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Health-Care Professions, Markets, and Countervailing Powers

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> Professionalism is an Anglo-American disease.
> —Eliot Freidson, 1983
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> Monopoly is essential to professionalism.
> —Eliot Freidson, 2001

For more than two decades, an international crisis of professionalism has pervaded health care and weakened the grip of professional organizations over the training and oversight of professional work, especially in the United States and United Kingdom where professionalism is a preoccupation. Governments and other institutional payers have moved in to monitor professional behavior, control costs, and reduce large variations in the quality of clinical practice (Hafferty and Light 1995; UK Secretary of State for Health 2007). The unquestioned trust in the medical profession to apply the best scientific and technical information and skills to the needs of patients and fulfill a tacit social contract has been shaken.

I focus here on some aspects of the shaken trust in the medical profession that have to do with "markets," a term that refers to dynamically constructed arenas of economic exchange but also to the actors in those markets who have been challenging the elevated status of professions as state-protected monopolies that claim to provide complex and vital services to clients for their benefit in an impartial manner. For decades during the Gilded Age and into the twentieth century, professions were widely regarded by Durkheim and others as standing over against markets. By the 1970s, however, historical and contemporaneous evidence indicated that the medical profession was a kind of self-serving monopoly operating within protected markets (Berlant 1975; Burrow 1977; Freidson 1970a, b; Larson 1977). This radical recasting, as well as evidence of overtreatment, undertreatment, mistreatment, and excessive charges, led to a revolt by governments, businesses, and other payers that transformed them into active buyers demanding accountability and good value. (I described the dynamics and evidence of this transformation in previous editions of the handbook [Light 1989, 2000]). Since 2000, however, organized professional bodies have mounted campaigns to restore their professionalism and lost trust, with Eliot Freidson's last work (2001) as an intellectual beacon and inspiration to them. Yet as we will see, the professions-and-markets debate ignores a graver development of the commercial construction of medical categories, medical evidence, and clinical behavior that sociologists have largely overlooked in their research on risk, illness, and treatment.

The Countervailing Powers Framework

Single accounts of the rise of professions, while describing their relationships with the state, universities, and other bodies, tend to be what

Andrew Abbott (2005) wryly describes as the "historiography of imminent development," and they tend not to consider the wider ecological context. The framework of countervailing powers enables one to consider through historical periods the changing tensions, alliances, interests, rhetorics, and degrees of control among key stakeholders (Light 2000). They include organized professional groups, the state as legitimator and regulator, payers such as the state and insurers, clients as individuals or larger organized bodies, and corporations that make up the medical-industrial complex. This framework resonates with and expands on Elliott Krause's (1996) major comparative study in which he emphasizes three parties—the state, capitalism, and the professions—at the corners of a triangle. They vie to construct the reality of a domain, the structure of markets, the culture of professional work and its organization, status, and power. Jill Quadagno (2004) has made a valuable contribution by analyzing, with her theory of stakeholder mobilization, how these conflicts translate into decisions.

The countervailing powers framework first instructs researchers through the process of identifying the domain or field force, the major actors, and the nature of relations between them. Each in turn is made up of countervailing powers, such as the occupational competitors for professional status and greater jurisdictional control in a given domain (Abbott 1988). The professional constellation of countervailing forces ranges from the crucible of its academic and research segment, with strong ties to the medical-industrial complex, to competing providers both within medicine and in alternate paradigms of healing, to forms of clinically managed care that employ protocols to shape how professional work should be done. The state is a constellation in itself of countervailing power groups or divisions with different functions and priorities: the sponsor of health-care services and public health, the funder of most basic research to foster innovation and economic growth (Light 2006), the promoter of commerce at home and abroad, and the creator and enforcer of regulations. Clients or patients as a whole are composed of diverse, often conflicting groups of varied size and wealth. As Everett C. Hughes (1994 [1965], 46) pointed out, by the 1960s law and medicine were carried out in complex organized settings where "it becomes hard to say who is the client; . . . is it the insurance company or the patient?" If who the client is remains unclear, especially when one client (the patient) wants to have all their medical bills paid and the other client (the insurer) wants to pay as little as possible (Light 1992), can either patients or insurers trust how professionals will exercise their autonomy and discretionary expertise? A certain amount of the doctor as double agent seems unavoidable, even in a public health service (Angell 1993; Stone 1997).

A profession or professional cluster interacts with other countervailing powers in a political and cultural marketplace, as well as in the economic marketplace. Buyers and customers, often not the same persons in health care, are the key agents in markets. If they are lazy or uninformed or uninterested, sellers have more opportunities to exploit them. An occupation selling its services can claim it is expert and ethical and needs state protection from charlatans; the question is whether patients and politicians will buy the argument. A surgeon can claim that a twenty-minute cataract operation is worth $1200 for his time (plus the bills for everything else), but will payers agree? Patients have become an increasingly important countervailing power, in part through patient-advocacy groups for specific conditions (often sponsored by pharmaceutical companies to advocate for costly drugs), but also through increasingly rigorous patient-reported outcomes measures (PROMs) (Picker Institute Europe). Patients with chronic conditions also become expert at them, and the expert-patient movement mobilizes this knowledge for better care. Whether these developments constitute deprofessionalization depends on how paternalistic one's model of professionalism is.

Sometimes stakeholder dominance characterizes the relations among countervailing powers. This imbalance can last for years, but the countervailing powers framework requires one to examine how the other parties are reacting and how the stable state may hide unfolding tensions and countermoves. A central problem with professional-dominance theory was that it could explain only how dominance begets more dominance and

not how countervailing powers organize against it to recast power relations (Light and Levine 1988). Any dominant party elaborates itself, offends other parties, and neglects important needs. Ironically, the launch of professional-dominance theory in 1970 (Freidson 1970a, b) coincided with the beginning of its demise, as physicians exploited every opportunity to raise fees and increase services, as corporations moved in to exploit the protected markets, and later as payers revolted against these excesses (Light 2004; Starr 1982). This is not the first time that sociologists theorize a historical trend as it is ending and a new era beginning.

An example of countervailing powers radically reframing what good professional health care meant and how it should be organized took place when President Richard Nixon in 1971 proposed universal access using a reorganization of health services based on market incentives that would turn the excesses and pathologies of Freidson's professional dominance on their head. Nixon proposed establishing a national network of health plans—based on rewarding prevention, primary care, and minimal use of hospitals or subspecialists—called health maintenance organizations, long regarded by the AMA as seditious hotbeds of socialism but now reconceived as enlightened business enterprises (Nixon 1972, item 63; Starr 1982). This proposal for well-managed, equitable, and universal health care did not happen, but one could see the countervailing powers in full force, contrary to professional dominance theory, reflecting a historic imbalance of power.

Besides the search for a wider analytic framework than theories of professional dominance or deprofessionalization, material for the countervailing powers framework came from a large comparative study of health professions in Germany that showed how the sharply countervailing relations with the state completely changed from Weimar to the Nazi period, and then again after 1945 under two contrasting visions of state and society (Light and Schuller 1986). By comparing in detail how professional-state relations altered mother-and-child care, abortion, psychotherapy, occupational health, drug supplies, ambulatory care, and hospital care in East and West Germany in the postwar decades, this large team project provided the materials for the countervailing powers framework.[1]

The internal elaboration of professional, state, or payer dominance can also result in unmanageable structures and neglect of vital needs. Backlashes occur, either overtly or surreptitiously, as they did in the first wave of market reforms of professional services in Europe (Light 2001). Success also has unintended consequences. In health care, a byproduct of clinical success is that more people live longer with chronic conditions and disabilities, changing the nature of professional work, clinician-patient relations, and the medical-industrial complex (Albrecht 1992; Mechanic 2006, ch. 6). Finally, larger external sociocultural movements can also change the entire domain of and relations among the countervailing powers, such as the civil rights movement and its manifestations in gay, disability, and women's rights.

As an organizing framework for research, the domains or arenas of countervailing powers benefit from Abbott's (2005) brilliant exposition of "linked ecologies," a systematic extension of formative Chicago-school studies of occupations by Hughes and in urban studies by Park, Burgess, and others. Just as each countervailing power in health-care markets is made up of its own countervailing powers in flux, so a given ecology is made up of other linked ecologies, "each of which acts as a (flexible) surround for others" (246). Thus jurisdictional claims by a profession have to succeed not only among other claimants for professional work but also with clients, insurers or health plans, and the state within the ecology of countervailing forces. The state itself "is itself an ecology, a complex interactional structure filled with competing subgroups and dominated by ecological forces quite similar to those driving the system of professions" (246). The same could be said for health plans or insurers and for clients or employers organizing their care.

Abbott provides a richly suggestive vocabulary for analyzing the sociological dynamics of professions and markets, such as actors, locations or arenas (the cluster of problems or areas of work), links, ties, claims, jurisdictions, settlements (arranged balances less exclusive or permanent than jurisdictions), bundles of political decisions and actions pertaining to a location, and hinges that

reward actors in two or more ecologies. Abbott summarizes: "The concept of linked ecologies recognizes that events within any particular ecology are hostage in some sense to events in adjacent ecologies" (2005, 254). He illustrates this conceptual framework by examining medical licensing in the United States and England in the nineteenth century and disciplinary settlements in universities. These analytic tools can be used to understand historic changes at the intraprofessional level, the interprofessional level, and the level of health-care systems.

Professions as a Countervailing Power against Markets

At the turn of the twentieth century, leading social thinkers in Europe and America advocated the spread of professionalism as the antidote to rampant capitalism, the antimarket countervailing power. Political economists were claiming economics to be a science (and a profession) (Bledstein 1976). Thus their theory of how unfettered self-interest benefits society was promoted as scientific, not ideological. But Durkheim (1957) observed that pure self-interest destroyed society: "It is not possible for a social function to exist without moral discipline. Otherwise, nothing remains but individual appetites," which are boundless and unable to control themselves. Hope lay in occupations developing moral discipline and becoming professional communities: "Therefore, the true cure for the evil is to give the professional groups in the economic order a stability they so far do not possess," so they can flourish (10, 16). The moral development of professions comes from being a community, a collegium "within which these morals may be evolved, and whose business it is to see they be observed" (16). Within professional groups, members compete for respect and status among their peers by exhibiting their service to others and excellence in their work, not by seeing who can undercut or take over whom.

Durkheim hardly mentioned how specific professions work and offered no evidence for how professional ethics could rescue society from big business and amoral market forces. But he was convinced, as were other leading intellectuals, that occupations could be a countervailing force against the ruthless capitalism of the early twentieth century. Each could develop its own moral order and form of professional ethics and together they would function as "a kind of moral polymorphism" in which "the greater the strength of the group structure, the more numerous are the moral rules appropriate to it and the greater the authority they have over their members" (Durkheim 1957, 7). Haskell, an important historian of the professions, characterized this view of professions "as a 'countervailing market,' structuring a set of inducements and sanctions that can pull the path of self-interest up out of the rut of purely pecuniary advantage" (1984, 217).

In a similar vein, across the English Channel from Durkheim, R. H. Tawney mounted an influential critique of a society based on material self-interest and acquisitiveness. He also believed that the professionalization of occupations would infuse them with a principled, disinterested dedication to serving society that would counter relentless market forces. "A profession may be defined most simply as . . . a body of men who carry on their work in accordance with rules designed to enforce certain standards both for the better protection of its members and for the better service of the public," he wrote in *The Acquisitive Society*. "So, if they are doctors, they recognize that there are certain kinds of conduct which cannot be practiced, however large the fee offered for them; . . . it is wrong to make money by deliberately deceiving the public, as is done by makers of patent medicines, however much the public may clamor to be deceived" (1920, 94–95). What Tawney overlooked was how actively doctors participated in concocting and promoting cure-alls in Europe and the United States. While they no longer concoct them, physicians today play a central role in promoting and prescribing the latest drugs, even though most have no evidence of being superior to existing drugs (Brody 2007; Goozner 2004; Healy 2004).

Professions as a countervailing power to markets, or civic professionalism, also lay at the center of progressive reforms advocated in the United States by John Dewey, Jane Addams, and Herbert Croly. The moral ecology of communities was

being destroyed by big business and the amoral pursuit of self-interest, they maintained. Croly (1965 [1909]) proposed that a new spirit of professionalism could become the moral salvation of U.S. society (see Sullivan 2005, ch. 3). A new citizenry would be responsible and enlightened by a new American hero, the civic professional. Jonathan Imber's 2008 study explores how the moral authority of physicians during this period was religiously infused.

Professionals were models of how to use expertise for social betterment by developing a scientific approach to crime, poverty, disease, bad food, dangerous drugs, poor housing, ineffective teaching, and many other spheres of life (Bledstein 1976). People would learn that self-fulfillment comes though mastery and dispassionate application of rigorous knowledge and skills along with others in a moral community. The cultural capital of professionalism was contrasted with economic capital, rather than regarding cultural capital as a complementary form of economic investment as we do today. The ethos of professional communities was the key attribute, not "autonomy," a term that then referred less to individual professionals than to the profession as a whole standing apart from amoral markets and ordinary occupations.

It may seem quaint to emphasize the degree to which big business in this earlier great era of raw market power regarded professions as communities of experts with a strong antimarket moral ethos. But a similar version of professions as a countervailing power to markets underlies the campaigns to restore professionalism today, as well as Eliot Freidson's (2001) construction of professionalism as an ideal type over against reliance on markets or bureaucracies as contrasting ideal types. An echo sounds in Sciulli's (2005) important review of professions, which emphasizes a fiduciary responsibility to advance client well-being, to apply services consistently to standards and to not tolerate opportunistic behaviors, to design institutions for governance and regulation of professional work, and to critically review their knowledge and practices. The strongest echo a century later is reflected in the work of the Carnegie Foundation for the Advancement of Teaching, a sustained assessment of U.S. professions aimed at restoring civic professionalism (Sullivan 2005). Freidson too emphasizes professionalism as an antidote to expert services being driven by consumers and profits, but more narrowly focused on those services and as a civilizing force and an exemplary community of service.

Are Professionals Altruistic?

Social scientists, even economists, so widely believed that professionals were altruistic while the rest of humankind pursued self-interest that when Haskell (1984) reviewed all articles in major social science journals from their inception through 1940, he could find no critique until Parsons's 1939 essay on the professions. Parsons found it implausible that different motives drive business executives than those that drive professionals, as if the two groups were cut from a different cloth or gene pool. He pointed out that professionals rationally apply universalistic knowledge and technical competence in value-neutral, functionally specific ways to all relevant clients. But so do business executives. Both provide services to customers. Both are egoistic. Both want to succeed. What differs is not their motives; rather, "the institutional patterns governing the two fields of action are radically different" (Parsons 1939, 465). These shape behavior and people's "motives" and define appropriate goals, actions, and rewards.

We cannot expect professionals to act too differently from the market structure and institutional framework in which they practice. Most will not be very altruistic or civic in a system focused on generating revenues and profits. Put them in a salary-based national health system like the Veterans Health Administration, however, and their motives will change. There seems little evidence that professions are a countervailing power against markets in a market-oriented system, and, as I argue later, professions have a natural affinity to markets and corporations that advance their interests. Still, a notable number of professionals since the mid-nineteenth century have dedicated themselves, against the market-oriented grain, to developing workers' health-care clinics, other mutual aid cooperatives, poverty medicine, and public health—all of which have played a critical role in changing institutional frameworks (Light

and Schuller 1986; Schwartz 1965; Tudor Hart 2008).

Freidson's Case for Professionalism

In his final work, *Professionalism: The Third Logic*, Eliot Freidson echoed an avalanche of articles in the 1990s that argued against managed-care corporations and consumerism as inherently anathema to professionalism (Hafferty 2003, 137–38). Freidson aspired to establish professionalism as the third alternative or logic to Adam Smith's theory of markets and Max Weber's theory of bureaucracy for how social life can be organized.

At the heart of professionalism is discretionary specialization, the application of technical knowledge, skills, and tacit knowledge to problems that appear in various manifestations, guises, and contexts, Freidson theorized (2001, 23–25). Therefore, professionals must have "monopoly, or control over their own work" (32). Full-time dedication to this work over a lifetime enables them to build up tacit knowledge and skills. The profession must control the division of labor and work, specifically, "each specialization controls the work for which it is competent, negotiates its boundaries with other specializations, and by that method determines how the entire division of labor is organized and coordinated" (55). The profession must determine the qualification of members and grant them permanent status in sheltered labor markets where they have the exclusive right to do certain kinds of work (73–78). Credentials provide clear market signals about who is competent and trustworthy.

Beneficial and Pernicious Competition

The neoclassical ideal type of market behavior assumes many buyers and sellers, clearly defined products or services, full information on prices and value, and other attributes in the first column of Table 16.1. By contrast, professional services are often characterized by uncertainties and contingencies, as professionals try something, see how well it works, and go from there. Information is often asymmetrical, incomplete, unreliable, and expensive. In health care there are often side effects from drugs, surgery, or other procedures that result in a large volume of iatrogenic harm (see Abraham, this volume; Light 2009). The patient's condition may also affect others when contagion is involved or may affect relations with others when mental or physical capacities are affected. In addition, medical markets usually have few hospitals or clinics, and institutional buyers

Table 16.1. Neoclassical markets versus markets for professional services

Conditions for beneficial competition	Conditions for pernicious competition
Product or service clearly defined; clear boundaries, property rights	Product or service needed uncertain and contingent; unclear boundaries
Buyers have full information on prices, quality, services	Buyers confront esoteric, complex, uncertain, and contingent information on services
Information cheap or free	Information and searching costly
No externalities. No harms or benefits to other parts of self or others in this transaction.	Externalities. Harms or benefits to other parts of self or others in this transaction.
Buyers rationally maximize clear preferences	Buyers scared, worried, vulnerable, conflicted
Many buyers and sellers, no relation to each other	Few sellers in a market; have historical, cultural, economic, political ties
No barriers to entry or exit	Barriers to entry and exit
Market signals quick; markets clear quickly	Market signals muddled and slow

Source: Adapted from Scott et al. 2000
*Italics indicate the predominant actors, logics, or governance mechanisms for each era (except in the current era, in which no predominant governance mechanism has yet emerged)

(insurance companies, health plans), creating a bilateral oligopoly, not a competitive market.

When one or more of the conditions necessary for beneficial market competition are lacking, the stage is set for pernicious competition, where the sellers or providers can exploit consumers and payers by charging a great deal for services or medicines of little value, and by delivering services of unknown quality or safety. Hospital and other service corporations have ties with suppliers in oligopolistic markets, and competition rewards inefficient fragmentation as each market player constructs niches to maximize profits (Geyman 2004; Lundberg 2000; Starr 1982). In sum, the failures in health care to meet the prerequisites of beneficial markets would seem to strengthen the case for professionalism to prevail instead, except that many physicians and their professional societies have demonstrated an affinity for commercial enterprises that enhance their repertoire of tools, equipment, devices, or drugs and that increase revenues—a prominent feature of the golden age of medicine (Light 2004; Starr 1982).

Professional Paternalism

It becomes clear in the chapters "The Assault on Professionalism" and "The Soul of Professionalism" of his book *Professionalism* that Freidson extends professional control to encompass "who is to perform what tasks and how much will be paid, on what terms." Still more broadly, in the development of the U.S. health-care system up to the 1960s, the profession "almost completely realized ideal-typical professionalism," he writes. "During the Golden Age, physicians had virtually complete control over the terms, conditions, and content of their work. They were free to charge all that the pockets of their patients could yield and to decide how much charity or free care to provide to whom" (2001, 180, 181, 184).

This remarkable characterization reflects a paternalistic ideal that leaves access and affordability up to each practitioner. It fails to take into account all the detail that Freidson himself provided thirty years earlier in his pathbreaking books *Profession of Medicine* (1970a) and *Professional Dominance* (1970b). Professionalization in the progressive era involved converting hospitals from charitable institutions into fee-based "doctors' workshops"; elaborating specialization for greater control over a niche, more prestige, and higher fees; developing provider-based insurance that reinforced professional control over fees through passive reimbursement; and establishing relations with medical supply and pharmaceutical companies that enhanced professional power (Light 1989; Starr 1982). These changes served as ecological hinges and new jurisdictions among the profession, charitable institutions, manufacturers, and insurers.

These organizational features improved the quality of medical services but resulted in an inverse relationship between the availability of services and the need for them (Quadagno 2005), an "inverse care law" (Tudor Hart 1971) reflected in Part I of this volume (see Link and Phelan; Kawachi; and Dubowitz, Bates, and Acevedo-Garcia). This professional focus on treating sick patients also fits the conservative capitalist agenda to treat injured or sick workers and get them back on the job without addressing the upstream occupational risks, forms of exploitation or inequality, or issues of public health that led to their becoming injured or sick (Brown 1979; Navarro 1976; Navarro and Muntaner 2004; Waitzkin 1983, 2001). The great industrial fortunes of the nineteenth century bankrolled the campaign of the medical elite for a model of professionalism based on clinical intervention and for stopping broader efforts to improve occupational safety, reduce poverty, and improve public health for all (see references in Light 1989). Herein lies a fatal flaw in Freidson's ideal type: individual professional autonomy pays little attention to social causes of ill health, social injustices, or inequities. The organized profession has opposed universal health care in virtually every country that has attained it. Lacking a societal frame, as Parsons implies, professionals usually pursue their self-interests. If "monopoly is essential to professionalism," as Freidson claims, should we not be worried about possible abuses (2001, 3)?

Autonomy's Fallout: Dominance, Then Revolt

The autonomous exercise of discretionary specialism that lies at the heart of Freidson's third logic

ironically led to the assault on professionalism that Freidson deplored. Freidson's own empirical studies of professional dominance were joined by an impressive number of studies by historians and sociologists summarized in the last edition of this handbook (Light 2000) and by more recent historical accounts (Gordon 2003; Light 2004). First, while the organized profession as a collectivity is granted autonomy, each professional claims this autonomy for him- or herself. This greatly weakens the possibility of collective autonomy in which professionals together monitor each other's practices and discuss better ways to treat certain kinds of cases. Individual professionals are protected from accountability and can cover up mistakes (Hughes 1958).

In a powerfully challenging review of Freidson's book, Fred Hafferty (2003, 140–41) cites numerous studies that document physicians missing a large number of clinical disorders, doing tests incorrectly, prescribing drugs for unproven indications, and ignoring dangerous side effects, which leads him to conclude: "I find it difficult to imagine how medicine can justify its calls for 'independence' and 'freedom of action,' given the prevalence of physician ineptitude and culpability." Individual autonomy leads to large variations in how individual clinicians diagnose and treat the same symptoms or problems, implying that the scientific basis for their decisions is thin or being selectively applied. Thus individual autonomy undermines the central claim of professionalism.

Second, these variations become amplified as autonomy leads to specialization, an extension of the "third logic" through internal segmentation, which gains for professionals greater autonomy, control over the scope of their work, capacity to do research, greater prestige, a competitive edge for patients, and income. Early specialization began, sometimes without any clear technical or therapeutic advance but often with advances based on professional rhetoric and theoretical models (see Stevens 1998; Halpern 1988; Scull 1979; Louden 2008; and Weisz 2006; Zetka 2008). Initial claims of expertise lead to—in Abbott's terms—settlements and, if successful, to jurisdictions. Specializing enables more detailed knowledge and research to develop, and certainly patients believe that specialty care is better, though considerable evidence questions how much better off many patients are. Structurally, specialization elaborates a linked ecology within clinical practice, with ties and hinges to terms of payment and commercial suppliers. It can also prompt "the erosion of medicine from within" (Zola and Miller 1973). Specialty societies erode the centralized power of the overall medical association, highlighting differences in agendas and priorities, and political control becomes more dissipated. Specialization also creates monopolistic niches and specialty societies that lobby for better pay for more elaborate care than for primary care (Light 2004; Stevens 1971). As a result, the market for primary care and family medicine is dying in the United States (McKinlay and Marceau 2008), even though integrated, nonprofit health systems like Kaiser-Permanente, the Veterans Health Administration, or the UK National Health Service find that primary-care teams can treat more than 90 percent of patient needs with greater continuity and at lower cost.

Freidson knew all this, wrote critically about it, yet hardly mentioned it as the dark, institutional side of his ideal type in *Professionalism: The Third Logic*, the side he researched with distinction for forty years (Halpern and Anspach 1993). "Where he concluded *Profession of Medicine* with concerns about a new tyranny of professionalism," Robert Dingwall observes, "*Third Logic* concludes with a call to sustain the independence of professions as a source of resistance to the greater tyrannies of markets and capital" (2008, 139). Freidson's chapter "The Assault on Professionalism" bemoans countervailing efforts by governments and employers, through insurers as their agents, to review and restrict tests, drugs, and procedures but does not cite the evidence that many of these are unnecessary and have harmful side effects. Freidson writes that peer review "created significant constraints on the freedom of physicians to do their work however they wished," but given the wide variations in quality of care, one might regard peer review as reinstating the social contract between the profession as a whole and society. Freidson describes the dismantling of legal protections of professions from antitrust strictures as tragic, without mentioning the self-serving forms of collusion and consumer exploitation that led

to the removal of those protections (Havighurst 2003). The failure to describe the pathologies of unfettered autonomy and the reasons why countervailing powers have risen up to contain them keeps several recent works on professions and markets from being either accurate or realistic (Ameringer 2008; Leicht and Fennell 2001; Relman 2007; Sullivan 2005). Changes such as evidence-based medicine, clinical protocols, and clinical pathways are part of the buyers' revolt summarized in Table 16.2. These changes aim to improve quality and to reduce variation and unnecessary procedures resulting from professionalism based on individual autonomy, though they have their downsides. Targets and guidelines fragment care of the whole patient into bits and deflect attention both from what is not measured and from how what is measured may interact with aspects of a patient's situation. Nevertheless, this new focus represents a fundamental realignment of countervailing powers, and even of the knowledge base of medicine (Timmermans and Kolker 2004), in which the state and insurer/payers redefine their roles, the nature of oversight, and the meaning of professionalism to base these on accountability (see Table 16.3).

The New Professionalism: Accountability and Value

Professionalism based on accountability is the outcome of countervailing powers today and a reconceptualization of medical science, practice, and profession. It represents a shift from a training-and-license model to a competency/performance model of professional work and thus to team models of care, like those that have been developing in the British National Health Service and elsewhere (Kuhlmann 2006). This shift lays the foundation for nonphysician clinicians to assume more professional work and even to replace physicians (McKinlay and Marceau 2008). What once was trust in the quality and integrity presumed of holders of medical degrees has become "enforceable trust" (Portes and Sensenbrenner 1993), or what Kuhlmann (2006) calls "justified trust," based on visible markers and measurable

Table 16.2. The buyer's revolt: axes of change

Dimensions	From provider driven	To buyer driven
Ideological	Sacred trust in doctors	Distrust of doctors' values, decisions, even competence
Clinical	Exclusive control of clinical decision making	Close monitoring of clinical decisions, their cost, and their efficacy
	Emphasis on state-of-the-art specialized interventions	Minimizing of high-tech and specialized interventions
	Lack of interest in prevention, primary care, and chronic care	Emphasis on prevention, primary care, and funding
Economic	Carte blanche to do what seems best; power to set fees; incentives to specialize	Fixed prepayment or contract with accountability for decisions and their efficacy
	Informal array of cross-subsidizations for teaching, research, charity care, community services	Elimination of "cost shifting"; pay only for services contracted
Political	Extensive legal and administrative power to define and carry out professional work without competition, and to shape the organization and economics of medicine	Extensive legal and administrative power to direct professional work and shape the organization and economics of services
Technical	Political and economic incentives to develop any new technology in protected markets	Political and economic restraints on developing new technologies
Organizational	Cottage industry	Corporate industry
Potential excesses and dislocations	Overtreatment, iatrogenesis, high cost, unnecessary treatment, fragmentation, depersonalization	Undertreatment, cuts in services, obstructed access, reduced quality, swamped in documentation of work

Table 16.3. Aspects of traditional versus new professionalism

Autonomy-based traditional professionalism	Accountability-based new professionalism
Quality focused on process and determined individually, so effectiveness and quality variable	Quality focused on outcomes established through clinical research, with guidelines, protocols, and care pathways
Subspecialization and hospital care as the center of power and prestige	Focus on primary care, prevention, and management; subspecialization and hospital care as backup New clinical research elite sets evidence-based standards and protocols
Physician-based practice and authority; delegated work to nurses, others	Team-based practice and collaboration
Oriented toward episodic treatment of acute problems	Oriented toward prevention and management of risks or problems to maximize functioning

outcomes. Demands for evidence of quality and value by countervailing powers are rescuing the medical profession from itself by hoisting it by its own petard, demanding it take science seriously (DeVries, Lemmens, and Bosk 2008). This effort can lead to new alliances among countervailing powers and also to the danger of commercial interests gaining unprecedented power by shaping clinical trials and evidence.

Despite the growth of evidence-based medicine, clinical guidelines, and systems for measuring quality, professional dominance is far from being reduced to "a historical curiosity," as a colleague put it to Robert Dingwall (2008). The managed-care backlash, encouraged by physicians, has forced employers and managed-care companies to become less assertive as a countervailing power and to shift the problem of cost containment to employees by making them pay increasing proportions of physician charges as well as insurance premiums (Robinson 2001). Since then, entrepreneurial specialist physicians have found myriad ways to increase tests, procedures, revenues, and profits.

Freidson ends his book on professionalism as the third logic with the chapter "The Soul of Professionalism," where he claims the worst scenario would be professionals turning into "merely technical experts in the service of the political and cultural economy," as in a national health service or universal health plan (2001, 212). Should this occur, he predicts, quality of service to clients will change as discretion is minimized. Line practitioners will be less satisfied, and consumers (his word) will sense a perfunctory, standardized treatment of their problems. The spirit of ideal-typical professionals will be lost, as will be "their distinctive moral position that considers the use of their knowledge in light of values that transcend time and place" (213). What that moral position is, or what values transcend time and place besides a dedication to quality work, is not described but harkens back to Durkheim, Tawney, and Croly, who were equally vague and romantic about the moral ethos of professions in their day.

Hafferty (2003, 146–48) draws on his close observations and research to report that medical students often arrive with a desire to help and heal others but that training makes them more cynical, a pattern found repeatedly over the past forty years. Medical students come to disavow altruism and fear burnout and vulnerability to manipulative, demanding patients. They "reject the presumption that being a physician involves obligations" and assert "a healthy and cared-for self . . . as a precondition to helping others." The point of being a doctor is to have a good life and not work too hard, he reports from the field. Yet student leaders of the American Medical Student Association have for years been outspoken critics of commercialized medicine and a system that leaves forty-six million uninsured and millions of insured patients paying large sums for uncovered portions of their bills precisely when they can least afford it (AMSA 2009). They join a long tradition of public-spirited physicians working against

the prevailing system. Thus the institutionalized ethos of most medical schools, residencies, and faculty weakens the "soul of professionalism," but an altruistic minority finds compatible places to practice on the margins, such as public hospitals, community health clinics, the National Health Service Corps, the Indian Health Service, some service-oriented nonprofits, and the Veterans Health Administration.

Besides ignoring decades of evidence on how autonomy undermines professionalism's promise to apply the best evidence, knowledge, and techniques to solve the problems of clients, Freidson and other champions of the medical profession do not acknowledge how much of medicine can be routinized around well-developed procedures, resulting in a level of quality higher than that produced by the variations of clinical autonomy. The best health-care systems, like Kaiser Permanente or the Veterans Health Administration, use protocols and standards of practice to attain high levels of quality, and England's National Health Service (NHS) has been working rapidly toward that end for the entire national system (Klein 2006; Oliver 2005). The NHS has steadily strengthened and broadened primary care into interprofessional teams, and the revolutionary new contract in 2003 builds in payments for realizing 146 population-based targets for prevention, diagnosis, treatment, and monitoring of chronic conditions that in effect define what the payer (the government) regards as good clinical practice. An important critique points out that paying in proportion to effort does not correlate well with paying in proportion to health gain, and vice versa (Fleetcroft and Cookson 2006). Further, payment for meeting clinical targets discourages providers from treating the more deprived and sicker patients who have more complex problems and take more time (Heath, Hippisley-Cox, and Smeeth 2007). Untargeted health needs also tend to become more neglected.

A protocol-driven contract like that of the new NHS embodies Freidson's vision of the worst that could happen to professionalism centered on autonomy: doctors and nurses reduced to mere technical workers told how to do their work by Big Brother. A new field study investigates this prediction by observing how the new NHS contract's clinical targets are being implemented (McDonald, Checkland, Harrison, and Coleman 2009). Certain general-practice partners, designated "chasers," use detailed electronic clinical records shared by all to chase up those who are not performing to standard. Contrary to Freidson's predictions, the "chased" actively support the content of the targets and the goal of implementing a uniform high standard of care. The researchers found that the new system overcomes a central problem: lack of specific information on how individuals practice (Freidson 1975). The protocols enable both managers and providers to measure clinical performance. A GP commented: "I mean although I hate it, I do, you know, it's very paradoxical but I actually think it's a good idea and I think it makes things tangible and quantifies things and although I think it's a lot of hard work, I . . . the bottom line is I think patients benefit from it" (McDonald et al. 2009, 1202). The larger implication harkens back to Parsons's conclusion that the institutional framework defines the goals and rewards of work. Without a larger societal mandate to prevent illness, manage chronic conditions, and maximize a population's capacity to function, professionalism in an open field becomes the victim of its own excesses and deficiencies. With a societal mandate, the better qualities of professionals can be harnessed to beneficial societal ends (Light 1999).

Professionalism as Selfless Service to All?

At the end of his widely cited book on professionalism, Freidson turns away from his celebration of the golden age of medicine when physicians could treat whom they wanted, how they wanted, and for as much as they wanted to lay down moral mandates. "The ideology of professionalism asserts above all else devotion to the use of disciplined knowledge and skill for the public good," he declares. The profession should "declare social policies which deny equal access . . . to be professionally unethical" (2001, 217). Such policies would include much of the professionally constructed health-care system and the social policies of medical societies over the past fifty years.

Maximizing personal income at the expense

of quality, Freidson continues, should be declared unethical too. So should investing capital in professional services with the aim of maximizing returns on profit, a practice that turns attention from less profitable to more profitable procedures, regardless of benefit. (Yet it is the assertion of "professional autonomy" that underlies the expansion of physician-owned clinics and hospitals for profit.) Finally, "there can be no ethical justification for professionals who place personal gain above the obligation to do good work for all who need it, even at the expense of some potential income" (218). And professionals should not use patents to maximize profits.

If observed, these principles would turn health-care professions into a powerful countervailing force against the markets in medicine and the marketlike behavior that result from professional autonomy. Freidson's precepts offer greater moral clarity than anything Durkheim, Tawney, or Croly wrote. They are at such odds, however, with the rest of his argument that one does not know what to make of them. It is hard to imagine sociologically how these principles could be carried out except in a universal public health-care system or a national health service. Every one of them is violated every day in the U.S. health-care system as physicians profit from their incorporated specialty practices that undercut integrated care, and from the billions they accept from manufacturers to use new drugs or devices before their safety and added benefits are established (Angell 2009). If Freidson had built his model of professionalism on his strong ethic of public good and social justice, it would have been profoundly different. It would have taken into account his groundbreaking empirical studies, including the practices, limitations, and biases of professional work in early group and prepaid practices (see Freidson 1961, 1975).

Sources of Diminished Trust

If one examines the many accounts of diminished professionalism and trust, one finds four quite different sources: rare cases of bad-apple abusive or incompetent practitioners; widespread variations in treatment and cost for the same problem, which suggests that autonomous professionals do not apply a common body of expertise; self-commercialization; and corporate cooptation or colonialization.

Distrusting Self-Regulation

Reflecting a central institutional dynamic in the United Kingdom but oddly peripheral in the United States and elsewhere, the few bad apples among practitioners in that country led British leaders to conclude that professional bodies failed to monitor, investigate, and address serious cases of abuse, fraud, or incompetence and thus jeopardized the public's trust in practitioners (Yeung and Dixon-Woods 2009). Professional ethics—which Bledstein (1976) characterized as "professional etiquette" and Berlant (1975) as a vehicle for monopolization—were implicated in colleagues' failure to report suspicious behavior and protect their fellow professionals rather than patients. It seems that the social contract and the public's expectations that professionals will be honorable, ethical, and up-to-date were not honored on the occasions when the profession's assurances were not upheld.

Such cases exist everywhere, but in the United Kingdom, they have contributed to historic institutional changes among the countervailing powers that surround the profession as the government has subsumed traditional professional functions. British regulation no longer assumes that medical professionals are competent until found otherwise but rather that they must be examined as "fit to practice" through detailed reviews of work, "revalidation," and remediation when needed. The profession was given a chance to design these reforms of accountability, but its proposals were "scathingly rejected," and institutional redesign was turned over to government officials. The General Medical Council (GMC), responsible for education and registration, has been transformed from an organization based on a nineteenth-century model with most members selected by the profession to a model of public accountability, with parity of lay and professional members appointed through an independent commission. The power to adjudicate cases

of professional misconduct has been transferred to the new Office of the Health Professions Adjudicator. All regulatory functions of the GMC are now overseen by an independent Council for Healthcare Regulatory Excellence accountable to Parliament (UK Secretary of State for Health 2007).

These new practices, standards, and institutions apply to all health professions in consistent ways that end the variable practices of professional organizations. Thus the autonomy of both individual clinicians and their professional bodies has been sharply curtailed, even though breaches of trust are rare. These new institutional arrangements in effect carry out parts of the mythic social contract that the organized profession did not monitor or enforce well. They aim to make professional work more trustworthy, and they provide a model for how state professional boards in other countries could assure the public that health professionals meet high standards. Few state boards in the United States measure up (Public Citizen 2008), yet similar cases of unethical or incompetent behavior have not led to significant U.S. reforms. Comparative research is needed on how the linked ecologies of countervailing powers operate in different countries.

Reining in Autonomous Market Behavior

The irony that autonomy leads to diminished trust by generating widespread variations in procedures, cost, and quality when specialists treat the same cases has led to evidence-based medicine and clinical guidelines (Hafferty and Light 1995; Timmermans and Berg 2003). Yet Americans receive care that meets established quality standards only about half the time (McGlynn et al. 2003). Quality varies considerably, not only by insurance status and other market variables, but even after controlling for them. Are quality and the application of professional expertise less variable elsewhere, in universal health-care systems that do not operate largely by economic markets? Historians maintain that medicine was ever thus—centuries of doctors running cottage practices based on charismatic and legal authority, marketing useless or harmful cures, and having little systematic knowledge of which treatments work better (Imber 2008; Wootton 2006).[2]

A variety of measures have been taken to establish clinical standards. From a market perspective, these are analogous to measures to protect the public from unacceptable variations in other service industries, but they represent a revolution in medicine. For example, a cardiac team trying to decide how to treat a patient who has severe congestive heart failure can use comparative data to estimate his five-year survival chances based on tracked cases—medication 9.4 percent, angioplasty 26.5 percent, or bypass surgery 46.2 percent—and then review treatment choices with the patient (Millenson 1997). New Jersey, like several other states, publishes the risk-adjusted mortality rates of hospitals and surgeons so that patients can choose a surgeon with a proven track record (State of New Jersey 2009). A profit-seeking managed-care company, however, can use guidelines to squeeze time, tests, and treatments for profit (Burdi and Baker 1999). Researchers find that unless physicians choose and develop evidence-based guidelines themselves, as they do in large physician groups or physician-run organizations like Kaiser-Permanente, they resist them (Audet et al. 2005; Rittenhouse et al. 2004).

In the United Kingdom, particularly in England, the government as payer and governor of a national health service has developed National Service Frameworks that detail clinical standards for large clinical areas (e.g., cardiology) or kinds of patients (e.g., children). It established NICE, the National Institute for Clinical Excellence, to assess which of hundreds of new medicines, devices, and procedures meet criteria for effectiveness and value. Such efforts generate controversies about approaches or products not included, and about over- or underrating. Clinical governance has become a public rather than a self-governing professional function, overseen by the English Care Quality Commission. Pay now depends in part on meeting quality targets and leads to a certain amount of gaming and displays of compliance. These changes tacitly shift decisions about how to stay within a budget to doctors practicing evidence-based medicine and diffuse responsibility for rationing when it occurs (Harrison 1998). It changes the professional basis of work from

the individual application of medical science to epidemiological evidence of effectiveness (Timmermans and Kolker 2004). Some observers may see this constellation of changes as professionalism destroyed; others regard it as professionalism finally realized (Millenson 1997). Still others in Scotland and Wales agree with the goals but not the particulars of the English approach. In the United States, there are many similar efforts to establish quality standards, one for each managed-care group or plan, specialty society, consulting firm, and government initiative, each with a somewhat different focus and approach.

Self-Commercialization

The third source of diminished trust, self-commercialization, although ever-present in medical practice, has shaped the large-scale institutionalization of practice and markets in the twentieth century (Larson 1977; Starr 1982). Contrary to the claims of Freidson and spokespersons for the profession, I contend that professionals have a considerable affinity for business and have embraced corporations that enhance their diagnostic and treatment capacities, even though new tests, devices, and drugs may not improve clinical results. Health-care corporations arose to exploit the protected markets the medical profession created in which margins were high and it was nearly impossible to lose. Calls to restore professionalism overlook the rapid escalation of costs, the unnecessary procedures, and the professional corporatization that occurred during the golden age of professional autonomy and dominance. Professions *as* markets and self-commercialization would characterize what led to the buyers' revolt (see Table 16.2).

William Sullivan, writing for the Carnegie Foundation's long-term project on restoring professionalism, misconstrues the decline of professional sovereignty as beginning when the profession partnered with government after Medicare and Medicaid were passed, resulting in "less room for autonomous maneuver" (2005, 57). Sullivan's account overlooks the history of Blue Cross and Blue Shield, a kind of nonprofit insurance that did not interfere with providers' freedom to bill as they liked (Law 1974; Somers and Somers 1961). Later, as commercial insurers began to write health insurance, they emulated this model of passive reimbursement. As Medicare and Medicaid took shape in 1964, the profession threatened not to treat the elderly and the poor unless both programs were based on reimbursing what providers charge. Services and charges rapidly increased, and Congress has been trying to curb both ever since. By addressing neither self-commercialization among physicians who turned their practices into corporations during the golden age of medicine from 1945 to 1975 nor the implications of this process for the social contract (which is never described), the Carnegie Foundation project is likely to be strong on rhetoric but ineffective.

A new account of U.S. health-care professions and markets by Carl Ameringer (2008), sponsored by the Milbank Fund, likewise misses the extensive self-commercialization in the 1950s documented in the authoritative study by Somers and Somers (1961), as well as expanded forms in the 1960s documented by several studies cited in previous editions of this handbook. Ameringer's starting point—the Federal Trade Commission's attack on collusive and protectionist medical practices after 1975—makes it look as if neoconservatives attacked a noble profession. Ameringer mentions neither the self-serving ethics and practices that resulted in excessive tests, drugs, operations, hospital procedures, and charges (Berlant 1975), nor prior concerted efforts by Congress to regulate professional expansion (Starr 1982). Physicians and hospitals effectively sidelined or circumvented these efforts. Self-commercialization is especially prevalent in the United States, where physician practices incorporated in the 1970s and where specialists have invested in stand-alone clinics or diagnostic centers that siphon profitable cases from general hospitals, weakening them and fragmenting care. This trend led many leaders to conclude that only the market discipline of corporate managed care could bring professionally driven health care under control. Mahar (2006) describes the resulting "Hobbesian marketplace" that pits providers against each other and against payers in a "war of all against all" that wastes up to one of every three dollars on administrative

complexity, profits, and unnecessary or unproven but overpriced procedures and products.

Corporate Co-optation

Beyond the long-standing ties between the profession and companies as countervailing powers, a more recent development involves the ways in which one commercial sector, the pharmaceutical industry, has succeeded in co-opting medical science, medical journals, and the creation of new risks or diseases. Pharmaceutical companies shape how physicians are trained, what they know about a given disease, how they think about alternate approaches to treatment, and what medications they have patients ingest (Abramson 2004; Brody 2007; Relman and Angell 2002). Models of pathology and risk are developed to sell drugs to treat them and often are based on synthetic or surrogate endpoints that eventually prove to have little clinical relevance, such as the serotonin model of major depression (Curtiss and Fairman 2008; Healy 2004; Horwitz and Wakefield 2007; Lacasse and Leo 2005; Moynihan and Cassels 2005).

Companies retain prominent clinical researchers and fund their work in order to create a commercialized science of heart disease, or menopause, or social anxiety disorder, or osteoporosis (Conrad 2007; Moynihan and Cassels 2005). Marcia Angell (2009), the former editor of the *New England Journal of Medicine*, summarizes the extensive investigations by the U.S. Senate into what she and Senator Charles Grassley call "the corruption" of universities, academic research, and prominent physicians through company grants, fees, and retainers that greatly increase psychiatric diagnoses, especially in children, and prescriptions for powerful drugs of unclear or unproven clinical benefit (see also Bass 2008; Lane 2007; Petersen 2008). These practices and institutional patterns of co-optation also appear to exist in other countries.

Commercial constructions of medical science are initially promoted through articles in medical journals, often written by hired ghostwriters and fronted by physicians who agree to be the authors of record for a fee (Ross et al. 2008). Articles on sponsored research are three to four times more likely to find the results favorable to the sponsor's product than are articles based on research funded by independent sources (Lexchin et al. 2003; Turner et al. 2008). Salespersons then give the published articles to practicing physicians as proof that the sponsor's drug is better than the one they are prescribing. This pharmaceutically managed bias in medical science thus leads physicians, patients, and managers to inaccurate conclusions about the efficacy and safety of new drugs.

At the same time, companies sponsor invitational conferences on a new disease model to give heads of specialty services around the country the opportunity to meet the leading clinical researchers, all expenses paid, at a five-star resort, where attendees have a light schedule and the rest of each day off. Company-sponsored sessions at professional specialty meetings further establish the purported veracity of the new disease model, as do thousands of continuing medical education courses for practitioners, most of which are now sponsored by pharmaceutical companies as well (Relman 2007; U.S. Senate 2007). Over 90 percent of physicians report receiving gifts, perks, or money from drug companies, and they choose to get information about what to prescribe from sales reps who are required to spend their large monthly allowance in ways that will most effectively result in their doctors writing more prescriptions for new drugs (Lee 2007). Lakoff (2005) refers to the pharmaceutical companies' "sculpting" of doctor-patient interaction, as physicians' expertise is shaped by market-based science and the gift relationship established by their receiving samples of costly new drugs, which the doctors then bless and give to patients.

These clustered techniques of what Suddaby and Greenwood (2001) describe as "colonizing knowledge" begin by commodifying knowledge, honing complex volumes of test results down to a simple message and story, which are used to persuade physicians to prescribe and patients to want a new drug. About a hundred thousand sales reps in the United States alone are carefully trained in the social psychology of friendship with all their physician customers to sculpt their prescribing decisions (Fugh-Berman and Ahari

2007). Personal sales reps are supplemented by industry-funded patient groups, which lobby their physicians and legislators for new drugs that cost thousands a year. Other physicians, including three past editors-in-chief of the *New England Journal of Medicine*, have written books about the co-optation of medicine and physicians' clinical decisions by the pharmaceutical industry and how it endangers patients (Abramson 2004; Angell 2004; Avorn 2004; Breggin 1991; Brody 2007; Glenmullen 2000; Kassirer 2005; Relman and Angell 2002). Six out of every seven new drugs offer no or few clinical benefits over existing ones and yet bear greater risk for adverse side effects (Light, in press).

Concluding Comment

This review of the relations between the medical profession and markets has gone from professions against markets. to professions as markets, to professions marketed and colonized. Strangely, almost none of the policies to restore professionalism or of the sociological studies of the profession mention or address this most pervasive threat to professional knowledge and practice. For example, Susan Chimonas, Troyen A. Brennan, and David J. Rothman at the Center on Medicine as a Profession studied how physicians handled the conflicts of interest that arise from seeing drug sales representatives and were so struck by the physicians' forms of denial and rationalization that they concluded "only the prohibition of physician-detailer interactions will be effective" (2007, 189). They are part of a larger group that has called on academic medical centers to join members of Congress and state governments in eliminating commercial conflicts of interest (Brennan et al. 2006). They call for the prohibition of all gifts, free samples, company-sponsored professional education, and ghostwriting so that independent, trustworthy professionalism can be restored. Wider patterns of professional commercialization have led Arnold Relman (2007), a champion of professional integrity for the last thirty years and past editor-in-chief of the *New England Journal of Medicine*, to conclude that all medical practice must be completely decommercialized under a salaried national health service. The physician-writer John Geyman (2008) summarizes the evidence and comes to a similar conclusion, with an emphasis on the profession serving the health needs of all, not just their patients. Durkheim and the later Freidson were wrong: the health-care professions do not embody a higher moral order for society but need to be rescued from market forces and from pursuing their own self-interests.

Notes

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1. One sees complete state dominance today in many dictatorships, usually to carry out internecine warfare and genocide, but sometimes to support population-based health care.
2. Imber (2008) notes that the basis for trust has shifted from medical professionals' moral integrity to their effective application of expert knowledge.

References

Abbott, Andrew. 1988. *The System of Professions.* Chicago: University of Chicago Press.

———. 2005. "Linked Ecologies: States and Universities as Environments for Professions." *Sociological Theory* 23:245–74.

Abramson, John. 2004. *Overdosed America: The Broken Promise of American Medicine.* New York: Harper-Collins.

Albrecht, Gary L. 1992. *The Disability Business.* Thousand Oaks, Calif.: Sage.

AMSA [American Medical Students Association]. 2009. "AMSA's 60th Annual Convention: AMSA at 60! Celebrating Passion, Professionalism, Pride." amsa.org/conv/.

Ameringer, Carl F. 2008. *The Health Care Revolution: From Medical Monopoly to Market Competition.* Berkeley: University of California Press.

Angell, Marcia. 1993. "The Doctor as Double Agent." *Kennedy Institute of Ethics Journal* 3:279–86.

———. 2004. *The Truth about the Drug Companies: How They Deceive Us and What to Do about It.* New York: Random House.

———. 2009. "Drug Companies and Doctors: A Story of Corruption." *New York Review of Books*, January 15, 56.

Audet, Anne-Marie J., Michelle M. Doty, Jamil

Shamasdin, and Stephen C. Schoenbaum. 2005. "Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement." *Health Affairs* 24:843–53.
Avorn, Jerry. 2004. *Powerful Medicines: The Benefits, Risks, and Costs of Prescription Drugs*. New York: Knopf.
Bass, Allison. 2008. *Side Effects: A Prosecutor, a Whistleblower, and a Bestselling Antidepressant on Trial*. Chapel Hill, N.C.: Algonquin Books.
Berlant, Jeffrey L. 1975. *Profession and Monopoly*. Berkeley: University of California Press.
Bledstein, Burton. 1976. *The Culture of Professionalism*. New York: W. W. Norton.
Breggin, Peter. 1991. *Toxic Psychiatry*. New York: St. Martin's Press.
Brennan, Troyen A., David J. Rothman, Linda Blank, David Blumenthal, Susan Chimonas, Jordon Cohen, Janlori Goldman, Jerome Kassirer, Harry Kimball, James Naughton, and Neil Smelser. 2006. "Health Industry Practices that Create Conflict of Interest." *Journal of American Medical Association* 295:429–33.
Brody, Howard. 2007. *Hooked: Ethics, the Medical Profession, and the Pharmaceutical Industry*. Lanham, Md.: Rowman and Littlefield.
Brown, E. Richard. 1979. *Rockefeller Medicine Men*. Berkeley: University of California Press.
Burdi, M. D. and L. C. Baker. 1999. "Physicians' Perceptions of Autonomy and Satisfaction in California." *Health Affairs* 18:134–45.
Burrow, James G. 1977. *Organized Medicine in the Progressive Era: The Move toward Monopoly*. Baltimore: Johns Hopkins University Press.
Chimonas, Susan, Troyen A. Brennan, and David J. Rothman. 2007. "Physicians and Drug Representatives: Exploring the Dynamics of the Relationship." *Journal of General Internal Medicine* 22:184–90.
Conrad, Peter. 2007. *The Medicalization of Society*. Baltimore: Johns Hopkins University Press.
Croly, Herbert. 1965 (1909). *The Promise of American Life*. Edited by A. R. Schlesinger. Cambridge: Belknap Press of Harvard University Press.
Curtiss, Frederic R., and Kathleen A. Fairman. 2008. "Looking for the Outcomes We Love in All the Wrong Places: The Questionable Value of Biomarkers and Investments in Chronic Care Disease Management Interventions." *Journal of Managed Care Pharmacy* 14:563–70.
DeVries, R. G., T. Lemmens, and C. L. Bosk. 2008. "The Subjectivity of Objectivity: The Social, Cultural, and Political Shaping of Evidence-Based Medicine." In *The Brave New World of Health*, ed. B. Bennett, T. Carney, and I. Karpin, 144–65. Sydney: Federation Press.
Dingwall, Robert. 2008. "In Memory of Eliot Freidson: Is 'Professional Dominance' an Obsolete Concept?" In *Essays on Professions*, ed. R. Dingwall, 127–41. Aldershot, UK: Ashgate.
Durkheim, Emile. 1957. *Professional Ethics and Civic Morals*. Translated by C. Brookfield. London: Routledge and Kegan Paul.
Fleetcroft, R., and R. Cookson. 2006. "Do the Incentives Payments in the New NHS Contract for Primary Care Reflect Likely Population Gains?" *Journal of Health Services Research Policy* 11:27–31.
Freidson, Eliot. 1961. *Patients' Views of Medical Practice*. Chicago: University of Chicago Press.
———. 1970a. *Profession of Medicine*. New York: Dodd, Mead.
———. 1970b. *Professional Dominance*. New York: Atherton.
———. 1975. *Doctoring Together: A Study of Professional Social Control*. New York: Elsevier.
———. 1983. "The Theory of Professions: State of the Art." In *The Sociology of the Professions*, ed. R. Dingwall and P. Lewis. New York: St. Martin's Press.
———. 2001. *Professionalism: The Third Logic*. Chicago: University of Chicago Press.
Fugh-Berman, Adrianne, and Shahram Ahari. 2007. "Following the Script: How Drug Reps Make Friends and Influence Doctors." *Public Library of Science Medicine* 4: e150.
Geyman, John. 2004. *The Corporate Transformation of Health Care: Can the Public Interest Still Be Served?* New York: Springer.
———. 2008. *The Corrosion of Medicine: Can the Profession Reclaim Its Moral Legacy?* Monroe, Me.: Common Courage Press.
Glenmullen, Joseph. 2000. *Prozac Backlash: Overcoming the Dangers of Prozac, Zoloft, Paxil, and Other Antidepressants with Safe, Effective Alternatives*. New York: Simon and Schuster.
Goozner, Merrill. 2004. *The $800 Million Pill: The Truth behind the Cost of New Drugs*. Berkeley: University of California Press.
Gordon, Colin. 2003. *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*. Princeton, N.J.: Princeton University Press.
Hafferty, Fred. 2003. "Finding Soul in a 'Medical Profession of One.'" *Journal of Health Politics, Policy and Law* 28:133–58.
Hafferty, Fred, and D. W. Light. 1995. "Professional Dynamics and the Changing Nature of Medical Work." *Journal of Health and Social Behavior*, extra issue: 132–53.
Halpern, Sydney. 1988. *American Pediatrics: The Social Dynamics of Professionalism, 1880–1980*. Berkeley: University of California Press.
Halpern, Sydney, and Renee R. Anspach. 1993. "The

Study of Medical Institutions: Eliot Freidson's Legacy." *Work and Occupations* 20:279–95.
Harrison, Stephen. 1998. "The Politics of Evidence-Based Medicine in the United Kingdom." *Policy and Politics* 26:15–31.
Haskell, Thomas. 1984. "Professions versus Capitalism." In *The Authority of Experts: Studies in History and Theory*, ed. T. Haskell, 180–225. Bloomington: Indiana University Press.
Havighurst, Clark C. 2003. "An Apology for Professionalist Regimes." *Journal of Health Politics, Policy and Law* 28:159–63.
Healy, David. 2004. *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression*. New York: New York University Press.
Heath, I., J. Hippisley-Cox, and L. Smeeth. 2007. "Measuring Performance and Missing the Point?" *British Medical Journal* 335:1075–76.
Horwitz, Allan, and Jerome C. Wakefield. 2007. *The Loss of Sadness*. New York: Oxford University Press.
Hughes, Everett C. 1958 (1951). "Mistakes at Work." In *Men and Their Work*, ed. E. C. Hughes, 88–101. Glencoe, Ill.: Free Press.
———. 1994 (1965). "Professions." In *On Work, Race, and the Sociological Imagination*, ed. E. C. Hughes, 37–49. Chicago: University of Chicago Press.
Imber, Jonathan B. 2008. *Trusting Doctors: The Decline of Moral Authority in American Medicine*. Princeton, N.J.: Princeton University Press.
Kassirer, Jerome P. 2005. *On the Take: How Medicine's Complicity with Big Business Can Endanger Your Health*. New York: Oxford University Press.
Klein, Rudolf. 2006. *The New Politics of the NHS: From Creation to Reinvention*. Abingdon, UK: Radcliffe.
Krause, Elliott A. 1996. *Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present*. New Haven, Conn.: Yale University Press.
Kuhlmann, Ellen. 2006. *Modernizing Health Care: Reinventing Professions, the State and the Public*. Bristol, UK: Policy Press.
Lacasse, Jeffrey R., and Jonathan Leo. 2005. "Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature." *Public Library of Science Medicine* 2:1212–16.
Lakoff, Andrew. 2005. "The Private Life of Numbers." In *Global Assemblages*, ed. A. Ong and S. J. Collier, 194–212. Oxford: Blackwell.
Lane, Christopher. 2007. *Shyness: How Normal Behavior Became a Sickness*. New Haven, Conn.: Yale University Press.
Larson, Magali Sarfatti. 1977. *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press.
Law, S. A. 1974. *Blue Cross: What Went Wrong?* New Haven, Conn.: Yale University Press.
Lee, Christopher. 2007. "Drugmakers, Doctors Get Cozier: Gifts Continue, Contacts Increase Despite Guidelines." *Washington Post*, April 29.
Leicht, Kevin, and Mary L. Fennell. 2001. *Professional Work: A Sociological Approach*. Malden, Mass.: Blackwell.
Lexchin, Joel, Lisa A. Bero, Benjamin Djulbegovic, and Octavio Clark. 2003. "Pharmaceutical Industry Sponsorship and Research Outcome And Quality: Systematic Review." *British Medical Journal* 326:1167–70.
Light, Donald W. 1989. "Social Control and the American Health Care System." In *Handbook of Medical Sociology*, 4th ed., ed. H. E. Freeman and S. Levine, 456–74. Upper Saddle River, N.J.: Prentice Hall.
———. 1992. "The Practice and Ethics of Risk-Rated Health Insurance." *Journal of the American Medical Association* 267:2503–08.
———. 1999. "Good Managed Care Needs Universal Health Insurance." *Annals of Internal Medicine* 130:686–89.
———. 2000. "The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power." In *Handbook of Medical Sociology*, 5th ed., ed. C. Bird, P. Conrad, and A. Fremont, 201–16. Englewood Cliffs, N.J.: Prentice Hall.
———. 2001. "Comparative Institutional Response to Economic Policy, Managed Competition, and Governmentality." *Social Science and Medicine* 52(8): 1151–66.
———. 2004. "Ironies of Success: A New History of the American Health Care 'System.'" *Journal of Health and Social Behavior* 45, extra issue: 1–24.
———. 2006. "Basic Research Funds to Discover Important New Drugs: Who Contributes How Much?" In *Monitoring the Financial Flows for Health Research 2005: Behind the Global Numbers*, ed. M. A. Burke, 27–43. Geneva: Global Forum for Health Research.
———, ed. In press. *The Risks of Prescription Drugs*. New York: Columbia University Press.
Light, Donald W., and Sol Levine. 1988. "Changing Character of the Medical Profession: A Theoretical Overview." *Milbank Quarterly* 66, suppl. 2:1–23.
Light, Donald W., and Alexander Schuller. 1986. "Political Values and Health Care: The German Experience." Cambridge, Mass.: MIT Press.
Louden, Irving. 2008. "General Practice and Obstetrics: A Brief History." *Journal of the Royal Society of Medicine* 101:531–35.
Lundberg, George D. 2000. *Severed Trust*. New York: Basic.

Mahar, Maggie. 2006. *Money-Driven Medicine*. New York: Collins.

McDonald, Ruth, Kate Checkland, Stephen Harrison, and Anna Coleman. 2009. "Rethinking Collegiality: Restratification in English General Medical Practice 2004–2008." *Social Science and Medicine* 68(7): 1199–1205. Manchester, UK: University of Manchester.

McGlynn, Elizabeth A., Steven M. Asch, John Adams, and Joan Keesey. 2003. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348:2635–45.

McKinlay, John, and Lisa Marceau. 2008. "When There Is No Doctor: Reasons for the Disappearance of Primary Care Physicians in the U.S. during the Early 21st Century." *Social Science and Medicine* 67(10): 1481–91.

Mechanic, David. 2006. *The Truth about Health Care: Why Reform Is Not Working in America*. New Brunswick, N.J.: Rutgers University Press.

Millenson, Michael L. 1997. *Demanding Medical Excellence*. Chicago: University of Chicago Press.

Moynihan, Ray, and Alan Cassels. 2005. *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients*. New York: Nation Books.

Navarro, Vicente. 1976. *Medicine under Capitalism*. New York: Prodist.

Navarro, Vicente, and Carles Muntaner. 2004. "Political and Economic Determinants of Population Health and Well-Being." Amityville, N.Y.: Baywood.

Nixon, Richard M. 1972. *Public Papers of the Presidents of the United States: Richard Nixon 1971*. Washington D.C.: U.S. Government Printing Office.

Oliver, Adam. 2005. "The English National Health Service, 1979–2005." *Health Economics* 14, suppl.: S75–100.

Parsons, Talcott. 1939. "The Professions and Social Structure." *Social Forces* 17:457–67.

Petersen, Melody. 2008. "Our Daily Meds: How the Pharmaceutical Companies Transformed Themselves into Slick Marketing Machines and Hooked the Nation on Prescription Drugs." New York: Sarah Crichton/Farrar, Straus and Giroux.

Picker Institute Europe. pickereurope.org.

Portes, Alejandro, and Julia Sensenbrenner. 1993. "Embeddedness and Immigration: Notes on the Social Determinants of Economic Action." *American Journal of Sociology* 98:1320–50.

Public Citizen. 2008. "Public Citizen's Health Research Group Ranking of the Rate of the State Medical Boards Serious Disciplinary Actions 2005–07." Washington, D.C.: Public Citizen.

Quadagno, Jill. 2004. "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945–1996." *Journal of Health and Social Behavior* 45, extra issue: 25–44.

———. 2005. *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*. New York: Oxford University Press.

Relman, Arnold S. 2007. *A Second Opinion: Rescuing America's Health Care*. New York: Public Affairs.

Relman, Arnold, and Marcia Angell. 2002. "America's Other Drug Problem: How the Drug Industry Distorts Medicine and Politics." *New Republic*, December 16, 27–36.

Rittenhouse, Diane R., Kevin Grumbach, Edward H. O'Neil, Catherine Dower, and Andrew Bindman. 2004. "Physician Organization and Care Management in California: From Cottage to Kaiser." *Health Affairs* 23:51–62.

Robinson, James C. 2001. "The End of Managed Care." *Journal of the American Medical Association* 285:2622–28.

Ross, Joseph S., Kevin P. Hill, David S. Egilman, and Harlan M. Krumholz. 2008. "Guest Authorship and Ghostwriting in Publications Related to Rofecoxib." *Journal of American Medical Association* 299:1800–1812.

Schwartz, Jerome I. 1965. "Early History of Prepaid Medical Care Plans." *Bulletin of the History of Medicine* 39:450–75.

Sciulli, David. 2005. "Continental Sociology of Professions Today: Conceptual Contributions." *Contemporary Sociology* 53:915–42.

Scull, Andrew. 1979. *Museums of Madness*. New York: St. Martin's Press.

Somers, Herman M., and Anne H. Somers. 1961. *Doctors, Patients, and Health Insurance*. Washington, D.C.: Brookings Institution.

Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic.

State of New Jersey. Department of Health and Senior Services. 2009. "Cardiac Surgery." state.nj.us/health/healthcarequality/cardiacsurgery.shtml.

Stevens, Rosemary. 1971. *American Medicine and the Public Interest*. New Haven, Conn.: Yale University Press.

———. 1998. *American Medicine and the Public Interest*. Updated ed. Berkeley: University of California Press.

Stone, Deborah. 1997. "The Doctor as Businessman." *Journal of Health Politics, Policy and Law* 22:533–56.

Suddaby, Roy, and Rayston Greenwood. 2001. "Colonizing Knowledge: Commodification as a Dynamic of Jurisdictional Expansions in Professional Service Firms." *Human Relations* 54:933–53.

Sullivan, William M. 2005. *Work and Integrity: The Crisis and Promise of Professionalism in America*. 2nd ed. San Francisco: Jossey-Bass.

Tawney, R. H. 1920. *The Acquisitive Society*. London: Bell.
Timmermans, Stefan, and Marc Berg. 2003. *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.
Timmermans, Stefan, and Emily Kolker. 2004. "Clinical Practice Guidelines and the Implications of Shifts in Knowledge for Sociological Accounts of Professional Power." *Journal of Health and Social Behavior* 45, extra issue: 177–93.
Tudor Hart, Julian. 1971. "The Inverse Care Law." *Lancet*, February 27, 405–12.
———. 2008. "A New Horizon for NHS Wales." *Bevan Foundation Review* 11 (autumn): 8–10.
Turner, Erick H., Annette M. Matthews, Eftihia Linardatos, Robert A. Tell, and Robert Rosenthal. 2008. "Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy." *New England Journal of Medicine* 358:252–60.
UK Secretary of State for Health. 2007. "Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century." London: Stationery Office.
U.S. Senate. Committee on Finance. 2007. "Use of Educational Grants by Pharmaceutical Manufacturers." Washington, D.C.: U.S. Government Printing Office.
Waitzkin, Howard. 1983. *The Second Sickness: Contradictions of Capitalist Health Care*. New York: Free Press.
———. 2001. *At the Front Lines of Medicine*. New York: Rowman and Littlefield.
Weisz, George. 2006. *Divide and Conquer: A Comparative History of Medical Specialization*. New York: Oxford University Press.
Wootton, David. 2006. *Bad Medicine: Doing Harm since Hippocrates*. Oxford: Oxford University Press.
Yeung, Karen, and Mary Dixon-Woods. 2009. "'Rotten Apples and Good Apples': Regulating the Medical Profession in the 21st Century." Leicester, UK: University of Leicester, Department of Sociology.
Zetka, James R., Jr. 2008. "The Making of the 'Women's Physician' in American Obstetrics and Gynecology: Reforging an Occupational Identity and a Division of Labor." *Journal of Health and Social Behavior* 49:335–51.
Zola, Irving Kenneth, and Stephen J. Miller. 1973. "The Erosion of Medicine from Within." In *The Professions and Their Prospects*, ed. E. Freidson, 153–72. Beverly Hills, Calif.: Sage.