

Chapter 2

Medical Authority

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“Medical authority” is an ambiguous term. There are two problems with it (as Bruno Latour said about network analysis): the word “medical” and the word “authority”. What exactly does medical refer to? The individual physician? The organized medical profession as a whole? Influential professional elites? Definitions of the human conditions? And what about “authority”? How exactly does it differ from other terms used by social scientists that cover similar terrain like “dominance” or “sovereignty, or even “power”? And what exactly is the object of this power. Given these limitations, and with the help of several dictionaries, one can come up with the following partial list of features that usually cover the term “medical authority”.

1. Authority over patients and their actions.
2. Authority to manage the activity of other health professionals.
3. Authority to define the material conditions and organizational structure of healthcare and its institutions.
4. Authority to define what *is* a disease or disability (which can lead to entitlements) and what is and is not appropriate therapy.
5. And perhaps most common in the scholarly literature, authority to define who is allowed to practice what procedures and what constitute proper standards of training, practice and professional behavior.

Although each of these meanings of “medical authority” has a somewhat different historical trajectory, and varies from country to country, there seems to be a general scholarly consensus that medical authority (or dominance or sovereignty), especially over patients, increased during the first half of the twentieth century and that it has been declining since the 1960s and 1970s.¹

More recent research speaks less about reduction than about the significant transformation of medical authority. This seems a more plausible approach. There is now a body of historical literature that questions whether there was ever a “golden age” of medical authority. Reviewing several recent books, David Jones argues, “medical authority has been consistently challenged ever since it first took its modern form in the late nineteenth century. Patients as consumers have repeatedly asserted their right and ability to evaluate critically physicians’ claims and to make their own decisions” (Jones, 2017; Engelmann, 2017). By the same token, numerous works in sociology, political science and organizational studies have moved away from the simple notion that there has been a zero-sum transition away from the authority of physicians to that of administrators or patient/consumers. Chamberlain argues that “instead of being in decline medicine is undergoing a process of restratification whereby the profession increasingly splits into elite and rank and file segments and the former subject the latter to new and more intrusive forms of peer surveillance and control in order to maintain regulatory privileges (albeit in a more publicly accountable form” (Chamberlain, 2012, vi). Others suggest that like other professions, medicine is now based on more diffuse and hybrid forms of authority that are entirely novel; these may include input from various healthcare occupations, politicians, administrators, scholars in such fields as health services research, patient and advocacy groups, and techniques for producing metrics and/or consensus decisions (Noordegraaf, 2015). In a study of medical training in the UK and the Netherlands, it is argued, “professional self-governance has turned into more hybrid forms of coregulation in which the medical profession, the state, and

other private actors continuously reinstate their positions and related claims to authority” (Wallenburg et al., 2012, 441). Given the multiple aspects of medical authority, it may well be that different interpretations actually apply to different types of authority.

For the purposes of this paper, I would like to focus on the self-regulation of physicians, today one of a number of health professions that, so we are told, work together in collaborative fashion, but who nonetheless retain special status. Physician self-regulation has been the source of much discussion for the past half-century and seems somehow near the epicenter of professional physician identity. But as interesting and consequential as social scientists find the balance of power and authority among professional elites, organizational or state authorities, patients, and as we now like to say “stakeholders”, I propose that another sort of transformation has contributed to changing notions of medical authority. For physicians, such authority is no longer based exclusively on formal professional credentials but increasingly on new techniques of regulation that aim to standardize and improve both physicians and their practices. While the goals of continuing improvement are real enough and are certainly consequential, these techniques also have symbolic value, carrying a re-assuring message to the lay world that medical authority guarantees both the safe practice and humanitarian values of physicians.

[A] Some Basic Concepts

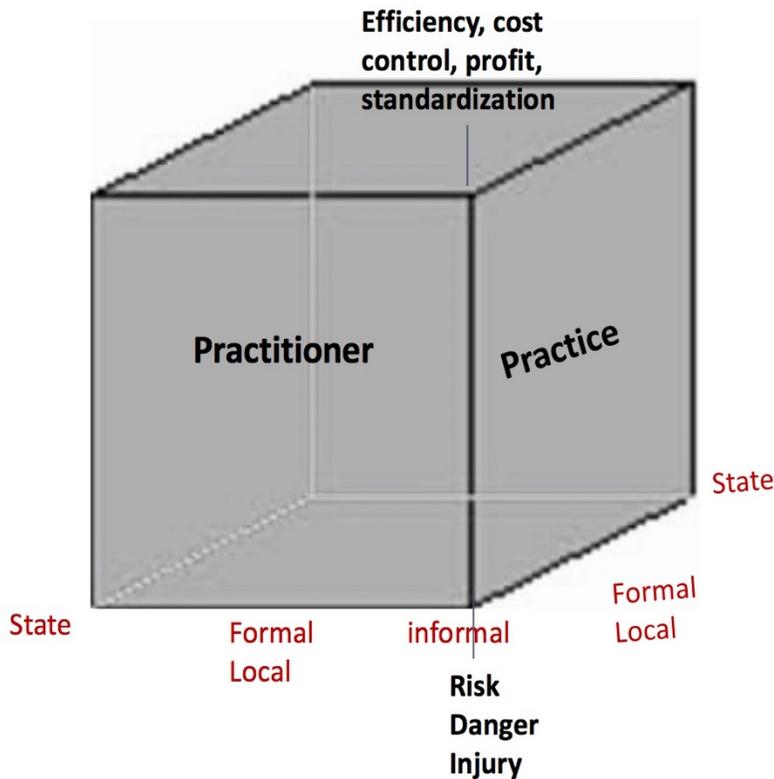
As medical practice became increasingly regulated during the course of the nineteenth and twentieth centuries, replacing the weak, fragmented and usually local forms of licensing and monopoly by guilds, royal colleges, and medical faculties, responsible local and state authorities lacking the necessary resources and expertise frequently delegated regulatory power to representatives of the profession who were chosen in various ways. There were important

exceptions like France where the elimination of traditional medical corporations left such authority in the hands of the state, which of course depended on its own medical experts for technical decisions (Weisz, 1995). The institutional basis of medical authority changed over time; it is probably fair to say that professional power oscillated, depending on the issues at stake, between academic and hospital elites and prominent rank-and-file practitioners, often outside the largest urban centers, organized in such representative bodies as the American or British Medical Association. At certain moments it reflected proximity to political power whether monarchical—the King’s First Physician—or democratic. Such authority was based on certain common assumptions: the need to defend the economic self-interest of certified medical practitioners by limiting competition; that trained physicians represented the most authentic medical knowledge; the desire of politicians and administrators, physicians, and probably the educated public as well, to have a relatively safe healthcare environment based on practitioner competence. While there was also considerable pressure to keep the field of healing as open as possible, this could not withstand the movement to regulate healers and restrict the right to practice to those defined as competent. (Whether such restrictions were effective in practice is another matter.) Widespread agreement existed among key actors that “scientific knowledge”, however one defined science, was the most appropriate guarantee of competence and that such knowledge could be codified and tested on examinations.

This meant that authority to define both acceptable practitioners and acceptable practices were variably situated along several parameters. Whatever elements of group self-interest that might be involved in defining such parameters, arguments for medical authority had to be based on notions of the public good. At one end was authority to define who was allowed to be a medical practitioner; at the other was very fuzzy authority over actual medical practice. The two were only loosely if at all related. Moving to the vertical axis that defines objectives of authority,

we can distinguish between concerns about the danger/risk that injury or even death that might result from poor medical practice and at the other end (or top) issues of efficiency, cost, control, and even standardized practice that administrators and even physicians became increasingly concerned with. Such objectives emerged initially in large institutions like hospitals or public health programs managing large populations, but gradually expanded to include individual private practice as this entered the public sphere through governmental financing or direct management. At the same time, authority over practice and practitioners combined informal norms, formal local or professional rules, and regulations and laws that had the authority of the state behind them.

Figure 2.1 Graphic View of Traditional Medical Authority



Using this framework, we can say that the content of acceptable practice was for some time secondary to recognition of acceptable practitioners so that the formal credentials of practitioners served to guarantee a minimal level of good practice; these, combined with legal consequences for certain types of malpractice and local beliefs and norms, constituted the basis for professional authority to practice medicine. This authority was usually granted by institutions of the profession, in partnership with political authorities (e.g. state legislatures) with some exceptions like France where the state played a more central role in partnership with medical elites. During the course of the twentieth century, governments became increasingly involved in defining competent practitioners and, eventually, acceptable practices. This was largely the consequence of healthcare's emergence as a "public good" critically important to much of the population and paid for increasingly by public monies. As such it became the target of new kinds of public scrutiny. There have been two consequences of this long-term process. One has focused on efforts to control practice through rules – clinical practice guidelines and evidence-based medicine. Another has centered on the practitioner and made both training and certification increasingly long, intensive and deep.

[A] Some Historical Background

It is well known by historians that medical practitioners since the middle ages were fragmented into separate self-regulating professions, each treating different conditions and social classes.² Physicians were university trained and specialized in internal diseases represented by physical signs like pulse or urine. Surgeons specialized in external conditions but also performed manual tasks like bleeding considered a method of balancing the humors; they significantly raised their status during the 18th century by taking on many of the trappings of learning and scholarship

affected by physicians. Lower status barber-surgeons combined two manual trades involving cutting. Finally, there were apothecaries, tradesmen who prepared pharmaceutical mixtures but frequently prescribed them as well. All these practitioners had their own guilds or colleges and there was some rivalry and conflict among them. Aside from these recognized professions there were also “non-regulars” who were not part of legally organized guilds. Several kinds of non-regulars achieved considerable stature during the 18th century as they developed valued skills: these included oculists capable of couching cataracts and dentists who developed new techniques for making false teeth and dentures.

By the early twentieth century, many countries could boast relatively unified modern profession. These were not homogenous and divisions abounded; but partition into autonomous silos came more or less to an end. While it is difficult to summarize so many developments in numerous countries, it is fair to say that educational reform was at the heart of many of the changes that took place. This allowed new forms of stratification and division to come into being and transformed the traditional dynamics of the profession. In France the process began early during the Revolutionary and Napoleonic periods with the central state creating and enforcing standardized training, certification and limited medical monopoly. In the US, after states in the 1830s and 40s abolished their licensing laws in the name of Jacksonian democracy, freedom of practice was the rule until the last decades of the nineteenth century when a complex movement made up of elite medical schools, the American Medical Association (AMA), and state legislatures re-imposed state licensing controlled by the profession. In Canada, the process was simpler. As government spread from Quebec and Ontario throughout the thinly populated country, weak provincial authorities delegated professional certification and regulation to representatives of the profession called “colleges” which gradually raised standards of medical training.

Britain probably came up with the most original solution: a state registry of physicians within a free market. Well into the nineteenth century, the division into separate professions of physicians, surgeons and apothecaries persisted. Each had its own system of licensing and governance. Rather than imposing legal unity, the reform act of 1858 created a medical register containing a single list of medical practitioners possessing one of the numerous recognized degrees. In exchange for this recognition, traditional occupations lost the limited monopolies, which they had possessed previously. In other words, after 1858, anyone could practice medicine but patients could easily find out which practitioners had a state-certified license with significant privileges attached. Here the monopoly was one of title rather than function. Anyone could practice so long as they did not claim to be a licensed healer. Gradually unification of recognized groups occurred as examining bodies got together to impose common educational standards.

The turn of the twentieth century seems to have been a critical period in this process of consolidation, rising status, and increasing authority, engineered largely through education reform. We know this most clearly in the case of the US because the reforms associated with the Flexner Report (a symbol rather than cause of these changes) have received so much attention from both defenders and critics alike. But similar processes were occurring in many western nations. These educational reforms raised standards and reduced (usually temporarily) the number of newly certified practitioners but also sought to improve the quality of those who made it through the training process. What made all this possible was the growing prestige of science as the arbiter of medical knowledge. Laboratory science in particular gained an important place in medical teaching and research, which forced medical schools to invest in equipment and specialized expertise, thus promoting the disappearance of less affluent institutions. Other factors included the growing popularity of alternative medicines, from homeopathy to osteopathy, which

forced doctors and medical schools along with many institutions of alternative medicine to identify closely with the scientific foundations of medical knowledge. Playing a role as well was the prestige of foreign models of medical training, notably Germany for the basic sciences and Vienna for the medical specialties.³

Surviving schools received new funding, improved their teaching, and raised recruitment standards. For a few years, at least, the well-trained physician was viewed as the guarantee of safety and rationality in medical practice, while providing a mechanism to control the market for healers. What destabilized the concept of the scientifically well-trained physician whose practices could be trusted was a new and rapidly expanding phenomenon: medical specialization. Specialization appeared among physicians in the 1830s and 1840s but did not achieve significant proportions until the early years of the twentieth century. From then on it continued expanding. By the mid-1930s, from 40-55 percent of all physicians in the great cities of Europe and North America called themselves specialists. The fact that they *could* all call themselves specialists was precisely the problem for there was no accepted definition of a medical specialist. In some cases, general practitioners decided that they had sufficient experience with a condition or organ to function as specialists. In others, courses of 4 to 6 weeks allowed physicians to hang out shingles as specialists. Finally, there were the really well trained (and angriest) specialists who spent years training in specialist hospital wards and resented the need to compete with individuals they viewed as unqualified.

One solution was to add a second form of training/certification to the MD degree designed especially for specialists. This was easier said than done because general practitioners were usually convinced that any new certification would transform them into second-class physicians unable to perform numerous procedures. Specialists who often resorted to general medicine (when patients needing specialist care were scarce) were in contrast afraid that the

price of certification would be to close general practice to them. These issues were eventually ironed out and systems of specialist regulation and certification were gradually set up in most western nations. The earliest ones were professionally organized and controlled (Germany 1923; Canada 1937; and in the United States continuous development of specialty boards during the 1920s and 1930s and up to the present). In both France and the United Kingdom, governmental systems were put into effect in 1947-48, as a part of the creation of national health or health insurance systems; here one had to clearly define specialists since they were paid more than general practitioners (Weisz, 2006).

By the 1960s, what guaranteed medical authority and competence of the physician were at least two levels of training and certification that were supposed to last an entire medical career. By then, however, this no longer seemed sufficient, partly because a growing research sector was constantly changing the knowledge base of medical practice and because government was now a major funder of healthcare, which had become organized around large bureaucratic institutions. This was true even in the United States, where government was by now paying for a significant share of health costs through the Veteran's Administration, Medicare and Medicaid. Issues of costs, safety, competence and appropriateness of care entered the public sphere in a major way. There were two sorts of responses to these developments.

[A] The Rise of Practice Guidelines

The first of these rested on efforts to standardize medical procedures.⁴ Such standardization occurred at three interrelated levels. First, outside the traditional private relationship between doctor and patient were large-scale institutional settings for biomedical practices that were not necessarily controlled by physicians. There, the standardization of classifications, measures, and

procedures was perceived as a requirement for a variety of purposes, including the evaluation of outcomes, co-ordination of large-scale organizational activity, and, later, third party payment. From the nineteenth century, public health was one such domain. Basic categories had to be defined and standardized in order to be useful, and doctors were constrained in a variety of ways—through standardized forms and/or instruments—to provide data that were uniform and comparable. Murderous epidemics definitely fell into the public sphere, and doctors as well as citizens were urged to act in the ways prescribed by public authorities who published instructions on how to deal with sporadic epidemics like cholera and yellow fever (Boston Board of Health, 1855). In the twentieth century, public health standards entered the world of clinical medicine as preventive public health expanded to the sphere of therapeutics through such mechanisms as programs to treat sexually transmitted disease, tuberculosis, child health and cancer. Hospitals, which grew at a prodigious rate from the end of the nineteenth century, also generated demands for standardized organizational structures, practices, and data collection.

Second, the results of medical research vastly complicated the world of medical practice and its regulation. Starting in the early twentieth century and accelerating after World War II, the expansion of research created new problems in translating this knowledge into better health care. Efforts to determine collectively the efficacy of so many new products and procedures intensified long-felt needs to standardize classification categories, instruments, measures, and research protocols. Just as the standardization of public health eventually influenced medical practice, testing protocols frequently found their way into clinical practice in such technically sophisticated fields as cancer research. Finally, research has continued to produce new and increasingly complex procedures and instruments that cannot be used effectively without elaborate protocols that determine the actions of all health professionals.

Third, the private relationship between doctor and patient gradually became part of a

public realm that was subject to new forms of bureaucratic control, rationality, and knowledge. This was one consequence of an expanding governmental role as a provider or purchaser of health services and as a guarantor of the public's health. Much closer scrutiny of practices revealed extensive variation among institutions and practitioners. Such variation was viewed as increasingly problematic in the new medical order, an indication that someone was doing something wrong. This knowledge of variation was an outcome of the new information about health systems, the production of which itself generated yet greater need for standardized classifications, measures, practices and entities. The complex mechanisms introduced to monitor, evaluate, and improve health care practices also demanded elaborate guidelines.

These pressures began to make themselves felt during the first third of the twentieth century. In the field of public health, many countries organized programs to prevent and treat TB; later cancer-care programs deployed new technologies that were complex and sometimes dangerous, notably the use of x-rays and radium, and that required guidelines and protocols for their safe and effective use (Dommann, 2006). New diagnostic laboratory tests also required elaborate instructions. The hospital efficiency movement, sought to bring scientific management and industrial efficiency techniques, to medicine (Reverby, 1981). The American College of Surgeons (ACS), created in 1917, served as a model for the other American specialties that followed the path of specialist certification. But it also began standardizing practices through therapeutic evaluation, assessing cancer therapies on the basis of case records, and periodically publishing results (American College of Surgeons. 1931). In 1905 the American Medical Association (AMA) established the Council on Pharmacy and Chemistry to analyze the composition and quality of new drugs, with the results published in its *Journal of the American Medical Association*. These standards formed the basis for the revised federal drug regulation introduced during the 1930s (Marks, 1997; 2006). During the interwar years as well, the AMA

also began evaluating the plethora of electrical instruments arriving on the market and tried to control diagnostic testing by recommending laboratories for doctors and hospitals to use (Weisz 2006). The British government, by contrast, used a very different approach when establishing the Radium Trust and the Radium Commission in 1929, with the former buying radium on a large scale and the latter distributing it to hospitals. These bodies thus were able to tie the distribution of radium to the hospitals' adoption of specific standards of therapeutic practice and, in the process, had a major impact on the structure of cancer therapy nationally (Cantor 2007).

After World War II, all aspects of the medical enterprise expanded dramatically, especially in the United States, which by then was the world's richest nation and the most profligate spender on health care. The expansion of both the public domains of medical practice and biomedical research, with their attendant multiplication of standards and protocols, made the standardization of medical procedures appear both feasible and imperative. The two domains were in fact intimately connected. One of the motivations for the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) III was to establish disease categories stable enough to be the subjects of fundable research (Healy 1997; Wilson 1993). Once established, however, these categories became fundamental to reimbursement procedures and thus to medical practice. The ongoing invention of complex technologies generated need for methods of assessment as well as protocols for their use.

From the mid-1970s on, the production of guidelines intensified and became subject to extensive comment and discussion. Between 1975 and 1984, guidelines were produced in many different countries, suggesting that the pressure for their spread cut across national borders. The United States nonetheless produced the majority of guidelines in an effort to come to terms with the rapid transformation of the American health care system (Weisz et al. 2007). New knowledge about practice variations, produced and analyzed over several decades by John Wennberg, was

especially influential in this process (Wennberg 1979). He and others who questioned the appropriateness of certain medical practices challenged the notion of a universal medical science and raised serious quality issues (McPherson and Bunker 2006). Such work was supplemented by questions raised by Archie Cochrane's influential book published in the UK, *Effectiveness and Efficiency*, about the scientific validity of many current and widely diffused medical procedures (Cochrane 1972). Variation had come to be seen as a problem to be remedied. Despite considerable medical resistance to the introduction of "cookbook medicine," by 1990 more than thirty-five physician organizations and specialty societies were reported to have developed guidelines; the AMA and the Council of Medical Specialty Societies had endorsed practice guidelines and were organizing specialty societies to set policy for their development; and academic medical centers had formed a research consortium on practice guidelines (Woolf 1990). By the beginning of the next decade, guidelines were ubiquitous enough for the National Library of Medicine's PubMed to add to its list of publication types the categories "Guidelines" in 1991 and "Practice Guidelines" a year later. American guidelines were produced by a wide array of public health, research, and advocacy institutions, as well as by numerous specialist medical societies. When the first articles on Evidence-based Medicine appeared in 1992, they gradually added a new level of formalization to guideline development, at least in certain circles; but they surfaced in a domain that was already well established.

Although guideline development occurred first and foremost in the United States, it has been adopted in much of the Western world during the past thirty years. It is fair to say that we now live in a culture of clinical practice guidelines. This culture has been undermined by numerous critiques ranging from the influence of pharmaceutical companies on clinical trials and guideline development, to the technical inadequacies of many clinical trials, to the lack of real world patients because of rigorous inclusion criteria. But it continues to prevail, despite

numerous qualifications, doubts and concerns, because nothing more reliable has surfaced to replace it.

[A] Recertification and Revalidation

As all this was going on, a related but independent process was underway. By the time a new specialty, family medicine, came into existence in 1969, mere specialty certification no longer seemed sufficient. Periodic *recertification* was introduced as a requirement of specialist status in this field. If this largely reflected the uncertain status of a new specialty lacking a clearly defined knowledge base and out to prove its bona fides, the logic of the choice proved difficult to resist. As medicine's critics multiplied, its knowledge constantly expanded and changed, and political leaders were required to justify the monies they were pouring into healthcare, an increasingly defensive medical profession, or at least parts of it, felt compelled to respond. Marc Berg has documented how editorialists in medical journals during these decades framed the problem of the perceived inadequacies of medical practice (Berg 1995, 1997). Consensus conferences, guidelines and EBM might be tools for solving these problems, but responsibility ultimately rested with the quality of physicians who applied or did not apply the results of these tools. Periodic recertification spread widely replacing the idea of life-long competence following initial certification. It was gradually accepted by individual specialty boards and was adopted by all specialty boards in 1999, using cycles of 7 to 10 years. It was accompanied by continuing education programs. Soon after, recertification was replaced by a new model known as "maintenance of certification" (MOC), which was introduced during the early years of the 21st century. It includes demonstration of professional standing, lifelong learning, demonstration of cognitive expertise and demonstration of performance. Controversial reforms of MOC in 2014

compel many physicians to enroll in continuous, fee-paying certification programs, completing tests every 2 years and performing practice improvement modules. Not surprisingly, “some physicians view these tasks and costs as excessive” and opposition and criticism have been intense (Teirstein and Topol 2015).

Not all physicians are subject to such recertification requirements. The 40% or so of American doctors who are not board certified are not bound by these regulations creating a rather large compliance gap. Nonetheless, periodic recertification, although not fully implemented, reflects a new ideal of competence and scientific authority, one that has to be constantly reviewed and upgraded in order to remain valid. The title of a 1989 article by Donald Berwick one of the leading voices of the American quality of care movement said it all: “Continuous Improvement as an Ideal in Health Care” (1989). Mention of Berwick is a good place to remind readers that recertification/revalidation did not take place in a vacuum. During the 1990s, along with guidelines, EBM, and recertification, Berwick was influential in advocating for greater safety in healthcare institutions, a position that was given wide publicity several years later when the Institute of Medicine published a major report suggesting that much unnecessary injury and death was caused by systemic and structural issues rather than individual mistakes (Kohn, Corrigan, Donaldson 1999; Institute of Medicine 2001). These and other movements of the period (the “professionalism movement” for instance) fed into the larger search for greater guarantees of physician quality. In the words of one Canadian medical educator: “Reading either the *Quality Chasm* or *To Err Is Human* ... confirms the accumulated wisdom that holding a medical degree, a general license, or acquisition of a specialty certificate is insufficient evidence to ensure quality of care or patient safety (Dauphenee 2013).

Perhaps because Americans were spending so much more on healthcare than anyone else, or perhaps because American doctors on the whole earned considerably more than their

colleagues elsewhere, the US was initially somewhat unique in its zeal to reform medical practice. Canadian doctors responded with noticeably less enthusiasm to the new professional norms. Certainly in 2004, the Canadian Adverse Events Study found considerable evidence of “substantial burden of injury” among hospital patients and generating increased efforts to promote safety (Baker 2014). But provinces (healthcare is a provincial responsibility in Canada) have opted for mandatory continuing education programs, without requiring re-examinations and recertification. Much the same is true in Europe. Several countries –Austria, Germany and Spain – focus on continuing medical education while others Belgium, France and the Netherlands also incorporate peer review (Merkur, Mossialos, Long, and McKee 2008). France in 2013 introduced a more extensive system of continuing medical development in which doctors and all health personnel are required to analyze their own practices and then act to acquire or improve any knowledge or competence that is deemed to be weak (Da Silva 2014). Austria, Germany and the Netherlands have all introduced professional development programs of one sort or another (Dauphenee 2013). The Medical Board of Australia (MBA) is currently examining the issue in order to work out a national strategy but has already rejected the idea of revalidation (Flynn 2017). Another agency, in contrast, the Australia Health Practitioners Agency (AHPRA) is planning to introduce revalidation (Langlois 2017).

Undoubtedly the most radical alternative to American-style recertification (managed by a professional body) was the validation procedure introduced in the UK in 2012 by government legislation. It involved:

- annual appraisal by a “responsible officer”
- continuing professional development
- quality improvement activity

- reporting of significant events
- feedback from colleagues
- feedback from patients
- review of complaints and compliments.

Published *Instructions to physicians specified:*

“Every five years, your responsible officer will make a recommendation to the GMC [General Medical Council] about your revalidation.

The responsible officer will draw on the outcome of your annual appraisals, combined with any available information from the clinical governance systems of organisations in which you practise....”

“It is for the GMC to decide in each case whether you may continue to hold your licence to practise.”

Making the process even more radical is the fact that the decisions made are not based exclusively on medical expertise. The GMC would have 6 lay and 6 medical members, all appointed following an independent appointments process. (However there seems to be a second more directly professional revalidation path for specialists through one of the Royal Colleges.) The introduction of laypeople into this process, more than any other detail, seems responsible for the idea currently widespread in the medical and sociological literature that the era of self-regulation (or “club practice”) of British medicine is now over. Authority, in this view has devolved not so much to state control (although to that as well) but to “stakeholder” control, for the chief barrier to revalidation is alienating the patients and colleagues who now report on

physician practice. As was the case with EBM, criticism has decreased as it has become clear that implementation is less demanding than regulations suggest. And inevitably, efforts are being made to develop standardized metrics to evaluate performance (Van der Meulen et al. 2017).

What lies behind these radical changes? Issues of safety have emerged in the UK, as in the US, with the added piquancy of several well-publicized malpractice scandals, like that of the serial murderer Harold Shipman and that of the Royal Bristol Infirmary. As in the US, demands by consumers and administrators for greater transparency and accountability play a large part in these reforms. As in the US as well, there is support from parts of the profession as it struggles to adjust to new conditions while retaining as much autonomy as possible. It is also possible that American models have come into play and influence British and European medical elites more generally. And, it is likely that as much as ensuring safety, these reforms are linked to desire for standardization, an end to practice variation, and the aspiration to bring order and functional rationality to unwieldy healthcare institutions that have emerged piece-meal over several centuries and are now supposed to be administered as parts of “systems”.

[A] Concluding thoughts

Periodic revalidation and maintenance of certification (MOC) are discussed frequently and passionately in the medical literature. But unlike EBM and clinical practice guidelines, they have not broken out of the narrow professional sphere to attract much attention from social scientists. This is not entirely surprising since it is not easy to actually find details of how these programs are working in practice as opposed to how they *are supposed* function. But part of the story may be that EBM has been far more interesting to social scientists because it appears to represent an epistemological rupture replacing one form of authority –expertise/experience– with another more “objective” one based on RCTs and meta-analyses. Indeed, its proponents initially characterized it

(quite naively) as a new “paradigm”. Periodic revalidation, in contrast, seems almost a natural continuation of developments in medical training that have been going on for two centuries: the accretion of new criteria and tests defining competence. Such continuity has indeed been stressed by some of its leading exponents (McGaghie, 2013). It also appears to be a common-sense response to the constant evolution of medical knowledge and practices that seem to render initial training quickly obsolete. But this is only part of the story. Like EBM, MOC and revalidation allow both the profession and healthcare administrators to try to get out in front of problems and undercut potential criticism. But there is also something about this quest for never-ending self-improvement that runs deeper and that reflects a medical self-image rooted not just in competence but in what I can only call humanitarian idealism which has a long history in medical rhetoric (Weisz 1987). Functionalist sociologists of the 1940s and 1950s took this claim seriously enough to make social altruism one of the defining features of modern professions of which medicine was the exemplar (Parsons 1949). While this type of sociology was soon replaced by more critical and dynamic approaches to professions, the tradition of humanitarian care remains pertinent for physicians. It is at the core of the emphasis on “altruism” as the first principle in the widely adopted Charter on Medical Professionalism: “This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship” (Medical Professionalism Project, 2002). This has remained a central concern within the larger Professionalism movement, despite cogent critiques of its applicability to both medical training and professional identity (Harris, 2017).

This last point raises an interesting issue. Reading the literature on revalidation, I am struck by how little reference there is to EBM. We are talking about a wide-ranging movement with equally wide-ranging motives; in some cases, little is said because the link is probably self-evident; after all what is going to define inadequacy or improvement in practice if not EBM-based

guidelines. But in other cases, the role of peers and patients in the UK and other countries suggests a rather different kind of logic in which professional collegiality and patient satisfaction play a far more important role than guidelines. This is reflected in the search for new metrics of evaluation. A study of INCEPT: A Multisource Feedback Tool for Professional Performance is being tested focused on “professional attitude,” “patient-centeredness,” and “organization and (self)-management” (van der Meulen, 2017). A survey of the subject internationally argued years ago “there is a move from continuing medical education (or clinical update) to continuing professional development, including medical, managerial, social, and personal skills” (Peck et al., 2000). Clearly in many contexts, continuing medical education and revalidation may well be functioning on a rather different register than EBM. One potential source for this shift are elite medical schools that have for the past century combined training with research, care with science (Dunn and Jones, 2010). Certainly from 1945, to the end of the century, it was the research function that was more valued in prestigious medical schools. This dynamic began to change during the last decades of the twentieth century partly because influential groups of patients were demanding a different kind of care but also because the training of primary care physicians became a political priority almost everywhere. Training in primary care has traditionally been more attuned to developing skills and human relations rather than advancing research, an area where domains like family medicine have had some difficulty in competing with specialties (Post et al., 2012). As primary care has taken on a larger role in medical education, its pedagogical values have infiltrated the curriculum.

EBM and MOC have several things in common, aside from the common aspiration to improve medical practice. Both can be seen as efforts to maintain some degree of professional control over definitions of credentials and quality of practice. It is true that EBM has shifted somewhat the balance of power within the medical profession away from traditional elites to new

centers of expertise while the British version of revalidation gives some influence to patients and to managers. But MOC in particular retains decision-making within the bounds of the organized profession. It is an alternative to outside administrative or political control. As one article that proposes to make MOC assessments less burdensome and more effective has concluded: “We believe that protecting the integrity of a peer-defined, discipline-specific credential is not the role of the government, health care delivery systems, or payers — it belongs to those of us who practice the discipline, maintaining highly specialized knowledge and demonstrating that we have done so” (Baron and Braddock, 2016, 217). To the extent that all such programs now emphasizes patient satisfaction, they constitutes an alternative way of dealing with the consumer culture that has patients rating doctors as they rate restaurants and electronics (Tomes, 2016).

Another feature they both share is reliance on faith, or to be less provocative, common sense thinking rather than on real evidence. As critics have long pointed in the case of EBM and more recently revalidation, neither has ever been reliably demonstrated to improve medical outcomes (Scallan, 2016). This could prove eventually to be a problem for EBM whose *raison d’être* is evidence. In the case of revalidation or MOC this may be less important. Medical authority, whatever its current status in comparison to the past, is in the final analysis not based on quantifiable results of physician practice but rather on public perceptions that physicians are the best trained and most knowledgeable experts in maintaining health and curing disease. This perception, like the claim that their commitment to patient well-being is total, is made concrete and substantial by a visible and never-ending quest for self-improvement.

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¹ The most influential if hardly original version of this argument is Starr's The Social Transformation of American Medicine: the Rise of a Sovereign Profession and the Making of a Vast Industry.

² What follows summarizes well-known developments that have been described in far too many works to be cited here.

³ On these changes internationally see Bonner's Becoming a physician: medical education in Britain, France, Germany, and the United States, 1750-1945.

⁴ This section draws on Weisz, Cambrosio, Keating, Knaapen, Schlich, and Tournay's "The Emergence of Clinical Practice Guidelines." The Milbank Quarterly, 75(2007), 691–727..