ranging from 0 (as negative as possible) to 10 (as positive as possible), the mean expressed attitude toward managed care ranged from 3.9 for residents to 5.0 for deans. This overwhelming expressed negativity suggests a certain level of narrative rigidity, a rigidity in storytelling in the face of chaos that does not allow medicine to move forward in a meaningful fashion.

Therefore, instead of working toward a solution, medicine finds itself professionally stuck. Unable to tell new stories, physicians begin to fall apart. One doctor pointed out the following:

Too many physicians are running scared and making bad, short-term decisions. They aren’t thinking about the future because they don’t know what they’re doing. Once you sign that contract, you’ve got to do what it says. And so, they’re getting stuck, and they’re unhappy. They want out.

An older physician put it this way:

You know, I have thoughts running in my mind like “How long am I going to keep doing this? How long can I stand it?” And I just heard yesterday one of the big interns down the road say he can’t hack it anymore. Me, I’m probably stuck in this practice ’til I die.

Stuck sums up medicine’s current professional crisis, that is, stuck in its double agency without the stories necessary to transform or transcend its narrative dysfunction, stuck in its struggles to balance issues of cost and care, stuck in its struggles with the culture of managed care, and stuck in its struggles to counterbalance the forces of decentralization. Stuck in these struggles, physicians search for tools to help. According to our research, they have found two: a moral navigation of systems and the use of a sociological consciousness.

Addressing the Problems of Profession

Although medicine remains stuck, a handful of doctors—whom we call proactive physicians—have begun to construct what we believe are two very useful and interrelated tools for addressing the problems of double agency: The first, which we call morally navigating systems, defines profession as the ability to work well within systems while bringing a moral compass to them; the second, which we call sociological consciousness, is the ability to think critically and reflexively about systems and the role that one plays in maintaining them. The importance of the first tool is that as a new definition of profession it helps proactive physicians understand that the more sophisticated they are about the systems in which they work, the better chance they have to morally navigate them. The second tool, sociological consciousness, helps them to do this.

Morally Navigating Systems

Common among proactive physicians addressing the problems of double agency is the tendency to redefine profession as working well within, while bringing a moral compass to, today’s corporate and bureaucratic health care system. Proactive physicians practice this new definition of profession because they realize that medicine’s
current conflict with managed care is part of a larger battle between the professions and the corporations. In the United States, medicine is not the only profession being corporatized; it is also occurring in academia, education, mental health, nursing, social work, and so on. Addressing this larger sociohistorical reality, proactive physicians acknowledge that the corporate structure of today’s health care system is here to stay, at least for a while.

Understanding this sociohistorical transition, proactive physicians also realize that the more knowledgeable they are about the systems in which they work, the better prepared they are to deal with the moral challenges that they currently face. They realize that the luxury of being in control or being just outside of the health care system is a thing of the past (McKinlay & Stoeckle, 1988; Starr, 1982). In fact, in so many ways, there is no longer an outside to today’s health care system. Even physicians in small, semirural solo and group family practices living on modest salaries and treating uninsured patients holistically find themselves confronted by the corporate model of health care. It is everywhere.

For proactive physicians, then, the best decision, professionally, is to embrace the new system and learn how to work well within it. As one proactive physician, an oncologist, stated,

You have to understand the basic sociological, political, and economic interactions. That’s probably where students [and physicians] need to spend much more time, so when they graduate, or as they go through the system, they have the tools to deal with present-day medicine.

Another physician in family practice said,

There are doctors who will tell you that all you have to do is be a good doctor and everything else follows. That is no longer true. A certain amount of time physicians have got to spend on understanding and managing the business of their practice, or they’re out!

Another proactive physician used his knowledge of diagnostic related groups (DRGs) to make the same point. He explained that his mentor was extremely strict about learning the DRG codes, which upset him as an overly busy resident. Now in practice, however, this knowledge helps him keep the needs of his patients first:

The experience helped me to work with hospitals and be a consultant. Hospitals had to maximize their DRG coding and educate physicians as to what they needed to document in their charts. It was a matter of focusing physicians and teaching them as to what’s important in the disease process and clinical findings to document that their patient is severely ill. That actually improved reimbursement.

However, more important, it also improved patient care:

“Not sick” or “doing well” or “eating well” or “no chest pain today” … that doesn’t get a hospital day anymore. It’s not about writing whole-page notes. It’s about writing what the conditions reflect and the appropriate things that, unfortunately, you have to think about: the auditors and the evaluators and the third-party payers and the review nurses and what they’re going to read in the chart and is that going to reflect why the patient needs to be in the hospital.
As these comments suggest, proactive physicians understand well the systems in which they work, and more important, they understand well that knowledge, particularly the lack thereof, influences the moral decisions that they make. As such, they understand that double agency has everything to do with the complex corporate and bureaucratic systems in which they work. The more knowledgeable they are about systems, therefore, the better able they are to address the problems of power and ethics and cost and care, provide an effective counterbalance to the forces of decentralization, and find ways to overcome their narrative dysfunction. A proactive female physician in family practice put it this way:

By being proactive and being adaptable, and by forming our network, we’ve learned a lot about what managed care is really doing. We’ve gone out, and we’ve formed networks. Also, I think we’ve just opened the communication lines. I really, really feel that these past 2 years of just networking has put me in touch with a lot of other physicians. Now the doctors are saying, “How can we all get together and make patient care better? How can we improve the quality of care? How can we decrease the number of CAT scans and MRIs we’re doing? How can we do these good things together?”

Thinking about double agency as morally navigating systems, however, is not the end to what proactive physicians use to address their professional crisis. If morality depends on knowledge, then how doctors go about getting their knowledge becomes important. Physicians have to ask themselves how they think about systems, where their knowledge comes from, and what purpose, or whom, it serves. Does it serve the administration? Does it serve patients? Does it serve medicine? Proactive physicians, therefore, need the critical skills necessary to situate politically the knowledge they receive, thereby allowing them to practice the best moral decision possible. We call this set of skills sociological consciousness.

**Sociological Consciousness**

Sociological consciousness comes from the work of Peter Berger (1963). It is the plan of proactive physicians to engage in what Nietzsche calls “the art of mistrust” (Berger, 1963, p. 30). The art of mistrust is not, however, the mistrust of other physicians, patients, administrators, or corporations. It is the mistrust that is carefully crafted and taught by an entire discipline, the sociology of knowledge. It is the mistrust of knowledge as it seems. It is the mistrust of the perceptions and roles that physicians easily fall into as they practice their profession and the mistrust of the knowledge used to run the corporate and bureaucratic health care systems in which they work.

Such mistrust, however, is not based entirely on the facts, as Relman (1998) would suggest. Such mistrust, so deliberately enacted, acknowledges but goes far beyond Relman’s call to learn well the “politics, philosophy, and economics of medical practice” (p. 1230). Such mistrust calls for more than the accumulation of important memorized facts such as managed care codes, contract clauses, and reimbursement schedules. Such mistrust requires more than the basics of how corporate health care works. Such mistrust sees the accumulation of facts as only leading to a certain level of knowledgeable ness and not to a critical intelligence. For as Foucault (1985) explains, “What would be the value of the passion for knowledge if it
resulted only in a certain amount of knowledgeableness?” (p. 8). Knowledgeable physicians are everywhere in the system. They demonstrate their knowledge through their ability to survive; they know enough to tend to their immediate needs but not enough to free themselves or anyone else from their current professional crisis.

Sociological consciousness requires more than the facts. It requires the ability to think. Thinking is not memorization; thinking is critical. It is the act of understanding things anew, differently. If medicine is to go on as a profession, it is necessary for physicians to think and perceive their situation differently. They need a thoughtful awakening, an awakening that deconstructs its way to the sociological heart of the matter to ask, “What is going on here?” More important, it asks, “What can I do, as a professional, to morally navigate my way through it?” Such mistrust, such critical awareness, makes up a sociological consciousness.

Again, as Foucault (1985) states, “There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all” (p. 8). Physicians, if they are going to move beyond their current situation, need more than the memorization of profession, something medical educators help them do well: Physicians are not supposed to think about profession, they are only supposed to learn it. Stuck now in a crisis, they search for a solution, but only within the narrow confines of what they already know. They keep looking for the answers by reflecting on the knowledge they already have. However, this is not thinking, this is not critical intelligence. Consider the following story.

A family practice residency director told us how he invited a recently sued colleague of his, who was bitter and depressed because of it, to talk with his residents about the joys of obstetrics. What the residents got instead was a lecture about the terrors of malpractice despite the fact that this colleague was not successfully sued.

“And the last bomb he drops,” the residency director said, “was ‘And don’t do obstetrics!'”

Politely waiting until his colleague’s scare tactics were over, the director spoke to him in private. “Why would you say that?” he asked. “You didn’t get sued in an obstetric case!”

“Yeah, but you know,” said the colleague.
“No, I don’t. Know what?”
“Well, you know . . . You can really get sued in OB.”
“You can get sued doing anything.”
“Well, you know . . . but those are big suits.”
“Are they?”

The interaction between this director, his colleague, and their residents is a good example of what happens to physicians in the absence of a sociological consciousness. Professionally, things break down and remain stuck.

In the corporate world of health care today, managed care shares as little risk with physicians as possible, making malpractice a major problem, both because of the potential legal harm it causes physicians and because of the high costs of premiums. Stuck with the responsibilities associated with malpractice, physicians practice defensive medicine—caring for patients to avoid lawsuits—which, in turn, adds to the problem because it raises cost. In reaction, managed care lowers cost by placing financial risk back on the doctors and penalizing them for spending too much, for example, capitation, gag clauses, restriction fees, and so on. It is little
wonder, then, that physicians feel damned if they do and damned if they don’t. In addition, it is little wonder, as in the case above, that some physicians tell residents, “Don’t do obstetrics!”

It is a terrible experience going through a lawsuit. It challenges your sense of self and makes you wonder if you are competent, and worse, it makes you paranoid and defensive. You become vulnerable, feeling trapped in an unforgiving and uncaring system. You lose your nerve and do things to make sure that you never get sued again, you are never quite the same person afterward, and you hate that.

We see this vulnerability, paranoia, and sense of helplessness in our above example. The colleague feels vulnerable due to his recent lawsuit because although he was lucky this time, maybe the next time he really will get sued. He cannot go through that again, and he does not want the residents to either, so he counsels them to stay away from obstetrics and they will be okay. The residents feel vulnerable too because they lack the tools necessary to situate the colleague’s story. No debate took place, and no facts were handed out. What they got instead was a monologue, paranoia, and the summons, “Don’t do obstetrics!”

Because these residents feel vulnerable, the forces of decentralization loom large. The system is closing in on them, and it is getting harder to breathe. Their idealism and dreams of being great doctors are momentarily suffocated by an overwhelming sense of powerlessness. They feel unable to do anything about the situation, or perhaps they protest, “I won’t be that kind of doctor!” Either way, because they and their peers lack a sociological consciousness, they suffer their new devastation largely alone, finding camaraderie only in commiseration.

Such commiseration, however, is problematic because it allows residents and doctors to do two things: First, it allows them to demonize and externalize their problems, blaming the system; second, it allows them to feel victimized and prey to the forces of decentralization and therefore unable to enact any larger power over their situation. We see this phenomenon in the tremendous expressed negativity and fatalism that physicians have toward the system, which comes out in the form of “take care of yourself.”

One proactive physician told a story about his work to get a physician hospital organization (PHO) going in his area. He and his colleagues got a group of physicians together, had all of them join the organization, collected the dues, and hired someone to negotiate contracts for the whole group, which is the primary benefit of joining a PHO: As a group, physicians have more leverage to negotiate a fair contract. Nevertheless, several of the more reactive doctors went out and signed contracts on their own, only to complain later to this physician and his colleagues about the terrible deals into which they had gotten themselves. This physician just shook his head in disbelief.

This is the problem with demonizing the system, externalizing one’s problems, and commiserating in expressed negativity toward managed care: It allows physicians to focus on their own immediate concerns and take a narrow view of their situation rather than push themselves toward social change and a larger activism. “Don’t do obstetrics!” As a result of reactively focusing on themselves rather than proactively focusing on the system, physicians find themselves trapped in their narrative dysfunction, leaning toward issues of power and cost rather than ethics and care, which was the proactive residency director’s point.

We asked this director and several other proactive physicians how they would have handled the situation differently. All of them gave us the same basic answer.
First, they would have given the residents the facts. They would have explained to them that nowadays in nonrural areas most family physicians do not do obstetrics (a growing trend since the 1980s) because of the threat of lawsuits and high malpractice insurance premiums. However, in rural areas, family physicians still do obstetrics because, historically, they are often the only primary care providers around for miles. They also would have explained that there are many ways to ensure against malpractice, for example, talking with patients about the potential risks involved in pregnancy and making them feel like a part of the treatment process, establishing a back-up plan for emergency situations and making use of advancements in technology such as the Internet, establishing good connections with local and regional obstetricians and pediatricians, and learning to live with the threat of lawsuits and the realities of our litigious culture.

Second, they would have made it clear to the residents that, in the end, being afraid is not a way to live. If residents want to do obstetrics, then they should. Caring for women and their babies is a very rewarding way to practice medicine. In the end, doing something you love almost always outweighs the associated costs. As one proactive physician commented,

Medicine is an excellent profession. There is a niche for everyone. I have no fears about medicine and what it has to offer. I think that it's in the best interest of medicine to educate these young people in the right way and give them the right direction. That's the way I feel about it. I don't have the blues at all.

CONCLUSION

Our findings support expanding Relman's (1998) argument to create a new grounded theory of professionalism applicable to medical practice as a whole, from students and residents to physicians in practice. Physicians need new ways to critically and self-reflexively think about the new corporate health care systems in which they work and find ways to integrate cost with care, ethics with economics, and professional commitment with bureaucratic expectation. Otherwise, physicians will continue to rely on what they already know, which is a tired knowledge-ability that is largely responsible for the current professional crisis in which they are stuck.

We as medical educators and continuing medical educators have to decide what we will do. Either we will continue to go through the motions, relying on our own knowledge-ability, or we will nourish our sociological consciousness and construct a new practice of profession grounded in the relationships between complex systems, self-reflexive and critical understanding, and morality. As proactive medical educators, we choose the latter.

REFERENCES


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