American Osler Society
John P. McGovern Award Lectureship

"The Back Forty" *American Medicine and the Public Interest* Revisited

Rosemary A. Stevens, Ph.D.

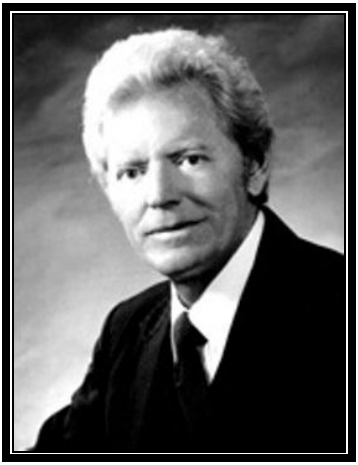
The 26th John P. McGovern Award Lecture

"The Back Forty": *American Medicine and the Public Interest* Revisited

by

Rosemary A. Stevens, Ph.D.

Delivered May 2, 2011
at the 41st Meeting of the American Osler Society
Philadelphia, Pennsylvania



John P. McGovern

John P. McGovern Award Lectureship

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences-in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.

Rosemary A. Stevens, Ph.D.

With the 1971 publication of *American Medicine and the Public Interest***,** Rosemary A. Stevens established a wide reputation as one of America's most distinguished and influential medical historians. The former dean of the College of Arts and Sciences at the University of Pennsylvania, she currently lives in New York City, combining scholarship in social medicine and public policy with an active "second career" as an artist.

The American Osler Society's invitation to revisit my book *American Medicine and the Public Interest*[1] after forty years is an honor. It is also a challenge. Times have changed enormously since 1971, and those of us who were there then have changed too. I am mindful of Dr. Osler's admonition as he left Johns Hopkins that the "real work of life is done before the fortieth year and that after the sixtieth year, it would be best for the world and best for themselves if men rested from their labors."[2] However since he ignored his own advice and worked in England almost up until his death at the age of seventy (in 1919), I will happily ignore it too.

This essay will begin by introducing the author of the book as she then was, and offer some general remarks to set the stage. The next section discusses *American Medicine and the Public Interest* in the context of 1971. (Can it really be forty years old?) In the last two sections I will consider each of the two major themes of the book: first, the specialization of the medical profession; specifically, how the structure of the medical specialties has changed in forty years; and second, the old, continuing, vexed questions about organizing specialty-oriented medical services for optimal effect in the United States. Reasoning that it is useful to know something about a reviewer, particularly one who shares genes with the author of the book being reviewed, I emerge a little bit from my professional historian shell to explain what I have done in the intervening decades, as I have toiled away happily in the "Back Forty."

The Book

The young woman who wrote *American Medicine and the Public Interest* was a relatively new immigrant from England who became a US citizen in 1968 during the writing of the book. That person seems both remote and familiar to me today. I had worked in the British National Health Service before coming to the United States, and then written about its history and the interweaving history of the medical profession in Britain from my new

American perspective.[3] It was curious to observe American medicine in the context of the British model of health services, characterized, as it was, by a core of general practitioners providing primary care, plus salaried, hospital-based specialists acting as consultants. The general practitioner, I wrote, monopolized the patient, while the consultants monopolized the hospital, and there was a professionally accepted referral system back and forth between them. There were many problems in the NHS, then as since, as multiple "reforms" attest from the 1970s through the present. However, its structure and rationale were self-evident.

In comparison to Britain there seemed no overriding logic to health services in the United States. Instead there was a sprawling, exciting, disorganized, conflicted array of medical services, professional organizations and health care policies, seemingly in endless flux. The shape and power structures of American medicine could only be understood, it seemed, through the warps, weaves and logic of history. But one characteristic of the American style was crystal clear: By the early 1970s seventy or eighty percent of American practitioners described themselves as specialists. Approximately 300,000 medical practitioners were supported and supplemented by 1.2 million non-physician workers in a wide range of occupations-further adding to specialization in terms of the division of labor in health care. Medicine had become "functionally fractionated and internally stratified."[4] Yet outside of hospitals there were few organized, collaborative service systems The American style of care was built on specialty roles and identities, but these were not complemented by systems designed to optimize the value of specialists in the provision of service for patients, the people who were already being called "consumers."[5]

In the new introduction to *American Medicine and the Public Interest* for its re-issue in 1998, with the century virtually completed, I made the claim: "Arguably, specialization is *the* fundamental theme for the organization of medicine in the

twentieth century."[6] I think this still holds. The book acquired the subtitle, "*A History of Specialization*." Perhaps it should have had this subtitle before. I was always intrigued by how the American medical profession's responses to specialization in the twentieth century proceeded independently from the organizational problems that came in its wake. Professional policies to improve the quality of care through education moved along in parallel and sometimes in conflict with considerations of the "public interest" as expressed by political proposals for organized health insurance (which were needed to pay for more valuable and expensive multi-specialty services), and organizational innovations such as multi-specialty group practice. Over the years, both before and after 1970, U.S. government programs, including Medicare, fractured medical services further by increasing market demand for insurance coverage and expanding the supply and types of personnel in a disorganized service system, without paying equivalent attention to creating comprehensive organizations for delivering services. Obviously there were political reasons for making these choices.[7] In the book, I attempted to look at all sides of the "specialism" question up to 1971.

At the time I was writing, the history of medical specialism had not been fully explicated. George Rosen's study of ophthalmology stood as a lonely beacon.[8] It was well-known that the American medical profession had provided a heroic example of public service through professional (undergraduate) education, on the assumption that better doctors meant better service to patients, and that the public deserved doctors with a medical education that was standardized across the nation's medical schools. Standards for medical licensure fell into line. We may observe here, from the twenty-first century, that the profession was enthusiastic about regulating the educational quality of its new members. The major reforms in the medical schools in the first part of the twentieth century were symbolized by Abraham Flexner's famous report of 1910.[9] Less well known was the impact of a second, overlapping

movement toward formal graduate education and specialty credentialing.

Legislative proposals for special licenses for surgeons were made in at least two states in 1914, raising a question of legal regulation of specialty credentialing that continues to our present. Professional regulation was recognized in the formation of the American Board of Ophthalmology, incorporated in 1917, followed by others, blossoming over time into a "voluntary" system of approved medical specialty boards, which eventually carved up the entire field of American medicine, becoming less voluntary and more "regulatory" in the process. The Advisory Board for Medical Specialties, now the American Board of Medical Specialties (ABMS), was established under professional control in 1933 to regulate the designation of new fields. Meanwhile the American College of Surgeons had established a national accreditation program for hospitals (the ancestor of JCAHO). Education and higher professional standards were powerful reforming tools-and showed that members of the profession were not averse to being regulated. However they represented only one face of specialization. Educational reformers did not concern themselves with a patient's access to appropriate specialty care, or the efficiency of practice arrangements. Quality was simply assumed. The registered trademark of ABMS in 2011 is in this tradition: "Higher Standards. Better Care." Meanwhile, over the generations, the proliferation of specialties imposed stresses on the profession as well as on the delivery of care.

The problems I was attempting to define in 1971 were not new. Even in Dr. Osler's day, the division of medical labor was difficult to ignore. Osler adamantly held the view that internal medicine was a general discipline, not a specialty, and that all doctors must be generalists no matter what their focus, but he excluded surgery, midwifery and gynecology from his definition of internal medicine, and worried (in 1892) that the family doctor was becoming an endangered species.[10]

The organizational implications of specialism form a second theme of *American Medicine and the Public Interest*, running side by side with the professional history of different specialties. How specialists might best work together, and specialty care best be delivered to the benefit of the patient were important themes throughout the twentieth century. Today, as forty years ago and even further back from then, old comments ring anew. "The specialist is at once the hope and the despair of modern medicine," a leading hospital administrator wrote in 1927. For all its manifold scientific, technological and clinical advantages, specialism had "split the forces of medicine into numerous small bodies which, valuable as they may be for skirmishing purposes and in certain critical emergencies, are powerless to act as an effective unit in the endless struggle against disease."[11]

The View from 1971

The year 1971 provided a fortuitously good vantage point for studying the professional and organizational implications of specialization. By 1971, 20 specialty boards had been approved by the American Board of Medical Specialties. The ABMS had imposed a moratorium on approval of new boards after World War II, making an exception for the new specialty of Family Practice (later Family Medicine), which achieved its board in 1969. Each board, sponsored by relevant specialty societies, saw itself as an autonomous domain in a competitive practice environment. Subspecialties were proliferating, though the primary boards, including Internal Medicine and Pediatrics, were trying the hold the line. Only ten subspecialties had been formally recognized by 1971, five of which were sub-fields of pathology. The boards of Internal Medicine and Pediatrics recognized cardiology as a subspecialty; Internal Medicine also recognized gastroenterology and pulmonary disease; and Psychiatry had carved out child and adolescent psychiatry. But the tensions between would-be specialists and restrictive boards would eventually have to break. The year 1971 offered a brief breathing point.

The role of government programs in fostering medical specialization was an important stressor. Educational, organizational and financial arrangements for medical care between World War II and the late 1960s had encouraged specialization through government programs such as VA graduate training programs, NIH funding of new postdoctoral programs and external research funding to medical schools, and Hill-Burton rural hospital construction, which provided centers for specialty practice across the country.[12] Medicare, four years old in 1971, gave its beneficiaries a hunting license to shop for specialists in the health care market, with government footing the bill. Medicaid programs were still getting off the ground in some states. The idea of legislation to set up a national network of privately run, competitive local health service systems called "health maintenance organizations" was strongly supported in some quarters in 1970–71. As originally designed the HMO would offer comprehensive care on the model of Kaiser Permanente. Some observers-myself included-thought that national health insurance was just around the corner. A "maelstrom" of ideas and proposals, "whirl[ed] around in profusion, based on a variety of premises, and uncertain as to their ultimate importance and effect."[13]

My panoramic view in 1971 thus included two possibilities. First, there was the possibility—remote, perhaps, but foreseeable assuming appropriate resources and incentives—that the new American Board of Family Medicine, backed by public policy, would draw new diplomates to practice as primary care physicians, and reorient the American medical profession toward a new form of generalism. It would, of course, have required enormous financial and regulatory support to make family practice the primary driver of organizational change. Second, there was a parallel possibility, also remote but foreseeable (we were optimists in those days), that expected federal support of health maintenance organizations would transform the organization of health care by setting up competitive multispecialty practice organizations in the private sector. This reform, too, would have required huge start-up

expenditures (venture capital), as well as an army of expert consultants. In both cases these were not forthcoming. The term HMO quickly fell from grace, as it came to signify insurance networks and managed care rather than coordinated, patient-centered clinical systems.[14] *American Medicine and the Public Interest* ends in 1971 in a spirit of guarded optimism, despite the "maelstrom" of ideas and policy proposals then whirling around in profusion, and continuing stresses on the medical profession. Then as now, it was easier to define the issues than agree on workable solutions.

A final contextual point worth emphasizing is that by 1971 the interplay between economics and medical specialization was quite evident. How could it not be? Medicine was becoming more superspecialized, more technologically and pharmaceutically sophisticated, less easy for individual patients to traverse, and steadily more expensive. There was money to be made on the corporate sides of medicine. Financially-driven health care was to flower in the 1980s, on through the managed care movement in the 1990s, continuing to our present. Sociologist Paul Starr tapped into a groundswell of anxiety in the medical profession in the early 1980s in his compelling book, *The Social Transformation of American Medicine*, about the rise of a socially "dominant" medical profession which was being overtaken and superseded by the "coming of the corporation."[15] As it happened, as we know with the wisdom of hindsight, the faceless "corporation" (or oligopoly of corporations controlling the provision of health care) did not come to pass, and the corporations represented by insurance companies failed to impose their own form of organization (managed care) on doctors and patients in the 1990s. Hospitals and specialty practices set up corporations of their own, but this was a different kind of corporate activity, with different sources of control.

From the perspective of 2011, the history of specialization is once again complex and messy, with economics and politics

interweaving. This may make *American Medicine and the Public Interest* more relevant today than it was ten or fifteen years ago, for it describes a shifting mix of interests and competing agendas that have formed American health care for decades. As George Rosen observed, specialization encouraged the perception of medicine as an economic activity. But the reverse was also true, put nicely by another social scientist in the early 1930s: American medicine was practiced in "an industrial world dominated by business;" and in that world "individual business competition" was imported into the medical profession, for better or for worse, "because there seemed no way to avoid it."[16]

Formal Structure of the Specialties: A History Continued

After sending *American Medicine and the Public Interest* to press in 1970 I turned to two projects whose subject matter had intrigued me while doing the research but were not central to the book. The first was a study of the implementation of the Medicaid program, done as a joint undertaking involving students in public health at Yale Medical School and students at the Law School. The second was a series of studies on the migration of physicians to the United States.[17] Both were hot topics in the early 1970s. Later work also grew out of the earlier research, including my related history of American hospitals in the twentieth century.[18] Even my present research on the early history of the United States Veterans' Bureau (now the Department of Veterans' Affairs) traces back to *American Medicine and the Public Interest*, for its central questions are in line with the jostling, style of American medical and political history delineated in the book. Specifically, why did the United States invent and implement a federally-run health care service for veterans during the business-oriented Harding and Coolidge administrations, when "socialized medicine" was anathema to organized medicine?[19] All of which is to say that in the 1971 book, viewed in retrospect, I was able to ask fundamental questions about American medicine, which led in turn to other studies. It was possible to make broad surveys forty years ago,

since surprisingly little relevant research had then been done-I had what I most like, a relatively clear field.

In parallel, through the interest generated by *American Medicine and the Public Interest* as a study of medical professional regulation, control of specialty formation, and particularly the role of the specialty boards, I fell into an unexpected additional career after 1971. Sociologists might say that I engaged in participatory fieldwork. During my research I had met many medical leaders of the time. John H. Hubbard, then president of the National Board of Medical Examiners, kindly gave me access to archives of the board. At his invitation I addressed the board meeting on the topic of the "National Board and the Public Interest" in 1972, joined the board as a public member in 1975, and served on its policy advisory committee. I had become an insider! One question then was how far the National Board would or should move into specialty examinations.

New specialties were evolving in the 1970s. Robert N. Butler, then director of the National Institute on Aging, invited me to talk about the pros and cons of developing geriatrics as a medical specialty in 1977. I argued for it, based on a history of failed attempts to create a recognized field for specialists on aging since the early twentieth century and the central role played by organizations in specialty recognition. I compared geriatrics to pediatrics, which had succeeded in achieving formal recognition, and noted: "Specialties when fully formed are so designated by certifying boards, by specified residency training programs, by defined departments or divisions in medical schools, as well as by national organizations."[20] Comparing geriatrics with pediatrics was a nice device, though not one I would use today. The meeting fell on my 42nd birthday and perhaps I was feeling aged. Internal medicine would rightly not relinquish expertise relating to older members of the population to a competing specialty group. After the usual debates and skirmishes, geriatric medicine became a formal subspecialty of the boards of Internal Medicine and Family

Medicine in 1988, and Psychiatry formalized geriatric psychiatry in 1991.

With such recognition geriatrics achieved designated medical school divisions, a place in medical teaching, and residency programs-the gold standard for organizational success. The question remained as to whether specialty and sub-specialty designation were to be left to a group of pre-existing boards with their own vested interests at stake. This was one of the themes of my book-and it is a theme that continues. Family Medicine was the nineteenth board approved (1969). Thoracic Surgery became a full board in 1970. Two more boards were approved in 1971, Allergy and Immunology, and Nuclear Medicine, bringing the total to twenty-two. How many should there be? How many fields of medicine were there? What was a specialty? Clamor for a new board of Emergency Medicine in the 1970s brought all such questions to the fore. Internists, surgeons and others considered emergency work part of their routine, and not requiring special skills. Yet hospital emergency care around the country was often abysmal. The American Board of Medical Specialties (ABMS) finally agreed to approve Emergency Medicine as the twenty-third board in 1979, after fierce, sometimes acrimonious debates. Only one more board has followed up to 2011, Medical Genetics, approved in 1991, bringing the total to twenty-four. Meanwhile, the focus for new fields moved to the establishment of subspecialties, organized under one primary board or more than one. Internal politicking remained.

In 1984 I became a public member of the American Board of Pediatrics, serving through 1990. These were years of enormous pressures on specialty associations and their related specialty certifying boards to wrestle with issues of generalism and specialism in their own fields of medicine. Pediatrics and Internal Medicine had similar concerns: to protect the general field as one of high moral, intellectual and scientific standing and clinical breadth, while recognizing a few areas where super-specialty

designation might be justified, typically in university referral centers, or where demands for a subspecialty were too powerful to resist. [21] Fed by open-ended health insurance and the promise of medical science to cure all ills, American patients were flocking to specialists, the more arcane the better. The market environment of practice in the 1980s seemed to demand badges of technical competence and an array of certificates on the doctor's office wall.

I was a member of the "New Subspecialties" committee of the American Board of Pediatrics, and chaired a board committee on future trends in certification. How I wish I had kept detailed notes of what I remember as heart-felt discussions. But I was an involved public member, not an academic observer, and at the time there was too much to do. Pediatrics then had five university-type subspecialties: in cardiology, neonatal/perinatal medicine, endocrinology, hematology/oncology, and nephrology. The line could not be held. Movements across medical practice were changing the rules. Critical care medicine was a case in point, established as a subspecialty of Anesthesiology in 1986, and followed by Pediatrics and Internal Medicine in 1987, and Obstetrics and Gynecology in 1991. Commonsense suggested that if board A established a subspecialty that cut across board B's domain, board B would be wise to create a comparable sub-field, if only to protect its more general domain—though ideally, of course, to offer patients better services. Orthopedic Surgery and Plastic Surgery tussled over surgery of the hand, leading to recognition by both boards in 1989. By then the board offered a total of 45 subspecialties.

The pressures became more intense in the 1990s, with fields like sports medicine, which became a subspecialty of Emergency Medicine, Internal Medicine, and Pediatrics in 1993. By 2010 the 24 approved specialty boards offered 36 general certificates and 112 subspecialty certificates. The American Board of Pediatrics had overtaken Internal Medicine as the board with the greatest number of subspecialties, 20 versus 19.[22] The boards presented

specialization as a byzantine array of qualifications, offered as evidence of professional education and examination. However, during the 1990s and the first decade of the 21st century, it became far less feasible than ever before for the boards to act as isolated professional agencies, focused on education and examinations. It could no longer be assumed that this was all that was necessary for a profession to show that it worked for the public good.

My second career as a public member for medical credentialing organizations took me to the ABMS between 1998 and 2006. ABMS meetings were rather like political gatherings with members from each board sitting together as a delegation at large plenary sessions, and much of the work done in committees. About 90 percent of American physicians were board-certified in the late 1990s, with or without a further subspecialty credential. Every physician was a specialist. Some obvious question arose. Did the boards define their role solely as a supermarket for specialty credentials? If so, why not have 40 or 50 primary certificates and a couple of hundred more for subspecialties? Physicians, health care organizations and licensing authorities could then select from the shelves whatever certificates met their needs, and use then as they wished. Or did the boards see a more overtly public role, with wider collective professional responsibilities? Concurrent moves toward consumer-centered care, quality appraisal, and information technology pushed the boards to the margin of health care. A key question of the time was "competence." The keynote address to the ABMS Conference on Professional Competence and Board Certification in March 1999 challenged the assembled board representatives to expand their professional responsibilities as guardians of medical competence as part of a broader public agenda.[23] How this would be accomplished remained to be seen.

Over the past decade the ABMS has changed quite considerably, tightening its corporate structure, working more closely with other health quality organizations, designating core competencies for examinees to meet, overseeing links between

various boards, developing time-limited (usually 10 year) certificates for all boards with associated maintenance of certification requirements, and fostering common subspecialty examinations. For example, the American Board of Board of Internal Medicine administers a subspecialty certificate in hospice and palliative medicine which is open to the candidates of ten primary boards.

However there are limits as to how far professional organizations can (and should) go when there have been few clear or sustained messages from the health care environment about the roles and functions of physicians. And here the other face of specialization, the organizational side, comes into play.

Organizing Specialist Services

American Medicine and the Public Interest ends with five prototypes for organizational change that seemed reasonable options in 1971. The first and oldest was the American model of the multi-specialist group, which historically speaking was a natural substitute for the old model of the omnicompetent general practitioner; all fields would be available under one umbrella to provide the patient with comprehensive care. A second, related model was hospital based comprehensive clinical systems. A third was the neighborhood health center. A fourth was based on primary care units, with the primary care organization contracting for specialist services. And fifth, "of emerging interest," my younger self observed, was a looser arrangement of health care networks coordinated through medical information systems. I made these suggestions in the hope that health insurance legislation would jump-start organizational change. (As I was writing, an insurance bill sponsored by Senator Edward Kennedy was specifying a model prepaid group practice.) Perhaps all of these models would be in place across the country by 1980.

I would have been surprised to learn that forty years later we were still grappling with similar questions in a much more specialized, more technically sophisticated, but much more expensive, less affordable context. Current reform models are the "medical home," designed to encourage physician directed primary care organizations, and the "accountable health organization," the designated vehicle under the Patient Protection and Affordable Care Act of 2010 to coordinate medical and hospital services for Medicare beneficiaries. "An ACO," according to draft regulations issued for comment in April 2011, would (among other things) be patient-centered, ensure coordination of care, have a good data system and use it, and "continually invest in the development and pride of its own workforce, including affiliated clinicians."[24] True to the messages of the time, the message is one of "value-based purchasing." What will actually happen? There is no way to know.

Other major movements since 1971, particularly from the 1980s, affect the dynamics of change in 2011. The commonplace use of computing and the Internet is perhaps the most obvious. Digital record-keeping and ordering tests have become standard practice. Specialty and subspecialty board examinations are now almost all conducted online. Digital communication makes it easier to establish virtual clinical care systems coordinated through an information network. New knowledge may bring new opportunities to evaluate services from a scientific perspective and conduct original research. I like to think that physicians have been given a new chance to capture the science of clinical care.

In the 1990s insurers dominated health care policy. In the language of that time, power shifted from producers to purchasers; that is from hospitals and doctors to insurance companies. In the past both employers and insurers had been relatively passive "payers," collecting and passing thought funds to those who actually provided the care. In the 1990s both saw their role as active "purchasers," with power to affect how care was delivered. Backlash by patients, providers and politicians followed.

Draconian restrictions on services were dropped, including a 48-hour limitation for a hospital delivery, and direct patient access to specialists was reaffirmed. Enough time has passed by now to hope for a more nuanced and sympathetic study of the managed care movement of the 1990s. After all, besides their efforts to reduce hospital admissions, restrict the length of hospital stays and control the use of specialists, insurers tried to invent their own form of primary ("managed") care after years of federal policy had neglected it. Today, unlike the 1990s, some public regulation of access to insurance and what is covered is accepted on both sides; for example, in insuring individuals with pre-existing medical conditions, and in setting standards to compare the offerings of different plans. That is all to the good.

The market-orientation of the 1980s and 1990s designated patients overtly as "consumers." In turn the United States created a vibrant culture of medical consumers, with individual choice of specialist, the privilege of bypassing a primary practitioner, and uncoordinated visits to different specialists-subject to private and public insurance limitations and the individual's pocketbook. There has also been a movement to encourage patients to take matters into their own hands, keeping their own computerized medical records, and avoiding a doctor altogether. "Worried about Cholesterol?" a recent article inquired. "Order your Own Tests." That way one could avoid spending money on a doctor visit. "You cut out the middleman," one patient explained.[25]

On the other side of the industrial or market orientation of health care came the now familiar pattern of competing medical professional corporations in selected fields, including orthopedics and oncology, sleep centers, pain centers, MRI centers, and other single-focus enterprises. In the last 10 to 15 years there has been serious discussion of such enterprises, pro and con, as "focused factories" in a market-driven system.[26] Conflicts are inherent in decisions taken over many decades. If the United States favored primary care, why did Medicare not ensure proper payment for it?

If coordinated care is a desirable goal, why create a consumer culture that favored segmented care? The answer is, of course, that there is not one set of health policies but many. Will current reform strategies produce constructive organizational change? They are worth a try. A key will be persuading both beneficiaries and doctors that the resulting services will actually be better-and not just judged by being less expensive.

The wheel comes full circle back to medical specialization. As I emphasized in *American Medicine and the Public Interest* four decades ago, primary care is a function rather than a specialty; it is what doctors do rather than how they are trained. To work well, primary care requires patients to use it and physicians to make good referral choices as necessary. Labeling and credentialing someone as a specialist is not enough to identify what a given specialist does, let alone how well they do it. A recent article from the American Board of Internal Medicine emphasizes that the structure of the American medical profession is "defined by the practice area in which the physician focuses and in which the patient expects expertise," and argues that recognition of focused practice may be the key for maintenance of certification requirements in the future. If not, the authors suggest, formal subspecialties may keep proliferating-in fields such as medical informatics, clinical pharmacology, vascular medicine, addiction medicine, and obesity medicine.[27] We might point out, too, that the sick consumer increasingly needs someone to explain what any given credential means, and this might best be done through self-regulating medical practices and other health care organizations. Without effective incorporation of specialty roles into patterns that patients can understand and navigate, what is the point of further fragmenting an already fragmented specialty certifying system?

What can we conclude from all of this? A conclusion on the positive side is that given the quixotic effects of American health policy over the years, its pushes and pulls, the medical profession is in remarkably good shape. The formal functions of the

profession-medical education, graduate medical education, specialty certification-have developed far more effectively as vehicles to encompass the vastly expanded, vastly more valuable base of medical knowledge and skills over the past forty years than has the organizational framework for specialized medicine. Medicine is still, as William Osler held, an honored, "thinking" profession, with a high mission and a noble heritage. A higher form of generalism is possible-and necessary. In our times this is more likely to be achieved through constructive organizational change than through redefining internal medicine, medical education and the specialties.

What will the future bring? As we know full well from past experience, that is impossible to predict.

References

1. Rosemary Stevens, *American Medicine and the Public Interest*. New Haven: Yale University Press, 1971. Paperback, 1974. Updated by the addition of a new Introduction. Berkeley: University of California Press, 1998.

2. William Osler, "Preface to the Second edition of *Aequanimitas*." In William Osler *Aequanimitas, With Other Addresses to Medical Students, Nurses and Practitioners of Medicine*. Third edition, Philadelphia: P. Blakiston's Son & Co. Inc, 1930, p viii. Osler's address "The Fixed Period" was given at Johns Hopkins University on February 22, 1905.

3. Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine*. New Haven: Yale University Press, 1966. Updated with New Introduction. Transaction Press, 2003.

4. *American Medicine and the Public Interest*, p. 3.

5. See Nancy Tomes, "Patterns or Health Care Consumers? Why the History of Contested Terms Matters," in Rosemary A. Stevens, Charles E. Rosenberg and Lawton R. Burns (eds.). *History and Health Policy in the United States*, New Brunswick, NJ: Rutgers University Press, 2006, pp. 83–110.

6. *American Medicine and the Public Interest*, 1998, p. ix.

7. The best (and excellent) analysis available at the time I was writing was Herman M. and Anne R. Somers, *Doctors, Patients and Health Insurance: The Organization and Financing of Medical Care*. Washington, DC: Brookings Institution, 1961.

8. George Rosen, *The Specialization of Medicine, with Particular Reference to Ophthalmology*. New York: Froben Press, 1944.

9. Abraham Flexner, *Medical Education in the United States and Canada*. A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin no. 4. New York: Carnegie Foundation, 1910. See Kenneth M. Ludmerer. *Learning to Heal: The Development of American Medical Education*. New York: Basic Books, 1985; and *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. Oxford: Oxford University Press, 1999.

10. See e.g. Osler, "Remarks on Specialism," *Boston Medical and Surgical Journal* 1892; 126:457-59. His general views are nicely summarized in Mark E. Silverman, T. Jock Murray and Charles S. Bryan, *The Quotable Osler*, revised paperback edition. Philadelphia: American College of Physicians, 2008, pp. 87–91.

11. S.S. Goldwater, "The Specialist: What Shall We Do With Him?" *Journal of the American Medical Association* 88: 22 (1927), 1691–92.

References

12. For a later, updated review see Rosemary A. Stevens, "History and Health Policy in the United States: The Making of a Health Care Industry, 1948-2008." *Social History of Medicine* 21: 3 (2008), 461–83.

13. *American Medicine and the Public Interest*, p. 528.

14. Bradford H. Gray, "The Rise and Decline of the HMO: A Chapter in U.S. Policy History, in Stevens et al (eds.), *History and Health Policy in the United States*, pp. 309–39.

15. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books, 1982.

16. Walton H. Hamilton, Minority Report. Committee on the Costs of Medical Care, *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care*. Publication no. 28. Chicago: University of Chicago Press, 1932, pp. 189–200.

17. Robert Stevens and Rosemary Stevens. *Welfare Medicine in America: A Case Study of Medicaid*. New York: Free Press, 1974. Updated with New Introduction. Transaction Press, 2003; Rosemary Stevens and Joan Vermeulen. *Foreign-Trained Physicians and American Medicine*, DHEW Pub. No. (NIH) 73–325, U. S. Department of Health, Education, and Welfare, 1972; Rosemary Stevens, Louis Wolf Goodman, and Stephen S. Mick. *The Alien Doctors: Foreign Medical Graduates in American Hospitals*. New York: Wiley-Interscience, 1978.

18. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. New York: Basic Books, 1989. Paperback, 1990. Updated with new Introduction. Baltimore: Johns Hopkins Press, 1999.

19. See Rosemary Stevens. "The Invention, Stumbling, and Re-invention of the Modern U.S. Veterans Health Care System, 1918–1924" in Stephen R. Ortiz, ed., *Veterans Policy, Veterans Politics: New Perspectives on Veterans in the Modern United States*. Gainesville: University Press of Florida, forthcoming 2012**.** My book is underway.

20. Rosemary Stevens, "Geriatric Medicine in Historical Perspective," March 18, 1977.Unpublished typescript.

21. On internal medicine, see Rosemary Stevens, "Issues for Internal Medicine Through the Last Century," *Annals of Internal Medicine* 105 (1986): 592–602.

22. Figures are from ABMS, *2010 ABMS Certificate Statistics*. Chicago: ABMS, 2011, and from ABMS statistics from previous years.

References

23. Rosemary Stevens, "Professional Competence and Board Certification," March 18, 1999. Unpublished, except at the time by www.abms.org.

24. US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Shared Savings Program: *Accountable Care Organizations*. 42 CFR Part 425 [CMS-1345-P] RIN 0938-AQ22, P26. 417 pages. Draft, pp. 23–26.

25. Anna Wilde Mathews, Worried About Cholesterol? Order Your Own Tests. *Wall Street Journal*, January 11, 2011, D1.

26. See e.g. Regina Herzlinger, *Market-Driven Health Care, Who Wins, Who Loses*. New York: Perseus Books, 1997; and Lawrence B. Casalino, Kelly Devers, Linda R. Brewster. Focused Factories? Physician-Owned Specialty Facilities. *Health Affairs*, 22:6 (2003), 56–67.

27. Christine K. Cassel and David B. Reuben, "Specialization, Subspecialization, and Subsubspecialization in Internal Medicine." *New England Journal of Medicine* 364; 12 (March 24, 2011) 1169–73.

John P. McGovern Award Lectureships

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.

4. *The 'Open Arms' Reviving: Can We Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990, in Baltimore, Maryland.

6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.

7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.

8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.

9. *The Leaven of Science': Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.

10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.

11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.

12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.

13. *Why We Go Back to Hippocrates* presented by Paul Potter, May 6, 1998, in Toronto, Ontario.

Cover — The John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

John P. McGovern Award Lectureships

14. *Health Care in the Next Millennium* presented by John D. Stobo, M.D., May 5, 1999, in Montreal, Canada.

15. "*Writ Large": Medical History, Medical Anthropology, and Medicine and Literature* presented by Gert H. Brieger, M.D., Ph.D., May 17, 2000, in Bethesda, Maryland.

16. *Reflections on American Medical Education* presented by Kenneth M. Ludmerer, M.D., April 18, 2001, in Charleston, South Carolina.

17. *John Shaw Billings as a Historian* presented by James H. Cassedy, Ph.D., April 24, 2002, in Kansas City, Kansas.

18. *The Evolution of the Controlled Trial* presented by Sir Richard Doll, May 23, 2003, in Edinburgh, Scotland.

19. *Practising on Principles: Medical Textbooks in 19th Century Britain* presented by W.F. Bynum, M.D., Ph.D., FRCP, April 20, 2004, in Houston, Texas.

20. *Just Call Us Children: The Impact of Tsunamis, AIDS and Conflict on Children* presented by Karen Hein, M.D., April 11, 2005, in Pasadena, California.

21. *A Leg to Stand On: Sir William Osler & Wilder Penfield's Neuroethics* presented by Joseph J. Fins M.D., F.A.C.P., May 2, 2006 in Halifax, Nova Scotia.

22. *Touching Where It Hurts: The Role of Bedside Examination* presented by Abraham Verghese M.D., M.A.C.P DSc (Hon), May 1, 2007, in Montreal Quebec.

23. *Managed Fear: Contemplating Sickness in an Era of Bureaucracy and Chronic Disease* presented by Charles Rosenberg, May 5, 2008, in Boston, Massachusetts.

24. *Is Scholarship Declining in Medical Education?* Presented by Patrick A. McKee, M.D., April 21, 2009, in Cleveland, Ohio.

25. *Selling Our Souls: The Commercialization of Medicine and Commodification of Care as Challenges to Professionalism* presented by Nuala P. Kenny, M.D., April 27, 2010, in Rochester, Minnesota.