Doctors and Their Autonomy: Past Events and Future Prospects

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The doctor in American society plays a role that must be played; and the importance of that role is, if anything, increasing as our society grows more complex and our population larger. In addition, and closely related, is the fact that the doctor is still accorded special status within American society, something that is not likely to change substantively, despite the increasingly critical comments about the medical profession in the American press (*1*). The most obvious manifestation of the profession's special status is, of course, economic. A recent survey on doctors' net incomes showed that the average figure for the nation was $53,600, with general practitioners making about $45,000 and specialists in obstetrics and gynecology in urban settings averaging more than $65,000 (*2*). Since these figures were gathered in 1975, it is safe to assume that today, nearly 3 years later, they are considerably higher.

There are other manifestations of the doctor's special status. For example, doctors are required to serve on juries only very rarely, and are seldom penalized for parking violations while on professional missions. These are admittedly small things, the analogues of which were known even to the Romans; but they are collectively quite significant (*3*). It will not do, however, to press the modern case on the basis of evidence from the ancient literature, legal or otherwise. The reason is that the medical profession as we know it today did not begin to emerge until much later. Our real argument begins in 14th-century England, and the story from that date can be built around several more or less continuous themes of which professional autonomy and its near relative, maintenance of monopoly, are but two. They are, however, the most appropriate themes to follow for present purposes, and, as we shall see, the legal record tells us as much as or more than the medical. The story is one of intermittent and progressive limitation of autonomy and, somewhat later, modification of the right to create and maintain monopoly. But through it all, the special social position of the doctor is visible and, to an extent, determinant.

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The First Step: Malpractice Law

The position of the medical profession in Britain in the several centuries following the Norman Conquest is difficult to pin down because, at the start, medicine and the priesthood were not easily distinguishable. The common law in its early stages is not known to have had anything to say about the medical profession since most doctors, if in conflict with the law, were probably dealt with under canon law or in local courts, but not in the King's courts, from whose decisions English common law derives. There is, however, a suggestion in the legal record of the early 14th century that a doctor was not liable for injury to patients unless he inflicted it with evil or criminal intent (*4*). There was no mention of culpability for ignorance or negligence, and it seems that if a patient of that time placed himself or his horse in the care of a bona fide doctor, human or horse, he had to bear his own loss if there were injury unintentionally inflicted. It may not have been as simple as that, since there are very few records of proceedings in England's numerous local or customary courts.

In contrast, actions of the King's courts have been recorded since the latter part of the 13th century, the chief sources of information about the earlier part of the record being known collectively as the Yearbooks. Several cases in the Yearbook record for the 14th century suggest that the position of the healing professions in the eyes of the law changed dramatically before the century was out. In 1373 Justice John Cavendish decided Stratton *v.* Swanlond (*5*), a case brought against a surgeon, in which the Justice said that if the patient is harmed as a result of the doctor's negligence, the doctor should be held liable. But, said Cavendish,

> . . . if he does all he can and applies himself with all due diligence to the cure, it is not right that he should be guilty therefor, [even] though there is no cure. . . .

The importance of this case is that it contains most of the significant elements of 20th-century common law of malpractice and represents the first official invasion of the medical profession's autonomy. In addition, it seems to be the true origin of the common law doctrine called fault, or "no liability without fault" as it is sometimes phrased. The language of the court is quite explicit: unless the doctor were somehow negligent or careless, he was not liable even if he failed to produce a cure. This stands in sharp contrast to the principle of strict liability, which requires that he who causes the injury must compensate the injured party regardless of intent, negligence, or any other consideration.

It is significant that the fault principle makes its first appearance in a malpractice case and it may indeed have been devised to protect the doctor, in an age when malpractice insurance did not exist, from the full rigors of strict liability. It may have represented a sort of quid pro quo, recognizing the doctor's special social status but limiting his autonomy ever so slightly in the public interest. In any event, after Stratton *v.* Swanlond the doctor was no longer totally autonomous, as he seems to have been earlier in the 14th century, barring activity that we in our own time would term criminal.

The Second Step: Due Process

In the two centuries following Stratton *v.* Swanlond, the medical profession in London became highly stratified, and the physicians, who were at the top of the heap, consolidated their position by adopting the methods of the craft guild. Precisely how London's physicians managed to prevail over their chief rivals is not altogether clear, but the surgeons were beneath them in the hierarchy and the apothecaries were beneath the surgeons (*6*). It may, however, be relevant that the physician's patients were the high and the mighty, while the poor, if they received any medical care at all, were treated mostly by apothecaries and various folk healers. In any case, the physicians prevailed on Henry VIII to charter their professional guild in 1518 as

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London's Royal College of Physicians, and some time later Parliament gave it extraordinary powers by law. Not only was it the licensing authority for London, but it could also imprison or fine offenders, dividing the fines it received with the Crown. Those whom it imprisoned had to remain in prison until the College agreed to their release. Common criminals could sometimes be released on bail, but not those offenders who were convicted and imprisoned by the Board of Censors of the Royal College of Physicians.

Thus it was that the Royal College, accountable to no public authority, received by parliamentary delegation extraordinary legal powers (*7*), and it is a matter of record that the College used these extraordinary powers to maintain and to strengthen its monopoly. Its numbers were very few and the demand for the members' services was therefore such that their incomes were kept at a high level. There is, however, a suggestion of a social contract in the arrangements: the College undertook to protect and to serve the public expertly in return for which it received high social station and economic advantage. The caveat emptor imperative might apply to ordinary marketplace transactions, but not to the doctor-patient relationship. These general concepts have to some extent characterized the relations between the medical profession and the public ever since.

But predictably the College overreached itself, and it sustained a rude jolt when in 1606 it sent one Dr. Thomas Bonham to Fleet Street prison for practicing without its license. Bonham, who had a medical degree from Cambridge, denied with some justice that the College had any authority over him and was released from prison on a writ of habeas corpus. But the College, undaunted, relentlessly followed up its earlier actions with the ultimate result that Bonham brought a civil action for damages for false imprisonment (*8*). This time the matter came before the Court of Common Pleas, of which the irrascible and combative Sir Edward Coke was chief justice. The decision was against the College on the ground of conflict of interest. The College, said Coke, could not legally summon a man, try him in its own court, fine him, then put a part of the proceeds into its own coffers. Coke also indicated that the power to imprison without trial is a limited one in law and does not confer "any irregular or absolute power to correct or punish any of the subjects of the kingdom at their [the College's Board of Censors'] pleasure." It was unlawful for the accused to have been imprisoned "without bail or mainprize, till he should be by the commandment of the President and Censors . . . delivered" (*9*).

Bonham's is one of the most famous cases in English legal annals, not only because it limited the right of a private organization, responsible only to its own members, to take away an individual's liberty or property. Even more important, it involved certain fundamental constitutional issues including the right of the judiciary to overrule the legislature.

What Coke actually said in this connection was that ". . . when an Act of Parliament is against common right and reason, or repugnant, or impossible to be performed, the common law will control it and adjudge the Act to be void" (*10*). This, in Coke's time and still in our own, was political dynamite and it got Coke into a great deal of trouble. It seemed reasonable within the context of Bonham's case, but it carried with it certain fundamental constitutional implications, some of which were later acceptable to American jurists but totally unacceptable in England. In Britain the legislature has, since 1688, remained unmistakably sovereign, answerable only to the electorate (*11*).

The whole issue of the supremacy of the legislature and its relation to the judiciary, along with the question of a Bill of Rights for England, is today being given new impetus by the debate on devolution. One can expect to hear Coke's arguments in Bonham's case cited again and again in the next few years. But for present purposes, the importance of the case is that it represented a second step in limiting the autonomy of the medical profession. The court, in effect, told the College that it could not, in the course of its pursuit of monopoly, infringe certain basic rights of the individual or use its own court arbitrarily as a means of enriching itself.

Step Three: Licensure

The College continued to use its parliamentary authority, but with much greater caution. It had, for years, tried charges of malpractice in its own court as well as inflicting punishment for practicing without a license. But, from the late 17th century onward, it tended to bring charges of both sorts into the regular courts. It remained, however, a licensing body until 1858 when the Medical Act created the General Medical Council and public authority took over licensure of medical practitioners. At the same time, public authority took control over medical education to a limited extent. Provision was made for professional influence and input, but the ultimate licensing authority was now quite firmly in the public sector (*12*).

In the United States, there were parallel events (*13*), but of special significance in both countries was the unification of the medical profession by the creation of national, guildlike professional organizations that were strong enough and coherent enough to influence public policy and legislation.

The American Medical Association (AMA) was created in 1847 and the British Medical Association (BMA), building on a prior regional organization, a few years later. Both organizations conceded quite early that licensure was a proper concern of government and to that extent accepted the loss of another component of their autonomy. In the United States it was not a serious loss since in most states membership on boards of registration was directly or indirectly under the control of state medical societies which themselves were constituent members of the AMA. Both of these great medical guilds promptly set about protecting the remaining autonomy of the medical profession chiefly by defending the profession's monopoly and the fee-for-service principle. In the United States, the AMA staked out the medical profession's territory in 1872 when it acknowledged that the protection of the health of the millions was the obligation of government but that private or curative medicine belonged to the doctors (*14*). Nearly 40 years later, it strongly reaffirmed its opposition to government intervention in the provision of personal health services (*15*), a view that had earlier been adopted in different form by the BMA. It was an emphasis that would one day bring the organized professions once again into conflict with the law.

The Fourth Step: Restraint of Trade

In Britain the trouble began in 1915 when the Coventry Provident Association began to hire physicians and surgeons to provide medical care to its subscribers. It was a straightforward prepayment scheme but it ran counter to the fee-for-service principle. The BMA, through its Coventry division, informed three of the doctors employed by the Provident Association that they must immediately resign. When they refused, the doctors were promptly expelled from the BMA, which also informed its constitu-

ent members of the action and urged that the three be ostracized and boycotted. This meant that the three doctors were virtually excluded from hospital privileges and from consultation practice and, as a consequence, they took the only action available to them: they filed civil suit for damages against the BMA and its Coventry division (*16*).

The verdict went resoundingly against the BMA. Among many other things, the judge had this to say (*16*):

> The coercive force of the defendant Association rests primarily upon what are called the ethical rules. . . . [A physician] may be exposed to degradation and dishonor at the whim of a body which is void of the slightest statutory sanction in that behalf. . . . Such sanction belongs to the General Medical Council.

He went on to say that he could not ". . . ignore the deliberate and relentless vigor with which the defendants sought to achieve the infliction of complete ruin." He awarded the claimants £2400 in compensatory and punitive damages, strongly intimating by his action (and statements) that the offense was clearly intentional and therefore had criminal overtones.

After that time, the question of contract practice, which the BMA had called unethical, was settled; and it became moot with the establishment of the National Health Service in 1948.

The corresponding legal event in the United States did not occur until 1940, but it was remarkably similar to the earlier British case. It arose when the AMA tried to ostracize several doctors who practiced on salary with a group health association in the nation's capital. Prepayment for health services was considered unethical by the AMA, and the association left no stone unturned to punish doctors who worked under such arrangements. The federal government finally brought suit against the AMA under the Sherman Antitrust Act for conspiring to restrain legitimate business and professional activity (*17*). The AMA was found guilty, and the U.S. Supreme Court refused to review the verdict of the court below. That ended the AMA's practice of conspiring against group health and prepayment plans, many of which operate successfully today in the United States.

It is astonishing in retrospect that the BMA and AMA allowed themselves to fall into such legal traps. No doubt each had adequate legal counsel and they probably regarded their conspiracies as calculated risks. However that may be, both medical associations got clear and unmistakable answers from the courts: organized medicine could not give its own guild rules the force of law by conspiring to the detriment of its members or against anyone else. The American case is especially interesting in that the AMA claimed that it did not come under the Sherman Antitrust Act because it is a professional society, not a trade organization. But the court was unimpressed and, by inference, made it clear that the AMA had conducted itself after the manner of a trade association seeking to maintain monopoly. Whether or not the leadership of the AMA was carrying out the will of its members in this instance cannot be known, since no poll was taken then or later. To the extent, however, that the AMA's House of Delegates represented the membership, the leaders of the organization were unquestionably acting in accordance with the majority opinion of its individual members. Indeed, the leaders of both organizations probably had very little choice. It is axiomatic that when such guildlike associations begin to fail to represent the interests and views of their members, they are in serious trouble as organizations. Unfortunately, court battles like these unmistakably obscure the numerous actions organized medicine takes that are clearly in the public interest. All that the public can see is a giant, wealthy organization acting solely in its own interests. Lost from sight, in the case of the AMA, were its vigorous and public support of quarantine legislation, the pure food and drug movement, the establishment of state departments of public health, and the refinement of medical education (*18*). But the legal actions of 1915 in Britain and 1940 in the United States redefined and further limited the autonomy of the British and American medical professions. They could no longer force adherence to a preferred scheme for remuneration, one that kept the fees charged by physicians out of the public view as much as possible.

Step Five: Quality Control

My thesis so far is that the medical profession has been required to surrender its autonomy step by step since the late Middle Ages. It began with the evolution of the common law of malpractice based on fault and ultimately on negligence as the law now defines it. Next came the decision of the Court of Common Pleas which set limits on the lengths to which London's Royal College of Physicians might go in enforcing its own monopoly. Then came legislation in the 19th century that placed licensure, and to an extent medical education, under public authority. In the 20th century came legal limitation of the right of the medical profession to control the means by which doctors are paid for their professional services.

So what is left? In answer, it may be permissible to draw on the thought and creativity of a society that has long since disappeared, but that has left us a powerful intellectual legacy. Plato, in one of his dialogues, explored the consequences of destroying the autonomy of the medical profession altogether. In *The Statesman*, one of the spokesmen, in making a point that is not now germane, used the medical profession as an example. The doctor abuses his autonomy, said the spokesman, and saves us or lets us die according to his own interests. "He cuts us up, burns us, and orders us to bring him money . . . as if he were exacting tribute." He is sometimes receptive to bribes from our enemies or from hostile relatives who wish us dead. He should, therefore, be placed under rigid state control.

To accomplish this, said the spokesman, we should call an assembly of all the people and invite opinions about "disease, and how drugs and surgical or medical instruments should be applied to patients. We should take a vote on all these things and whatever the majority decides about each of them should be inscribed in stone and possess the force of law. We should then elect our physicians from among our number for one year terms, and severely penalize them if they fail to carry out the letter of the law." What is more, said the spokesman, we should forbid all research, since the truth would already be laid down. Those doing research anyway should pay a grievous penalty "for corrupting the young and persuading them to practice the art of . . . medicine in opposition to the laws. . . . [For] nothing and no one . . . ought to be wiser than the laws."

The second spokesman, replying to all this, draws the conclusion that by such means all art [and all science] would be utterly ruined and, research being forbidden, could never rise again. He added: "and so life, which is hard enough now, would then become absolutely unendurable" (*19*).

In our own time, Plato's fantasy has a familiar ring to it, what with the increasing paperwork imposed on today's practicing physicians, the increasing threat of penalty through malpractice actions, and the rigid restrictions placed by third-party carriers on how much they will pay for what. Can all this fail to lead to total subjugation of the profession along the lines

laid down in Plato's dialogue? May not government, or the threat of malpractice actions, one day tell the doctor precisely what he may or may not do, even unto the patient's bedside?

The answer is in the negative for the simple reason that the peer judgment principle and application of technical expertise are indispensable no matter who pays the physician and no matter what the courts have to say about professional standards. Even in the Soviet Union and Great Britain, the medical profession maintains a considerable degree of what Freidson calls technologic autonomy, something he says ". . . is at the core of what is unique about the profession" (*20*). But what the American medical profession is now facing is not really further loss of professional autonomy, unless we define the term as the right of the individual physician to do precisely as he will, once he is legally licensed, without fear of judgment of any kind. What lies ahead is the prospect of routine, and one hopes judicious, peer judgment on the basis of properly defined standards of professional performance systematically applied. The signs of change in this direction are overwhelming. Professional meetings and the medical literature are filled with discussions of utilization review, medical audit, and mediation and arbitration panels, all designed to monitor one or more phases of the doctor's professional performance (*21*). None of this is really new, the need for outcome appraisal having been recognized soon after the turn of the century (*22*).

But it was the passage of Medicare and Medicaid laws, the rise of the so-called malpractice crisis, and the passage of the Professional Standards Review Organization (PSRO) law that brought matters to a head. Space does not permit detailed consideration of each of these complex matters, but they are all of a piece in one very critical sense: all focus sharply on the definition of standards and the creation of guidelines governing the application of those standards.

Where Malpractice Fits In

Looking at the malpractice problem first, if only because it is probably the least important in a relative sense, we find that the most prominent of the proposed remedies all embody some form of definition of compensable injury (*23*), and many others do so at least by inference. The need for such information, although denied by some trial lawyers, was firmly recognized and expressed by one of our greatest legal authorities, Oliver Wendell Holmes, in 1881. Holmes put it this way (*24*):

> Any legal standard must, in theory, be capable of being known. When a man has to pay damages . . . he is . . . supposed to have known what the law was. If, now, the ordinary liabilities in tort arise from failure to comply with fixed and uniform standards of external conduct . . . , it is obvious that it ought to be possible, sooner or later, to formulate these standards at least to some extent and that to do so must at last be the business of the court. It is equally clear that the featureless generality, that the defendant was bound to use such care as a prudent man would do under the circumstances, ought to be continually giving place to the specific one. . . .

But today, nearly a century later, the featureless generality still prevails where medical malpractice is concerned. It is still not possible even for the most knowledgeable and conscientious physician to know whether or not he has broken the law until a court says what it thinks the law is. There are discernible principles in the law of medical malpractice, but a wide variation in the application of those principles from court to court and case to case forces writers of legal textbooks to equate the exceptions with the rule. It may indeed be the ultimate business of the courts to define compensable injury, but it does not follow that the process must take place countless times, over and over again, in the adversary climate of the courtroom. Such definitions primarily require the application of medical expertise, before the fact of injury, by appropriate expert panels outside the courtroom for the eventual use of the courts. And quite predictably this is one way—perhaps the most appropriate way—the malpractice problem will be eased if not altogether solved (*25*).

The General Monitoring of Quality

But the definition of compensable injury is not, in itself, enough. Much more fundamental is the creation of standards of professional performance without specific reference to malpractice, an activity to which the medical profession even today is no stranger. The Medicare law made hospital-based utilization review mandatory, a requirement that was later extended to Medicaid (Title XIX) as well. The focus was primarily on cost control and only tangentially on control of quality. Experience with the utilization review mechanism has been largely unsatisfactory (*26*), a fact that has led to experiments with various forms of medical audit. But it was the PSRO law of 1972 (*27*) that put peer review firmly and probably permanently on the American medical scene. It is not appropriate to attempt to summarize this complex and clumsy piece of legislation beyond pointing out that it contains within it the seeds of its own failure (*28*), and will require substantive revision in the future. Nor is it possible to subscribe fully to the expectations set out by Simmons and Ball when they say that "as PSRO becomes operational nationwide, that system will prove an efficient and effective system of control over the quality of outcomes of medical care" (*29*). More likely, it will be a successor to the PSRO mechanism that will do so. But the principle of routine peer review that is incorporated within the PSRO law is here to stay and will undoubtedly alter the climate within which medicine is practiced in the United States.

Ultimate Mechanisms

For a number of reasons, we have not yet faced the fundamental fact that the two basic ingredients in the peer review principle are separate and distinct: the first is the creation of standards; the second is the monitoring process by which standards are applied. The two entities differ significantly in that one is properly a national activity, the other a local one. Fortunately, we have familiar mechanisms on which to build the peer review system of the future.

For the setting of standards, of which definitions of compensable events is merely one component, national mechanisms have existed and operated in a limited way for a very long time. These are the specialty societies and boards, including those representing generalists and family physicians, all of which have been setting professional standards for many years. Every time these organizations prepare an examination question and every time they arrange programs for national meetings or for continuing education requirements, they are recognizing, and sometimes setting, professional standards. Although they have set standards primarily to determine qualifications for certification and, in some cases, for preventing professional obsolescence, they act tangentially very much in the public interest. Many hospital governing bodies are guided by traning standards set by specialty groups; in establishing the credentials of medical defendants and expert witnesses, the courts quite regularly take notice of certification by specialty boards according to standards that are applied nationally.

And in the establishment of the fact of negligence, expert witnesses who are themselves certified specialists not infrequently draw on standards developed by their specialty societies, a trend that may confidently be expected to become more widespread.

The objection that standards set by specialty societies and boards are unfair to doctors who are not board-certified loses its relevance when the national trend toward certification as a specialist is taken into account, especially since general and family medicine have taken their place among the specialties (*30*). What is now needed is joint action by specialty boards and societies, carried out under public authority, to set professional standards, define compensable injury, and prescribe equitable guidelines for the application of standards and definitions. Standards, definitions, and guidelines must, in addition, be reviewed and revised at suitable intervals in order that they may be kept current, and every practicing doctor should have ready access to them through continuing education activities. The process should have both educational and preventive functions, and should provide services to the courts reliably but secondarily. The setting of standards, however, is inescapably a professional matter, involving the systematic assembling of a vast amount of existing experience into a new body of knowledge, designed more for practical than for theoretical purposes.

Standards and definitions are useless unless they can be consistently and regularly applied, and deviations from them promptly identified. This requires a local monitoring mechanism, examples of which have been in use in many of the nation's hospitals and group practices for decades. What is now needed is a screening process the mesh of which is of such size as to retain instances of clearly questionable professional performance so that they may receive evaluation by peers on an individual basis. The design must be such as to render the process effective and fair but not be so cumbersome that it is self-defeating. It must also be able to extend beyond the reaches and the requirements of the law, in the expectation that by such means the incidence of both compensable events and substandard practice may ultimately approach an irreducible minimum.

What is needed is an integrated system of peer review which will not only protect the patient from substandard medical care but will, when necessary, serve the legitimate and proper needs of the courts while, at the same time, relating effectively to the state authority charged with professional discipline. Such an integrated system cannot replace either the courts or the disciplinary authority, but it must have the potential of reducing the incidence of compensable medical injury (*31*) by identifying and controlling inadequate or unnecessary medical services, and by identifying members of the profession who, for one reason or another, are not rendering acceptable care.

But, one must ask, may not such a system—in view of the great difficulty of creating workable standards and of the possibilities of abuse that are inherent in it—actually represent precisely the sort of thing Plato described in *The Statesman*? May it not represent the final stage in the destruction of the medical profession's autonomy?

I think not. But the system would indeed represent the end of the tradition that each doctor is, within himself, totally autonomous and all but exempt from criticism or from penalty for incompetence, ineptitude, or venality. But more significant is the fact that actual and proper standards and definitions can only be worked out by the profession itself, acting on the basis of its own expertise and knowledge, but not primarily to enhance its autonomy and monopoly. One might add that the vast and difficult activities that lie ahead for the medical profession are, for the most part, no more than its basic professional ethic requires. Public and legal counsel, as the labor goes forward, are essential; but the action and the obligation are still fundamentally matters assignable to the medical profession.

In this connection, the group of able sociologists who have in recent years concerned themselves with theories of profession and especially with the working of the medical profession, have usually posed the primary question quite well. "How," asks Bledstein, "does society make professional behaviour accountable to the public without curtailing the independence upon which creative skills and the imaginative use of knowledge depend?" (*32*). And Berlant, in a book dealing indignantly with the antisocial aspects of professional monopoly, wisely declines "to make specific policy recommendations with respect to the organization of the medical profession . . . in either Britain or the United States" (*33*). Freidson is a bit more courageous, and to some doctors, alarming, in his view that social control of the medical profession requires bureaucratization, "an indirect, external control system" (*34*). However, the control system Freidson has in mind is not really nonmedical or antimedical. He acknowledges the obvious necessity for professional expertise in any such system, but denies the right of the profession to design and control the system in its own interests, financial and otherwise. But the retention of legitimate, and even obligatory, autonomy actually has nothing to do with the maintenance of monopoly and special privilege as, for example, the Royal College of Physicians saw it in the 16th century.

The difficulty, as the profession goes about the taxing business of determining standards and guidelines, will not arise because it wishes to maintain and enhance monopoly. The chief difficulty will probably be of an altogether different sort. For decades the profession has been viewed as a monolithic giant, its members always speaking with a single voice. It is actually no such thing, and the primary question now is: Can the profession, working when appropriate with public authority, bring the strength and expertise of its many segments to bear, in good faith and to unassailable purpose, on the problems at hand?

The question must go unanswered largely because there is no relevant precedent. But there is surely no reason to believe that American society now wishes to destroy the medical profession by removing all traces of its autonomy. On the contrary, the special status, both social and economic, of the profession is under no massive and immediate threat. But the obvious message of the times is that the profession should retain the most fundamental aspect of its autonomy in order that it may apply it, in the public interest and in its own, to the setting of expert and ethically defensible standards, and to the creation of effective monitoring mechanisms.

This is a far cry from total destruction of the profession's autonomy as in Plato's fantasy. It is, in fact, something the medical profession has already done for specific and limited purposes. The pace is now accelerating. And if the future system for setting standards, prescribing guidelines, and creating monitoring mechanisms turns out to be judicious, effective, and fair both to patient and to doctor, it will be because the medical profession has mobilized and unified itself to genuinely professional purpose.

References and Notes

1. Some critics of the profession are responsible and should not be ignored (see below), but others are self-serving and digressive. In the latter category is E. Berman's *The Solid Gold Stethoscope* (Macmillan, New York, 1976); so also is I. Illich's *Medical Nemesis* (Pantheon, New York, 1976).
2. *Health Lawyers' News Rep.* **5**, 3 (September

1977). The survey was done by private firms for the Social Security Administration.
3. *Theodosian Code*, C. Pharr, translator (Princeton Univ. Press, Princeton, N.J., 1952) 13.3.1–19, pp. 387–390. In late Roman law, some physicians and certain other professionals were exempt from public obligations, including paying taxes and military service. See also *Justinian's Digest* (Central Trust Co., Cincinnati, 1932), 27.6.2, vol. 3, p. 123; and 50.6.6, vol. 5, p. 235.
4. *Nottingham Eyre* (1329), folio 218 (Egerton manuscript No. 2811, British Museum). Also A. K. R. Kiralfy, *A Source Book of English Law* (Sweet and Maxwell, London, 1957), p. 184.
5. Stratton *v.* Swanlond, Year Book Hilary, 48 Edward III, plea 11, folio 6 (Hilary, 1374). Two related cases are Year Book Michelmas, 43 Edward III, plea 38, folio 33; and Year Book Trinity, 46 Edward III, plea 19, folio 19. All three are in C. H. S. Fifoot, *History and Sources of the Common Law, Tort and Contract* (Stevens, London, 1949), pp. 81–83. The corresponding plea roll is in A. K. R. Kiralfy, *A Source Book of English Law* (Sweet and Maxwell, London, 1957), pp. 187–188.
6. G. Clark, *History of the Royal College of Physicians of London* (Clarendon, Oxford, 1964), vol. 1, pp. 14–18. See also S. W. P. Holloway, *History* **49**, 299 (1964).
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8. Dr. Bonham's Case, 8 Coke Rep. 114–121 (1610); College of Physicians Case, 2 Brownlow and Goldes. 256–266 (1609). See also 2 Brownlow 255–267 (1675); 128 Engl. Rep. 928–934 (1609). Bonham was sent to prison on 7 November 1606, but was out within a week. There was a second action against him in late 1608. For the Royal College's view, see G. Clark, *History of the Royal College of Physicians of London* (Clarendon, Oxford, 1964), vol. 1, pp. 208–214.
9. 8 Coke Rep. 119–120.
10. 8 Coke Rep. 118.
11. See generally S. E. Thorne, *Law Q. Rev.* **14**, 543 (1938); T. F. T. Plucknett, *Harvard Law Rev.* **40**, 30 (1926–27); J. W. Gough, *Fundamental Law in English Constitutional History* (Clarendon, Oxford, 1953), pp. 30–47.
12. An Act to Regulate the Quality of Practitioners in Medicine and Surgery, Statutes of United Kingdom, Great Britain, and Ireland, 22 Victoria, chap. XC, pp. 299–312 (1858); An Act to Amend the Medical Act (1858), Statutes of United Kingdom, Great Britain, and Ireland, 23 Victoria, chap. LXVI, pp. 259–262 (1860).
13. See generally R. H. Shyrock, *Medical Licensing in the United States, 1650–1965* (Johns Hopkins Press, Baltimore, 1969); R. C. Derbyshire, *Medical Licensure and Discipline in the United States* (Johns Hopkins Press, Baltimore, 1969), pp. 13–45.
14. T. M. Logan, *Trans. Am. Med. Assoc.* **23**, 46 (9 May 1872).
15. Minutes of House of Delegates, *J. Am. Med. Assoc.* **74**, 1319 (8 May 1920). See generally C. B. Chapman and J. M. Talmadge, *Pharos* **34**, 30 (1971).
16. Pratt *et al. v.* British Medical Association *et al.*, British Ruling Cases **9**, 982–1021 (1915).
17. United States *v.* American Medical Association *et al.*, 110 Fed. Rep. 2nd ser. 703–716 (1940). See also M. Fishbein, *A History of the American Medical Association* (Saunders, Philadelphia, 1947), pp. 534–550.
18. The AMA is today often severely criticized on the ground that its interest was not in improving the training of doctors, but was rather in preserving monopoly and discouraging competition by limiting the size and number of American medical schools. The criticism is easy to lodge, difficult to refute, and impossible to substantiate.
19. Plato, *The Statesman*, H. N. Fowler, Transl. (Heineman, London, 1967), pp. 147–157.
20. E. Freidson, *Profession of Medicine* (Harper & Row, New York, 1970), pp. 42–45.
21. Dissatisfaction with professional performance is inherent in a number of studies, many done by members of the profession: R. H. Brook, M. H. Berg, P. A. Schechter, *Ann. Int. Med.* **78**, 333 (1973); C. W. Eisele, V. N. Slee, R. G. Hoffmann, *ibid.* **44**, 144 (19 ➡ H. M. Somers, *Milbank Mem. Fund Q.* **55**, 193 (1977); B. C. Payne, *J. Am. Med. Assoc.* **201**, 126 (1967); J. P. Bunker, B. A. Barnes, F. Mosteller, *Costs, Risks and Benefits of Surgery* (Oxford Univ. Press, New York, 1977); R. Stevens, *American Medicine and the Public Interest* (Yale Univ. Press, New Haven, Conn., 1971); O. L. Peterson, *J. Med. Educ.* **31**, 1 (1956); D. G. Warren, *J. Leg. Med.* **21**, 23 (1974).
22. E. W. H. Groves, *Br. Med. J.* **2**, 1008 (1908); E. A. Codman, *Surg. Gynecol. Obstet.* **18**, 491 (1914); H. R. Kuehn, *Bull. Am. Coll. Surg.* **58**, 7 (1973).
23. C. C. Havighurst, *Duke Law J.* (1975), pp. 1256–1263; J. O'Connell, *Ending Insult to Injury* (Univ. of Illinois Press, Urbana, 1975), pp. 97–111; American Bar Association, *1977 Report of the Commission on Medical Professional Liability* (American Bar Association, Chicago, 1977), pp. 99–100.
24. O. W. Holmes, *Common Law* (1881) (Harvard Univ. Press, Cambridge, Mass., 1963), p. 89.
25. The American Surgical Association took an important step in this direction in its "Statement on professional liability" [*N. Engl. J. Med.* **295**, 1292 (1976)].
26. J. D. Blum, P. M. Gertman, J. Rubinow, *PSROs and the Law* (Aspen Systems, Germantown, Pa., 1977), pp. 1–17.
27. 42 U.S. Code Annotated, No. 501, chap. 7, subchap. xi, 1301–1320, pp. 309–333 (public law 92-603) (1972); see also *Fed. Reg.* **38** (part 2), 34944–34951 (20 December 1973).
28. P. Caper, *N. Engl. J. Med.* **291**, 1136 (1974).
29. H. E. Simmons and J. R. Ball, *Univ. Toledo Law Rev.* **6**, 739 (1974), p. 763.
30. E. J. Levit, M. Sabshin, C. B. Mueller, *N. Engl. J. Med.* **290**, 529 (1974), p. 545.
31. The incidence of compensable injury is probably higher than it should be. Pocincki *et al.* estimated that such injury (due to negligence) occurs in about 2 percent of all hospital admissions, but that only 1 in 17 of those injured file claims {L. S. Pocinki, S. J. Dogger, B. P. Schwartz, in *Report of Secretary's Commission on Medical Malpractice* [DHEW (OS) report No. 73-89, Department of Health, Education, and Welfare, Washington, D.C., 1973], appendix, p. 50}. In a more recent study it was found that "potentially compensable events" occurred in 4.7 percent of admissions to the hospitals they studied, but that in only about a fifth of such events would claims have been successful [D. H. Mills, Ed., *Medical Insurance Feasability Study* (Sutter, San Francisco, 1977), pp. 96–105].
32. B. Bledstein, *The Culture of Professionalism* (Norton, New York, 1976), p. 334.
33. J. L. Berlant, *Professionalism and Monopoly* (Univ. of California Press, Berkeley, 1975), p. 307.
34. E. Freidson, *Doctoring Together* (Elsevier, New York, 1975), p. 249.

The Quality of Medical Care

Methods for assessing and monitoring the quality of care for research and for quality assurance programs.

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We have granted the health professions access to the most secret and sensitive places in ourselves, and entrusted to them matters that touch on our well-being, happiness, and survival. In return, we have expected the professions to govern themselves so strictly that we need have no fear of exploitation or incompetence. The object of quality assessment is to determine how successful they have been in doing so; and the purpose of quality monitoring is to exercise constant surveillance so that departure from standards can be detected early and corrected. But, first, we must specify what it is that is being assessed and monitored.

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Definition of Criteria and Standards

For this article I shall assume that the object of assessment and monitoring is medical care itself, which is the interaction between the physician and his (or her) client. This interaction is itself divisible into two domains. One is that of technical performance. Here, the heart of the matter is the application of medical knowledge and technology in a manner that maximizes its benefits and minimizes its risks, taking account of the preferences of each patient. The other domain is the management of the personal relationship with the patient in a manner that conforms to ethical requirements, social conventions, and the legitimate expectations and needs of the patient.

For purposes of assessment the definition of quality must be made precise and operative in the form of specific criteria and standards. Here one encounters a fundamental problem. If quality consists in a precise adjustment of care to the particular requirements of each case, is it possible to formulate detailed specifica-

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