupy a bed and use hospital facilities, but rather on the DRG within which individual diagnoses fall. The hospital is reimbursed at the same flat rate for a variety of individual patients who have different, though related, diagnosed problems, and who have different degrees of complications connected with those problems. The flat rate is set statistically by the cost of the average number of days in hospital and the average variety of services and facilities. If, in fact, a patient must stay longer than the norm and use more than the usual services, the hospital must absorb the above-average cost. If, on the other hand, the patient can be discharged earlier than usual, and use fewer services and facilities than the average, the hospital can pocket the difference in cost. In any case, cost is controlled by the flat rate prospective payment. What are the motivational assumptions underlying this system?

1. *Economic Motivation*

The immediate, superficial assumption underlying this method of reimbursement is that the hospital will receive adequate reimbursement for an average mix of patients, and that it will be motivated to eliminate unnecessary days and services in order to avoid costs above and beyond the set rate of reimbursement. Indeed, because it is possible for the hospital to keep the difference between its own lower cost and the fixed rate, and therefore make a profit, it is assumed that its members will be motivated to undertake cost-saving efficiencies that go beyond those required to break even. These manifest assumptions rest largely on the plausible belief central to economics that people are motivated primarily by the desire to avoid financial loss and increase financial gain.

[2]For a clear and thoughtful description and analysis of DRGs, *see* Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576–91 (1984).

2. *Organized Social Influence on Individual Decisions*

But there are also other assumptions. One is that the hospital administration will be motivated to put pressure on its attending physicians—either by its own actions or by the actions of its medical staff or a staff committee—to minimize both patients' days in hospital and their use of services and facilities. It is assumed that work in hospitals is arranged in such a way that administrators and members of the medical staff have both the power and the inclination to exercise significant influence over the behavior of individual physicians. That is, physicians' choices are not purely individual, but rather are embedded in a social organization that influences those choices.

3. *Stable, Objective Criteria for Decisions*

Still another assumption is that the diagnoses at the heart of the method are made on the basis of some objective and stable set of criteria. Frequently, there is more than one way of categorizing or diagnosing a patient's problems, including the choice of what is primary and what is secondary. There is some evidence that physicians select a target outcome and choose their diagnoses accordingly. Thus, should they want their patient to spend more time in hospital than is the norm for one DRG, they select a diagnosis in another, related diagnostic group which provides the reimbursement that pays for such a length of stay. For example, a discharge diagnosis of difficulties due to preexisting heart disease can be shifted into related codes which include acute myocardial infarctions and chest pain, for which there is higher reimbursement. This phenomenon has been called "DRG creep" in the trade.[3] It suggests how vulnerable the system is to those who create its records. The service is not exactly and irrevocably specifiable independently of the discretionary judgment of the "worker." And the way that judgment is employed to fill out administrative forms and medical records is no doubt subject to a variety of motives and influences.

4. *Nonmaterial Professional Incentives*

It is also important to note that while the DRG method deliberately creates financial incentives for cost-saving, it would not be employed if it were assumed that financial gain was the sole criterion for decisions. The method assumes that professional standards and ethics limit the incentive to increase income or profit, so that concern for the well-being of the patient, as well as concern for the integrity of the service itself, will take precedence over gain. Underneath it all, therefore, such a policy does not assume that either physicians or administrators will act in a purely calculated, materially self-interested fashion.

[3]For a sophisticated discussion, *see* Simborg, *DRG Creep, A New Hospital-acquired Disease*, 304 NEW ENG. J. MED. 1602–04 (1981).

5. *Effective Control by Review of Records*

Finally, I may note that the DRG method of payment does not rely on complete trust in either individual or organizational financial incentives or in professionalism. It relies on a complex administrative structure of reviewing claims for payment. The procedures for review, payment, and adjudication of ostensible violations of the stated rules are formal and bureaucratic, and are maintained not only for accounting purposes but also for establishing and administering sanctions in the event of the discovery of untoward activities. The method assumes that an administrative structure standing outside individual hospitals and consultation rooms can effectively check practice patterns by reviewing the official records reflecting the actions and claims of practitioners and the organizations in which they work. Underlying it is, of course, the above assumption that the records are objective and reliable.

II. TYPIFYING LABOR MARKETS

It should be apparent from the foregoing that the health care system is based on a number of quite different, even conflicting assumptions, and that its elements are organized by a variety of quite different, even conflicting methods. On the one hand, it assumes that physicians and others can be motivated to change their behavior by purely self-interested, material incentives. On the other, it assumes that response to financial incentives by physicians will be constrained by an ethical concern for the well-being of those to whom they provide services and a professional concern for doing good work. Reliance on economic incentives is predicated on the actions of individuals freely making calculated choices, but those actions take place within formal organizations like hospitals and HMOs which structure choices in ways that preclude considering them to be wholly free or individual. Furthermore, practice takes place within a broader administrative and fiscal framework that organizes routine and systematic procedures for reviewing and approving or disapproving claims and decisions by the use of standardized administrative criteria. And the primary providers, physicians, are embedded in a social system composed of colleagues in various collaborative and supervisory positions, and of administrators in various positions of organizational and agency authority.

Clearly, there is no single, consistent set of assumptions that guides the financing and organization of health care, but traces of several different sets, each one of which is markedly different than the other. Since the logic of none of them is fully developed, and policy is typically created opportunistically, piece by piece, there is real danger that conflict between elements of one set will cancel out the benefits expected from elements of another. In order to be clearly aware of that possibility, it is useful to examine the fully elaborated logic of three methods of organizing work into labor markets.

A. Three Types of Labor Market[4]

I believe that the best way to conceptualize the organization and financing of health care is to treat it as a labor market. However, in order to do so, we must recognize that there is more than one way of organizing a market. I suggest that there are three distinct ways of doing so. There is first the free market, in which workers compete freely to be chosen and paid by employers or clients. Second, there is the bureaucratic market, which is hierarchially organized and controlled. And third, there is the professional market, which is organized and controlled by the specialized occupations themselves. In the first, the consumer is in command; in the second, the manager or executive; in the third, the specialized worker. In order to understand how those markets work, it is essential to specify the incentives each relies on to motivate and direct the energies of their participants, and the values attached to work. Consonant with the logically ideal and therefore relatively simple structures of the models, differences in incentives and values may be put starkly.

1. *The Perfectly Free Labor Market*[5]

In the free market model, the common interest of all participants is in monetary price and gain. Workers have no necessary interest in the kind of work they do or in the way they do it, nor are they bound to any particular workplace. Indeed, if one job pays more than another, they will promptly move to it. All that is important to them is maximizing the income they gain from their work: they will perform their work only as well and as rapidly as is necessary to maximize income. Furthermore, they act solely as individuals, each competing with the other without any sense of common interest or inclination to organize themselves collectively.

The primary concern of those who consume their labor is the price of goods and services, and they seek the lowest price. Given the extent to which the model requires that the individual consumer be fully informed about the nature of the goods and services available and rationally calculate value and advantage, the quality of goods and services is assumed to be reflected in their price. The same may be said of those who contract with workers to produce a particular good or service: they are driven by competition in the marketplace to keep the price of their products as low as possible, and since their aim is to

[4]What follows is an extremely abbreviated version of a chapter in my work-in-progress, Freidson, Professionalism and the Fate of Knowledge (unpublished manuscript).

[5]There is, of course, a large amount of literature on the free market, which is the paradigm underlying economics. Extremely influential has been M. FRIEDMAN, CAPITALISM AND FREEDOM (1965). For a more neutral, academic discussion of labor markets in particular, *see* Parnes, *Labor Force: Markets and Mobility*, in 8 INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL SCIENCES 481–87 (D. SILLS ed. 1968); Kerr, *The Balkanization of Labor Markets*, in 92 LABOR MARKETS AND ECONOMIC OPPORTUNITY 92–110 (1954).

increase their income or profit, they are driven to reduce costs by various efficiences, including minimizing the wages of labor and using the cheapest possible production techniques and resources. Price and profit are the central measures of success, with efficiency defined by the minimization of price in the production of a particular good or service.

2. *The Bureaucratic Labor Market*[6]

Actions are much more constrained in the bureaucratic labor market, and incentives and values differ. Those officials in command emphasize reliable and predictable production of specified goods or services. The price of such goods or services, while obviously a consideration of some importance, is nonetheless subordinate to their reliability and the predictability of their supply. Quality is defined by formal rules and standards which guide the review and evaluation of the performance of the workers. The individual consumer can choose only among those goods and services that the governing officials of the bureaucratic labor market—national, sectoral, or local—have decided to produce, and must pay the specified price for their standardized quality without necessarily being able to trade off lower quality for lower price. Workers can compete for jobs in the bureaucratic market by gaining the qualifications required for them. Once employed, they compete for advancement by conforming to the rules of the organization and gaining whatever additional qualifications are required for mobility. And they can gain the security of some version of tenure or seniority and thus a life-time work career in the organization. While monetary incentives have some importance, the predictability and security of working conditions provide their primary incentive. They gain those benefits by conforming to the formal standards established and enforced by the hierarchy.

3. *The Professional Labor Market*[7]

In the occupationally controlled or professional labor market, the relationships among the participants and the incentives for their work are yet again different. The choices of worker by both consumers and employers are limited to those allowed to work by the corporate occupation or its representatives. While there is some economic competition among members of the occupation within their sheltered position in the labor market, their occupation's emphasis is on community and "brotherhood" or collegiality. The tendency to establish a basic income floor, if not the full equilibrium of a "single price," considerably reduces the incentives of material interest.

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[6]The classic source of the model of rational-legal bureaucracy is M. WEBER, THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATION (T. Parsons & E. Shills eds. 1947). Relevant to conceptions of it as a labor market is Kerr, note 6; O. E. WILLIAMSON, MARKETS AND HIERARCHIES: ANALYSIS AND ANTI-TRUST IMPLICATIONS (1975).

[7]This ideal-typical conception is built upon the work of a number of British and American analysts, the most important of whom are T. Parsons, W. J. Goode, Jr., Terence Johnson, Magal S. Larson, and Andrew Abbott.

Professionals' income being somewhat protected both from the pressures of individual consumers or employers and from vigorous competition from others inside and outside their occupation, their central commitment is to do the work well and to gain the approval and respect of their colleagues. Their evaluation of each other's work does not emphasize the criterion of cost: what is applauded is the quality and virtuosity of work irrespective of cost and even outcome. Inspired and perhaps irreproducible management of a rare and little-understood problem takes precedence over the reliable management of routine cases. Committed to their work, professionals believe it to be both intrinsically valuable and beneficial to others. In performing their work, therefore, they believe they are contributing to the well-being of others, and that their commitment to their work represents commitment to serving the good of others.

B. Contrasting Incentives and Values

Put baldly, one can say that in the free market model the prime incentive is material gain, and value is measured by money. Its legitimacy is established and sustained by imputing efficiency to it; its prime benefit is low cost to the consumer and profit to the provider. In the bureaucratic model, the prime incentive is security, and value is measured by reliable conformity to established standards. Its legitimacy is established and sustained by imputing legality, or rule-conformity, to its products. In the worker-controlled or professional model, the prime incentive is the respect or approval of colleagues, and value is rooted in the quality of work. It gains its legitimacy from the authority and value of the knowledge and skill of the workers which justify the cost of their work, even when it does not succeed.

In each case workers compete with each other, but they compete for different things and by different means. In the perfectly free market, competition is over price and profit or gain, which depends on satisfying the demands of consumers no matter what they may be. In bureaucracy, competition among workers revolves around conformity to established standards and rules in order to gain the approval of superordinates. In professionalism, competition is focused around the virtuosity and quality of work that gains the honor and respect of colleagues, and symbolic rewards like awards and citations in which financial gain is a marginal consideration.

III. THE MISSING PREREQUISITES FOR A FREE MARKET

When we use the three logical models to sort out the strands of the American health care system today, it becomes immediately apparent that the perfectly free market has very limited relevance. Under ordinary market circumstances customers are free to patronize those who will give them what they

want, whether or not it is professionally approved. But in health care the patient is not an ordinary consumer. Indeed, consumers are even less free in the marketplace today than they were yesterday.

Throughout the history of Western medicine, most conventional analyses have concluded that, due both to the complex and esoteric knowledge involved in medicine and to the emotional and physical incapacitation that often accompanies illness, patients are not in a position to be adequately informed and fully rational consumers who are capable of looking after their own interests in the medical marketplace. It is for those reasons that restrictive licensing which limits the patient's freedom to choose health practitioners is justified.[8]

Today's health care system adds a structural restraint on the patient's freedom of action. These days it is out of the question for the vast majority of consumers to finance their own health care out of pocket. Some sort of group-based insurance, whether involving fee-for-service or capitation payment, is essential, as is partial financing by employers or government. What this means is that while patients may be the primary end-consumers, they are in a poor position to make direct and free individual choices of what they believe they need. "Third-party" health insurance carriers, whether private or public, are the powerful consumers, as are large-scale employers who negotiate contracts with insurance carriers or with health providers. Those brokers of health care dictate the range of alternatives and limits for individual consumers' choice of financing and delivery plans, as well as choice of treatment once covered by a plan.

For patients, choices in the health care labor market are not made freely from day to day or illness to illness, as each occasion to consume arises, based on experience from previous occasions, because insurance plan coverage has already set the direction and limits of choice. True choice of alternatives is made periodically at enrollment or renewal time. When that choice is made, it is based on what is at best a dim awareness of the full implications of complex contractual instruments specifying what complaints or conditions are or are not "covered," which health care occupations and which members of those occupations can be consulted, issues of "co-insurance," "deductibles," and the like. The choice, furthermore, is speculative, being addressed to the terms of *future* care at a time when one is not sick and has no immediate sense of concrete need. Once the choice is made under such poorly informed conditions, a complex and economically powerful administrative system controls what consumers may choose when they feel the need for a service, granting them the use of a particular service only so long as it is covered as part of the package and deemed to be necessary.

It should be clear that to the past view of how patients' choices are limited by ignorance and disability must be added further limitation by today's orga-

[8]For discussion of this issue and the varied positions of sociologists and economists, *see* Begun, *Economic and Sociological Approaches to Professionalism*, 13 WORK & OCCUPATIONS 113 (1986); Dingwall & Fenn, *Respectable & Professional Sociological and Economic Perspectives on the Regulation of Professional Services*, 7 INT'L REV. L. & ECON. 51 (1987).

nized methods of financing and administering care. Even less than yesterday can we conceive of the patient as a well-informed, well-equipped consumer who is free to make choices and bargain as an autonomous individual in the marketplace. But without a well-informed, rational consumer who is free to make choices, one absolutely essential requirement of the free market model is missing. And given occupational licensing, which prevents free entry into the labor market and also limits the range of consumer choice, another essential element of the model is missing. There is very little chance that these conditions will change. With the fundamental terms of the free market model missing from the health care system, the model is relevant more as a source of ideological critique than an analytical guide.

The health care system is not structured by the free economic competition of all who wish to sell services and goods, with consumers free to choose what they wish. The nature and substance of whatever choice consumers have is limited by the increasing concentration of economic resources into the hands of relatively few public and private organizations that pay for health care and, to a lesser degree, organize it.

The health care system of today is best defined as a mix of the bureaucratic and professional models, with elements of the former rapidly growing in importance as the administrative structure surrounding practice expands. It is only *within* the organized and regulated structures of the system that competition can exist, and it need not necessarily be directly grounded on material gain. Policies that try to introduce the material incentives and values connected with the free market model into a system from which the essential conditions for anything resembling a free market are absent will not only fail, but will also threaten the conditions upon which the effective functioning of the system depends. The same may be said for policies that so intensify elements of the bureaucratic model as to stifle those of the professional model that is at the heart of the present system. When fully developed, each model is hostile to the other. Each must be considered a logical alternative to the other. Policy must choose one to advance, and employ elements of the others only as corrective supplements that do not undermine it. And for all the patent faults that real rather than ideal professionalism has shown, I suggest that it is a more desirable model for health care policy to advance than either bureaucracy or the free market.

IV. PRESERVING TRUST AND DISCRETION

A. The Free Market and the Destruction of Trust[9]

Consider the basic grounding of the models, and their relationship to the nature of health care. The free market model entails the unfettered competition

[9]On the significance of trust, *see* BARBER, THE LOGIC AND LIMITS OF TRUST (1983). For an analysis of the contingencies of trust between principals and agents who are in a position to betray it, *see* Shapiro, *The Social Control of Impersonal Trust*, 93 AM. J. SOC. 623 (1987).

of individual workers concerned with maximizing their incomes by serving or selling to individual consumers who are fully informed about services and products and capable of exercising rational, calculated choices designed to minimize their cost. The only way by which a free market can be thought to work to the consumer's advantage lies in full information, for if those offering goods and services are concerned solely with gain, their claims cannot be trusted. Solely for self-protection against the fraudulent claims, inadequate services, defective goods, and overpricing that one might expect from producers, consumers must be knowledgeable, calculating, and free to choose or refuse a good or service.

Consumers of health care are less well equipped to protect themselves than in other areas of consumption. They can and should be better informed than they are now, but there are serious limitations on what is ultimately possible. In health care, the consumer must trust in the competence and probity of those who provide health services as well as the third parties who purport to act as their agents. If the free market model were dominant in organizing health care, the consumer could not trust them. Nor could health workers trust each other.

B. The Bureaucratic Model and the Destruction of Discretion

What about the bureaucratic model? One important contemporary school of economics—the "transaction-cost" approach of Oliver Williamson[10]—argues that under certain circumstances the dangers and costs of "opportunism" (that is, fraud and malfeasance) in transactions make it more "efficient" to forsake the market and instead to organize transactions and relationships by hierarchical authority. In essence, the bureaucratic model is substituted for the free market model in order to reduce the dangers of "opportunism" and gain "efficiency."

In that model, transactions are routinized and organized, reducing uncertainty by establishing predictable and controllable costs. The thrust is to control performance by formulating specific rules governing responsibilities and uniform standards by which to evaluate it. This reduces discretionary activity as much as possible. Current policy efforts to create a reliable administrative framework for reviewing and controlling medical decisions in hospitals and other practice settings, in conjunction with definite standards to justify such decisions, hope to control costs by such a method.[11]

To evaluate this bureaucratic solution, we must note that health services are addressed to the central core of human existence—physical and mental

[10] *See supra* note 6; O. E. WILLIAMSON, THE ECONOMIC INSTITUTIONS OF CAPITALISM (1985).

[11] A useful description of administrative controls now being made possible by both computer technology and development of quantifiable standards for appraising medical decisions is found in Feinglass & Salmon, *Corporatization of Medicine: The Use of Medical Management Information Systems to Increase the Clinical Productivity of Physicians*, 20 INT'L. J. HEALTH SERVICES 233 (1990).

well-being and the conditions of survival as a human being. The way one conceives of health care tasks and outcomes reflects the way one conceives of the people being treated. Standardizing the conception of tasks and outcomes for the purpose of measuring and controlling them also standardizes the conception of people and their difficulties. In essence, people are reduced to formally defined categories. They become objects produced by reliable methods at a predictable cost. While the bureaucratic method may solve the problem of trust by its reliability, it undermines the flexible discretionary judgment that is necessary to adapt services to individual needs. If it were to be the dominant goal of policy efforts, it would in essence industrialize consumers in the course of industrializing services.

C. The Professional Market, Trust, and Discretion

It is only the professional, or worker-controlled model, I believe, that contains within it potential solutions to the problems of trust and discretion. Unlike the free market model, its very existence depends on consumer trust. Furthermore, based as it is on collegiality, it is grounded on mutual trust among members, sustained by negotiating the boundaries of competition from other workers and limiting the kind of competition that can take place. Central to its members' commitment is concern with the quality of their work and its evaluation by direct collegial or peer judgment rather than by cost or standardized official categories. In essence, I believe that the overall strategy of social policy should be aimed at keeping the professional model at the center of health care while checking and correcting the vices of its practitioners by carefully chosen elements of the other models.

V. THE THREATS TO PROFESSIONALISM

Thus far, my analysis has been based on the underlying logic of ideal typical models without any serious attention to the empirical forms they take today. But a social policy that takes only ideal models for its guide is almost certain to have undesirable consequences. In the case of professionalism, we need have no illusions about reality. Where possible, professions have been prone to employ their monopoly to advance the economic interests of their members well past the bounds of necessity, and they have been much too reluctant to judge the performance of their members critically and exercise effective control over them. Trust has been abused and discretion unchecked. The health care system cannot be left in the hands of physicians without careful checks and balances. Both market and bureaucratic methods should be used to reduce cost and control performance, but only elements of those that do not destroy or seriously weaken what is desirable in professionalism.

The dangers become apparent when we consider the use of policies based

primarily on manipulating economic incentives in an ideological climate that claims professional work to be no different from any other kind of economic activity. Under such circumstances, those who work alone without much contact with colleagues or practice institutions are encouraged to milk the consumer or the paying agent wherever they can. And those who work in a practice network or institution are led either to conspire collectively to maximize income or to disintegrate into unrestrained competition. Surely none of these possibilities is desirable. Policy should discourage those who are inclined to devote their efforts primarily to maximizing their income while encouraging those who assign greater value to doing good work for the benefit of others.

Furthermore, policy that creates the conditions for unfettered individual competition for material rewards can only seriously weaken the social network essential to sustaining the norms and sanctions of competence and service characterizing ideal typical professionalism. Professional competition runs the risk of destroying what Coleman calls the "social capital" of professionals.[12] Social capital is defined as the structure of social relations between and among actors engaged in a productive (or economic) activity. An atomized collection of individuals with no definite boundaries is likely to have little social capital. On the other hand, a closed structure of social relations can facilitate the development of norms and sanctions that can lead people to work for the public rather than their individual good. According to Coleman, "reputation cannot arise in an open structure, and collective sanctions that would ensure trustworthiness cannot be applied."[13] Without denying the potential usefulness of policies encouraging competition and material incentives in a limited context, therefore, I believe it is important that their effect on the structure of social relations surrounding health care be carefully taken into account.

In contrast to policies designed to maximize the initiatives of the free market based on individual self-interest, it might seem that policies aimed at maximizing the terms of the bureaucratic model would create a social structure (or system of governance) to solve the problem of trust by binding and organizing the behavior of workers through the exercise of hierarchical authority and the systematic institution of formal rules and standards. This is Williamson's solution.[14] However, quite apart from the fact that this discourages discretionary actions adapted to truly individual needs, Granovetter notes that such a policy does not actually "produce trust but instead is a functional substitute for it. . . . *Substituting* [bureaucratic] arrangements for trust results actually in a Hobbesian situation, in which any rational individual would be motivated to develop clever ways to evade them; it is then hard to imagine that everyday economic life [in the organization] would not be poisoned by ever more ingenious attempts at deceit."[15]

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[12]Coleman, *Social Capital in the Creation of Human Capital*, 94 AM. J. SOC. 95 (Supp. 1988).
[13]*Supra* note 12, at 107-08.
[14]*See supra* notes 7 & 11.
[15]Granovetter, *Economic Action and Social Structure: The Problem of Embeddedness*, 91 AM. J. SOC. 489 (1985).

Formal bureaucratic devices of control are hostage to the spirit and substance of the social relations of their participants. This is especially the case for health care, where, because the work has not been successfully automated or routinized, supervisors must rely on formal records rather than the direct appraisal of work. The success of the organization depends greatly on the way its members exercise their discretion to choose to perform and to record the outcome of their work. An enormous variety of empirical studies carried out over the past half-century has shown that when they feel no loyalty to "the system," people do not passively obey it, but instead actively seek ways of "getting around" it wherever they can. Heavy-handed emphasis on individual material incentives or on conformity with bureaucratized standards can be expected to lead to the manipulation of the system to the detriment of policy intentions and the validity of the records themselves.

VI. SAVING PROFESSIONALISM FROM ITSELF

Let me briefly indicate some of the areas where attention is needed if professionalism in the present-day practice of medicine in the United States is to be advanced and the need for the compensatory use of material incentives or bureaucratic control reduced.

A. Strengthening the Spirit of Professionalism

If professionalism is to flourish it is essential that practice be infused by the conviction that one's decisions must be routinely open to inspection and evaluation. Competitive advantage gained by trade secrets and property rights has no place in professionalism, where one's obligation is to provide colleagues with all the data upon which one bases a decision or conclusion, and to make public one's results. This norm of openness pervades science and scholarship, but seems to be lacking among practitioners in medicine. Physicians tend to have an individualistic conception of automonous clinical judgment that leads them to resent examination, evaluation, and commentary on their work by anyone, even colleagues.[16] This notion of individual autonomy of judgment appears to develop during the course of training,[17] and underlies resistance both to peer and administrative review. It surely influences the spirit in which peer review is carried out, and must be changed if peer review is to be effective. In order to encourage a truly professional spirit of openness, the climate of medical teaching, practice, and peer review must be changed to make openness the norm.

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[16]E. FREIDSON, PROFESSION OF MEDICINE: A STUDY IN THE SOCIOLOGY OF APPLIED KNOWLEDGE 137-84 (1988).

[17]W. CARLTON, IN OUR PROFESSIONAL OPINION: THE PRIMACY OF CLINICAL JUDGMENT OVER MORAL CHOICE (1978).

B. The Practice of Professional Review

While the spirit of performance is an essential element of fully professional conduct, the way performance is organized either limits or facilitates its expression. Peer review is an essential of fully developed professionalism. In health care, peer review requirements have been extended into both practice institutions and administrative review organizations, yet how peer review is organized and, more important, how it is actually carried out is very poorly understood. Here, the usual academic call for "more research" is certainly justified. An intelligent policy of strengthening peer review (and professionalism) must be well informed. It is essential that direct studies of the organization and operation of the quite varied forms of peer review be undertaken in order to provide a secure foundation for future policy.

C. The Support for Professional Goals

Finally, I suggest that considerably more attention must be paid to avoiding circumstances in which practice patterns are inappropriately influenced by organized economic pressures and bureaucratic constraints. Both in health care and in other professionalized areas the formal organization of work has been changing in important ways. More and more physicians are becoming employees of organizations, and many of those organizations are operated for the profit of private investors. Because the health care system is rooted in professionalism, close attention to the impact of these developments on professionalism is essential, as is reconsideration of some of the law upon which the organization of work is based. What forms of incorporation, for example, are appropriate in organizing and financing work whose prime justification lies in advancing the well-being of the customer? What loyalty do professionals owe to their employers; what duty is there to make ostensible trade secrets public when they bear on the well-being of patients in particular and the public in general? What rights must physicians have to participate in ostensibly managerial policymaking in order to preserve the integrity of their work while also preserving their right to bargain collectively?[18] Are new forms of incorporation, institutional licensing, chartering and accreditation, and labor law needed to encourage the provision of critical human services in a form that better serves the public good? Answers to questions such as these are essential to the development of policies designed to move our health care system toward the professional ideal.

[18]Rabban, *Distinguishing Excluded Managers from Covered Professionals under the NLRA*, 89 COLUM. L. REV. 1775 (1989); Rabban, *Can American Labor Law Accommodate Collective Bargaining by Professional Employees?* 99 YALE L.J. 689 (1990).

CONCLUSION

Policies designed to reduce the cost and maintain and improve the quality of health care by relying primarily on material incentives and individual competition or on the establishment and enforcement of bureaucratic standards are more likely to fail than not. Hope for their success implicitly assumes that the ethics conventionally attached to professionalism will prevent dishonest or cynical manipulation of the system. But without additional policies designed to strengthen the positive elements of professionalism, the social environment that sustains and reinforces those ethics is likely to be damaged. The goal should be to strengthen collective commitment to the quality of work for the benefit of patients, duly tempered by considerations of cost and reliability, and advanced by effective modes of peer discipline—in short, commitment to the maintenance and control of responsible discretion by working colleagues, and making the professional model more of a reality than an ideal or a promise. Measures designed solely to counteract professional abuse without also strengthening professionalism itself will lead us to an impoverished, and maybe not even cost-controlled, health system that neither physicians nor patients deserve.