# THE SHORT HISTORY AND TENUOUS FUTURE OF MEDICAL PROFESSIONALISM

## *the erosion of medicine's social contract*

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**ABSTRACT** The profession of medicine is based on a shared set of tacit and explicit agreements about what patients, doctors, and society at large should be able to expect from each other, a social contract that defines the profession. Historically, the development of this set of agreements depended upon the creation of social organizations that could speak for the entire profession. Over the last several decades, however, the perceived need for these organizations, and especially the umbrella organization for the profession, the American Medical Association, has waned. The reasons for this are complex, but the consequences are significant: an eroding social contract, fragmentation, lack of cohesion and integrity, and loss of the public's confidence. The present social contract is one-dimensional, overly simplistic, and failing to sustain the public's trust. To address these problems, a renewed social contract is necessary. Although this renewed contract should be based on foundations similar to the original, it must directly confront such contemporary challenges as resource allocation and conflicts of interest. Equally as important, to reinvigorate our social contract more physicians will need to come to grips with a basic truth: to sustain professionalism we need a strong, unified professional association.

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THE EXACT BIRTH DATE OF MEDICINE as a profession is murky and depends on one's definition of "profession." But if one accepts a bare-bones definition—a group that publicly "professes" to share uniform training and standards of practice, which they promise to use in service to others—it is possible, roughly, to date the birth of medical professionalism. And it is much younger, and perhaps more fragile, than many might imagine it to be.

Some would date medical professionalism to the Hippocratic era. Margaret Mead has noted that Hippocratics first separated the roles of healer and sorcerer (Bulger and Barbato 2000). They famously swore an oath professing standards of conduct, and they promoted empirical observation as the basis of medical practice. Nonetheless, as the eminent historian Ludwig Edelstein (1943) has argued, the Hippocratics were a minority sect, who did not succeed in creating uniform standards of practice and behavior for all Greek physicians. Contravening some Hippocratic dicta, Greek physicians performed abortions and assisted in suicides (Baker 1993). The rich and the powerful could even hire Greek physicians as medical hit men. According to the Roman historian Tacitus, the emperor's wife, Agrippina, hired a Greek court physician, Gaius Stertinius Xenophon (ca. 10 BCE–54 CE), to poison her husband, the Emperor Claudius (*The Annals*, Book XIV, 1–16). Popular acceptance of this account suggests that the Hippocratic prohibition against harming patients was not uniformly practiced by Greek physicians. Instead, most physicians of the time were simply specialists in the uses of chemicals and botanicals, unbound by a uniform code of conduct or standards of practice. As the medical historian Albert Jonsen (2000) put it, in Hippocratic times "there does not appear to have been anything like a medical profession" (p. 9).

Others might date medical professionalism to the Middle Ages or to the Renaissance, when standard curricula in medical schools, novel public-health efforts, and the hiring of "plague doctors" by towns began to clarify some of the social obligations that medical doctors should take on. For instance, in 1666 William Boghurst, a London apothecary, asserted that physicians were obliged to treat patients during epidemics. Yet these obligations and social roles were neither clearly articulated nor widely accepted—indeed, the standard advice of physicians facing the plague in this era, both for themselves and their wealthy patients, was *cito, longe, tarde*: go quickly, go far, and don't come back too soon. The fact that towns had to hire specific doctors to stay and care for patients during epidemics suggests that a commitment to continue providing care was not acknowledged as part of the physician's role.

The term *medical ethics* and the modern use of *profession* first appeared in the early 19th century, when an English physician, Dr. Thomas Percival of Manchester, introduced them in his book, *Medical Ethics* (1803). Percival (1803) clearly articulated specific social roles for all physicians and hoped to see these widely adopted. While it is tempting, therefore, to date the birth of medical professionalism to 1803, Percival's efforts to get the British medical profession to agree to a written set of ethical standards for all physicians were, unfortunately,





sharply rebuffed. The sentiment in England at the time was that proper gentlemen didn't need written ethical standards, because they already knew how to behave. In fact, as Baker et al. (1999) put it, codes of ethics were considered "undesirable" because they were "useful only to persons who, lacking decent character, wish to pretend that they had one."

In the end, it was the American medical profession that, in the mid-19th century, created the first national set of ethical and practice standards. Eventually, similar standards were almost universally accepted, thereby creating the modern concept of the medical profession. American physicians were primed for the task of creating a full-fledged profession for several reasons. Perhaps most important was the Americans' attraction to the notion of a social contract—a notion conceived by French, English, and Scottish Enlightenment thinkers, but implemented most fully in the young American republic, created by rebels against inegalitarian classism. In the United States, people were to relate as equals. Social relations were to be built upon more-or-less explicit contracts between willing parties, not such nebulous notions as noblesse oblige or gentlemanly honor. This way of thinking led to the desire to specify the terms of social relations. In medicine, this specification would take the form of a written code of ethics.

In 1847, American medicine was in disarray. There were no uniform standards for medical education, medical practice, or medical ethics. Most medical care was ineffective and often life-threateningly dangerous. Caveat emptor ruled the field. The free market was leading to the rampant production of a wide variety of uneducated and unorthodox practitioners. The survival of scientific medicine was under threat—at risk of dying before it had been fully born, let alone produced any of the miraculous cures it would later deliver. In this environment, a group of "orthodox" practitioners met to draw up a set of educational and ethical standards, by which they might define—and defend—the nascent "profession" of scientific medicine. The document they produced, the 1847 Code of Medical Ethics of the American Medical Association (AMA), was the first national code of ethics for any profession.

This code of ethics, which was hailed at the time for being as revolutionary as the Declaration of Independence (Baker et al. 1999), was clearly derived from the work of Percival, the Hippocratics, and others. Yet it was also quintessentially American. It laid out a three-part social contract, with reciprocal obligations spelled out between physicians and patients, physicians and other physicians, and physicians and their communities. In many cases these obligations were significant and specific. The three chapters of the code were drawn along the lines of these reciprocal obligations. With regard to community-physician obligations, for example, a physician is "required to expose his health and life for the benefit of the community, [and] he has a just claim, in return, on all its members, collectively and individually, for aid to carry out his measures." In relations with individual patients, physicians were to "be ever ready to obey the calls of the sick," "secrecy and delicacy" should be "strictly observed," and so on. But in return,

patients were to select only properly trained physicians and to "faithfully and unreservedly communicate to their physician the supposed cause of their disease" (yet a patient should not "weary" the physician with "tedious detail"!), and, of course, "the obedience of a patient to the prescriptions of his physician should be prompt and implicit" (Baker et al. 1999, appendix B and C).

These reciprocal obligations did not depend on the personal virtue of the practitioner, though it was certainly hoped that virtuous individuals would join the profession. Instead, the obligations of medical professionals were laid out, explicitly and in writing, so that patients, the community, and physicians all would be aware of these standards. The profession aimed to make uniform claims about the quality of its practitioners, which would be the basis of public trust and improved public health (and—not coincidentally—the foundation for the establishment of self-regulation and monopoly power).

One can certainly argue about the extent to which these reciprocal sets of obligations were lived out, and the degree to which physicians, in particular, lived up to the ideals they espoused in the code. One can also raise questions about the extent to which patients were a willing party to this new contract. Nonetheless, the general notion that all physicians have specific and unique obligations, and a special, privileged role in society, became widely accepted only after this new group of professionals was willing to (1) put these matters in writing and (2) develop mechanisms for self-regulation to encourage adherence to its new code (Wynia 2006). Indeed, the social status of physicians was eventually raised to near-stratospheric heights, based in part on this explicit social contract that demanded altruism, civic-mindedness, devotion to scientific ideals, and a promise of competence and quality assurance through self-regulation.

## The Role of Professional Associations

Since professions are group-based social entities, being part of a collegial community is an essential feature of professionalism. In particular, when a profession is based on a written social contract—a code of ethics—the organization that writes this code becomes very important. If a practitioner wants to affect the social contract, the way to do so is through the professional association. And participation in local, state, and national professional associations became important for many other reasons as the medical profession became socially recognized and successful—that is, as the social contract played out.

Some activities of the early AMA were guild-type activities, such as the fact that bank loans and malpractice insurance were often contingent upon AMA membership. Other activities and standards more clearly promoted the public good, or were plainly altruistic—such as the obligation specified in the AMA Code that "when pestilence prevails," physicians must continue to care for patients despite the risk to their own health and even (after 1912) "without regard" to remuneration (Huber and Wynia 2004).





Being a member of one's professional association was also how one kept up-to-date on the evolving science of medicine, a special challenge to far-flung solo practitioners in the United States. It was how one forged collegial relations—needed for referrals and assistance during surgery, for example. The famous physician Sir William Osler repeatedly noted the importance of professional societies as the fertile ground in which professionals grew: "You cannot afford to stand aloof from your professional colleagues in any place. Join their associations, mingle in their meetings, gathering here, scattering there; but everywhere showing that you are faithful students, as willing to teach as be taught" (Bryan 1997, p. 51).

As this quote suggests, professional associations played an important role in developing the non-monetary reward system of early medicine. According to early sociologists of the medical profession, monetary rewards were scant and a surprisingly rare motivator for those entering the medical profession. Talcott Parsons, for example, suggested that people who became doctors tended to be driven less by money than by a desire to look good in front of their peers (Latham 2002). Insofar as this was true, presenting work to one's peer group was important not only to science, but to the development of a cohesive, collegial professional community.

Participation in professional associations was also an ethical obligation. For medical leaders in particular, participation was seen as a core altruistic obligation to the future of the profession. Again, according to Osler: "no physician has a right to consider himself as belonging to himself; but all ought to regard themselves as belonging to the profession, inasmuch as each is a part of the profession" (Bryan 1997, p. 50). Once, when Osler was asked by a medical student whether he (the student) should attend a local medical society meeting, because he wasn't sure what he would get out of it, Osler responded, "Do you think I go for what I can get out of it, or what I can put into it?" (Bryan 1997, p. 49).

## Advances in Science, Loss of Humility

By the turn of the century, scientific medicine was beginning to show its promise. While previous generations of doctors had believed, often falsely, that they had something of medical benefit to offer the ill, the generation of doctors that understood public hygiene and inoculation actually did save lives, and dramatically so. Between 1900 and 1920, deaths from typhoid, diphtheria, and gastritis were cut by more than half, and tuberculosis deaths dropped by one-third. By the 1940s, with the introduction of penicillin and streptomycin, influenza deaths plummeted, and tuberculosis deaths were falling so rapidly that the disease was widely expected to be eliminated. When books like DeKruif's *The Microbe Hunters* (1926) noted both the self-sacrifice and success of physicians in combating infectious diseases, many Americans came to see physicians as heroes.

Sadly, one effect of gaining heroic status was the loss of any remnants of

humility that doctors might have retained from their Hippocratic roots. Interestingly, the Hippocratics' emphasis on humility had been based on an awe of the gods' powers over human life and a belief that physicians would be guilty of hubris if they intervened contrary to the gods' plans. Later generations of physicians saw the human body as mechanistic, amenable to manipulation and measurement, and the subject of scientific scrutiny and learning. They should have (and some had) derived humility from their belief in scientific questioning—recognizing that scientific knowledge is always tenuous and subject to further refinement (Wynia and Kurlander 2007). John Gregory (1724–1773), for instance, called such scientific humility "diffidence" and held that "candor, which makes him open to conviction, and ready to acknowledge and rectify his mistakes," is a moral duty for physicians, urging that errors in care be used to study and improve medical practice (Gregory 1772, pp. 209–10). Samuel Bard, founder of the Columbia College of Physicians and Surgeons, told graduating medical students in 1769: "Whenever you shall be so unhappy as to fail, in your Endeavors to relieve; let it be your constant Aim to convert, particular Misfortunes into generaly Blessings, by carefully inspecting the Bodies of the Dead, inquiring into the Causes of their Diseases, and thence improving your own Knowledge, and making further useful Discoveries" (pp. 13–14). Scientific humility, insofar as it drove scientific inquiry and the development of new treatments, was tremendously successful. But, perhaps predictably, as science made advances and medicine had greater success, it became harder for physicians to remain humble. Those physicians who sought out errors to learn from them, brave pioneers of quality improvement like Richard Cabot (1868–1939) and Ernest Codman (1869–1940), were often vilified by other practitioners.

Some of this vilification reflected basic human nature—the reluctance to admit error or have one's errors exposed. But it might also have reflected an ongoing divide early in the development of the profession, between the science and art of medicine: researchers were more interested in science, while clinicians were more devoted to art. To be sure, many believe that this divide was, and remains, largely artificial, since practicing medicine without attention to science would be foolish, and caring for human beings without attention to art would be cruel: both are necessary to good medical practice. In effect, however, in some of these debates the term *art* was code for the notion that individual practitioners should be allowed to practice according to their own best judgment, often uninformed by the latest science and without meaningful oversight from colleagues or anyone else.

## Defining Professional Autonomy

In a way, this early fight about science versus art was about the definition of something we would now call "professional autonomy." At least since the found-





ing of the AMA, there had been an undercurrent of concern amongst practitioners over the following question: would professional autonomy mean that the profession, as a group, was to establish standards (rather than having them established by the state or through the marketplace) and ensure that all members lived up to them? Or would it mean that each individual professional, once found to be qualified, would be allowed to establish their own patterns of practice?

We'll return to this question momentarily, but early on—certainly throughout the Progressive Era (ca. 1890–1913)—it appeared that the debate was being resolved in favor of professionals, as a group, establishing standards and mechanisms of self-regulation (Burrow 1977). For example, within a year of its founding, the AMA established committees to set standards on medical education, medical sciences, practical medicine, surgery, obstetrics, and medical literature and publications. Committees on anatomy, physiology, materia medica, chemistry, forensic medicine, vital statistics, hygiene, and sanitary measures soon followed (Haller 1981). The proposed arrangement was clear: individual practitioners would benefit from professional social privileges garnered by the AMA, but in return they were expected to follow the dictates of the profession, as set by AMA committees.

As science advanced, the divide between clinicians and scientists seemed to narrow. New scientific measurement tools, such as the stethoscope, various blood tests, and microscopy, became part of the medical care armamentarium. The clinicians' preference for artful rather than scientific practice looked to be on the wane. Dr. John H. Musser, President of the AMA in 1904, remarked, "With the incoming of scientific precision there is the outgoing of so-called art. Diagnosis by intuition, by careless 'rule of thumb'. . . is as little trustworthy as the shifting sand of the Sahara" (King 1983, p. 2478).

## Other Perils of Scientific Success and Authority

Linking practice to science led to great advances in patient care and public health. Sadly, however, the downsides of this success-linked-to-science were substantial: physicians not only came to lose humility and respect for "the art," but their customer service orientation as well. Medicine became increasingly complex, and microscopic phenomena weren't always easy to explain. Perhaps more important, a mechanistic understanding of the human body meant that medicine could provide tremendous benefits whether or not the patient understood or believed in how these benefits came about (such as with inoculations). So physicians pushed for public-health mandates at the population level and adopted a highly paternalistic attitude towards patients at the individual level.

But pride, paternalism, and the loss of art and customer service were, sadly, not the only negative consequence of this focus on scientific competence as the

source of physicians' social authority. Another was that physicians' civic obligations eventually came to be taken for granted, seen as unimportant, or misconstrued; and many were nearly abandoned.

First, in the wake of vaccination, antibiotics, cardiac surgery, organ transplantation, and other miracles, any professional obligations beyond scientific competence no longer seemed necessary. Saving lives was sufficient to garner high levels of public respect. Second, some civic obligations, such as the professional duty to continue caring for patients during epidemics, were eventually seen as "anachronistic," because the achievements of scientific medicine had made them so. As the U.S. Surgeon General put it in 1970, "the era of infectious diseases is coming to an end" (Huber and Wynia 2004). It's not hard to imagine a profession with this level of hubris feeling little need for any ethical regulations—after all, what could be more ethical than eliminating disease?

Third—and more complex—is that the profession accrued so much credibility there was no longer any question that it should be self-regulatory. At first blush, this development might seem to promote the civic obligation of self-regulation, but gaining the unquestioned capacity to self-regulate created an unfortunate backlash. From the time of its founding, a goal of the AMA had been to develop a heavy mantle of credibility around physicians that would create a professional monopoly, or "professional closure," with the assistance of the state. That is, those who were not qualified, according to standards established by the profession, would be closed out of practice by the state. If successful, professional closure would protect the public from unscrupulous and unscientific practitioners. It would also raise the status, and presumably the pay, of qualified practitioners. (It is, in my view, impossible to fully disentangle these altruistic and self-serving motivations.) As physicians delivered on their promises to improve medical care, and risked their own lives in doing so, the profession became extremely successful in arguing for regulatory closure. In fact, medicine was *so* successful in this regard that many of our self-regulatory mechanisms, such as medical licensure, accreditation bodies, and various other professionally derived structures and processes, were accepted as legally binding—which blurred the lines between the state and the profession. Victims of our own success, many physicians no longer recognized these various regulatory structures as a part of professional self-regulation and necessary to maintaining our social credibility over the long term; instead, they came to be perceived as meddlesome outside bodies, sent in by the state to scrutinize us and disrupt our practice.

Finally, though it pains me to admit it, the burgeoning field of medical ethics also contributed to the loss of physicians' sense that professionalism entails civic responsibilities. Early bioethics, responding to legitimate concerns—ranging from paternalism, as noted above, to physician participation in Nazi crimes against humanity under the guise of obligations to society—strongly stressed the importance of autonomy as a principle of biomedical ethics and deemphasized





or even denigrated physicians' civic duties. Some urged physicians to ignore civic considerations altogether and think only of the welfare of the individual patient before them. For instance, in 1984 Norman Levinsky wrote in the *New England Journal of Medicine* that "physicians are required to do everything that they believe may benefit each patient, without regard to costs or other societal considerations" (p. 1573). Such a statement reflects the domination of medical ethics by respect for individual autonomy, but it also illustrates the loss of a cardinal facet of the social contract that had grounded physician professionalism, and which the sociologist Talcott Parsons had described: the obligation of physicians to serve as mediators between private and community interests (Latham 2002; Wynia et al. 1999).

In sum, in the late 20th century there developed a very different sense of professionalism, epitomized by the notion that one should care only about the patient sitting in the exam room. As a simple, one-dimensional ethics, this notion of strict individual advocacy appealed to patients' immediate interests, and it seemed easy for doctors. But it could hardly be more different from the initial understanding of professionalism as comprising a complex set of reciprocal obligations between physicians, patients, and the community.

## THE PHYSICIAN AS TRUSTEE

Under the original social contract for the medical profession, doctors had obligations to patients but also obligations to the community—and it was recognized that these could come into conflict. While stewardship of shared financial resources was not an obvious issue early on (before health insurance came into existence), conflicts arose around patient wants and desires, and the hope of the community for those patients to be productive members of society. When these responsibilities conflicted, a good professional would serve as a mediator, seeking to do the best possible for all concerned.

Even more than for other professions, this mediator role was an important part of the social contract for physicians. In simple, practical terms today, the agreement is the following: physicians are given certain social privileges to protect the ill (such as by allowing time off work) in exchange for a collective promise to help society by working to return the ill to productive life. So, ethically, physicians cannot sell notes to excuse otherwise healthy people from work, despite the fact that there might be a ready market for them.

This was recognized in the 1847 Code of Medical Ethics, which noted that a physician's skills "are qualities which he holds in trust for the general good." And our commitment to serving the larger public good played a crucial part in the professional standing that medicine first achieved during the 19th century. As Cruess and Cruess (1997) put it: "[19th-century] legal measures for the first time granted medicine a broad monopoly over health care—along with both indi-

vidual and collective autonomy—with the clear understanding that in return medicine would concern itself with the health problems of the society it served and would place the welfare of society above its own" (p. 943).

## PROBLEMS WITH A ONE-DIMENSIONAL SOCIAL CONTRACT

Under a simplified, autonomy-centric view, however, physician ethics came to look something like lawyerly ethics. Namely, zealous advocacy for one's client became the primary, if not only, duty of the physician. But the practical and conceptual problems with such a simplistic stance are substantial (Sage 1999), and they are playing out today.

The main problem is that a zealous advocate cannot also serve as the opposing counsel and the judge. But in medicine, unlike in the legal system, there is no opposing counsel. And even if there were, there is no impartial judge to weigh the physician's arguments against those of this hypothetical advocate for the larger community. To make zealous advocacy work as the physician's sole ethical responsibility, and to produce just outcomes when the needs of individuals and communities came into conflict, there would need to be a system in place to which the physician would have to plea—and in which the physician would not have the final word.

This scenario is not very appealing to most physicians. An adversarial medical care system would be profoundly inefficient and frustrating for patient and doctors alike. Yet it is what *must* evolve if physicians insist on adopting a one-dimensional advocacy role. And indeed, we are developing just such a system today, with control over medical decisions devolving to health plans and purchasers, to which physicians and their patients must plea.

## SIMPLE CONTRACT, COMPLEX PROBLEMS

This new social contract, based only on advocacy for individual patients, has other ramifications as well. For instance, professional closure weakens. New groups of practitioners arise, unqualified according to the old professional standards but free to practice according to the dictates of the market that an autonomy-centric social contract promotes. We are not there yet, but we are experiencing a slow reversion towards the days before 1847, when anyone could hang a shingle and call themselves a "doctor."

Also, in the long-running dispute over what professional autonomy means, a simplified social contract decisively tilts the playing field towards those who would redefine professional autonomy to mean the right of individual doctors to treat patients according to individual preference, rather than the right of the group to self-regulate by setting and enforcing practice standards.





As the contract devolves away from groups and towards individuals, there has been a reversion away from codes of ethics and back towards an ethics of individual virtue. Incidentally, this is not to be confused with "the virtues" à la Aristotle, who believed virtue to be habitual and based upon carefully following rules over a long period of time, until they become ingrained. Rather than emphasizing that physicians are bound by a shared set of behavioral standards, which students should embrace until they become second nature, ethics courses in medical schools today tend to focus on training students to think things through for themselves. This, of course, is laudable and a necessary brake against professional group-think, but it's hard to believe we should depend completely on each individual's analysis. Such reliance will predictably lead some physicians to take wrong actions that they believe they can justify, and others will start out with a very different understanding of acceptable actions. To put this in colloquial terms: the problem with teaching ethical analysis and then relying on the "red-face test" to maintain professionalism is that some people don't embarrass easily. Sometimes, we'd be better off with clear rules and a meaningful obligation to follow them.

Finally, with a one-dimensional, individually focused contract, there is less perceived need for organizations like the AMA that wrote and enforced the old, more nuanced and group-oriented, social contract. This is hardly the only cause of the AMA's membership woes, but it is a key part of a negative membership spiral. Ironically, AMA members—comprising practicing physicians—largely bought into the simplified social contract, in which the association itself became less important. With its loss of stature among physicians came losses in membership and social prestige, and a reduced ability to influence the environment of medical practice. Then, more doctors chose to abandon the organization, because it came to be seen as ineffectual even in its more limited role. Organizational leaders facing such a situation can easily become desperate, casting about for ways to please the remaining members. In their efforts to serve them, it is easy to further alienate those on the margins, by moving even further from the core mission around which the AMA was created: writing the social contract for medicine and ensuring that all physicians are living up to it.

Specialty associations have tried to inherit some of the AMA's power to establish their own, independent social contracts with some success, since they can better focus on negotiating for a relatively homogeneous membership. Sadly, however, these efforts often result in the increasing fragmentation of the profession and frequent episodes of internecine conflict. As cohesion in the professional community declines, so does professional social capital, resilience, and effectiveness.

## WHERE TO GO FROM HERE?

Given recent history and current trends, it seems that relatively few physicians might weep over the passing of the AMA, but since no alternative organization is being proposed to take its place, the alternative is to have no national association for all physicians. Most of us probably know, intuitively, that "every one for oneself" is not a solid basis on which to maintain a profession. "Every specialty for itself" isn't much better. In short, without a unified professional association we cannot have a profession.

Can we rebuild medicine's social contract to meet the challenges of the new century? Can we create a new progressive era for medicine, retaining our commitment to science while building back in and reinforcing our obligations of service to society, artful practice, humility, and professional autonomy (in its original sense)? Is it possible to rehabilitate old institutions, such as the AMA, to help accomplish this task?

We don't want or need the same social contract today that we developed in 1847. A contemporary social contract should focus far more attention on matters of resource distribution, quality measurement, and the interactions of the various players in the health-care system. (It's not just patients and doctors anymore: purchasers, regulators, and other practitioners must be brought into the contract.) And, in fact, these ideas are gaining traction within the AMA (Ethical Force Program 2008).

Many progressive physicians, however, have lost hope for the AMA and its capacity for evolution, even though most know little of how the AMA actually works. In my view, rumors of the AMA's demise are premature. The fundamental role of professional associations is to write the social contract for the profession. Our options are to have multiple organizations perform this task—with different social contracts for each specialty—or to have a uniform social contract for all physicians. There are good reasons to favor the latter.

Second, the AMA remains engaged in this task, and the process through which it works (though imperfect), is, on the whole, fairly solid. The AMA is a representative democracy, with representatives from all major specialties and every state. Naturally, democratic structures reflect the majority thinking of those who are involved. So the profession of medicine, and the AMA in particular, faces something of a Pogo problem: we have met the enemy . . . and he is us.

Finally, American medicine exists within a democratic society. Physicians are not alone in establishing our social contract, we do so in constant negotiation with various communities. Often, these negotiations take place through democratic processes, and our professional associations are the means we have of projecting the voice of medicine into public policy debates. If certain physicians don't like the tenor or content of the voice of American medicine, it is not enough to leave. There is, as Osler understood, a professional obligation to be engaged and help change what the voice is saying or how it is being said.





Nevertheless, some of us have become inured to political polarization over the last 40 years. Some might see all of organized medicine as beyond redemption—too much in hock to corporate interest, too attached to a political party, too reactive. As a result, the AMA might have lost large segments of two or more generations of physicians, who are so cynical about organized medicine that they cannot imagine an evolved AMA, one that might (at least sometimes) reflect their values and help orient the profession towards public service. Sadly, in my experience many leaders of academic medicine—though progressive at heart and generally not lacking a sense of empowerment—are in this position. They hold a deep-seated cynicism about the AMA and its ability to change—or their ability to help change it.

We should not give up on these leaders: their skills and knowledge can be invaluable. At the same time, though, we need to directly engage young professionals who haven't yet adopted this cynical attitude. Activism among young physicians is rising, as is AMA membership, even while it continues to fall among more senior members of the profession. In the last year, membership in the AMA among physicians under 40 rose 2.2%, while membership among those older than 40 fell 2.8% (Julie Gill, AMA Membership and Marketing, personal communication, May 15, 2008). Perhaps the best we can hope for from some medical leaders will be a bemused silence, as the young progressives under them learn how to use our professional association to reinvigorate the social contract of the medical profession.

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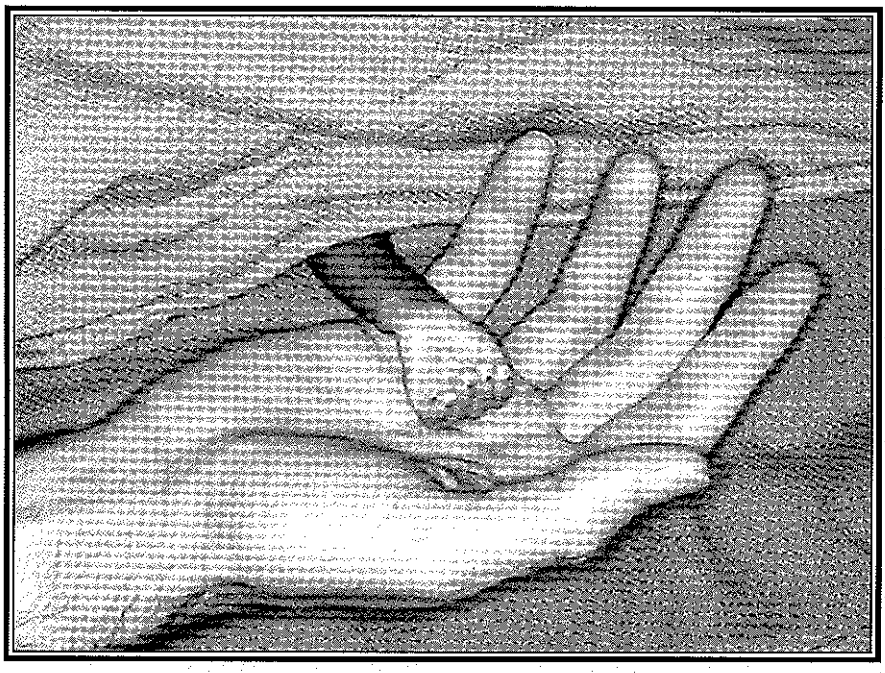
# PERSPECTIVES
## IN BIOLOGY AND MEDICINE



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**Special section on MEDICAL PROFESSIONALISM**