

# *Specialization, Specialty Organizations, and the Quality of Health Care*



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Specialization is a defining word for American medicine in our time. If it were still possible for a generalist to understand medicine as a body of knowledge and skills, we would not now have mighty health care corporations, millions of workers in hundreds of health care occupations, sprawling academic medical centers with their associated networks, or even managed care. However, while technological innovation and improvements in the quality of health care available to earlier generations testify to the manifold benefits of medical specialization, its downside has also long been evident.

For more than a century specialization has been portrayed as a force for disorganization in medical care, challenges in medical education, opportunities for profit seeking, and power plays among rival claimants (Rosen 1944; Somers and Somers 1961; Stevens 1971; Starr 1982; Ludmerer 1985, 1999). Today competition for market share in lucrative fields such as cardiology characterizes our health services, jurisdictional disputes mark professional organizations, and massive government programs, including Medicare, Medicaid, and the National Institutes of Health, subsidize and underpin the whole.

For the past two decades medical specialists have moved efficiently into market niches. Health policy has been largely silent about regulating and organizing such services, but signs of change are promising. Here I focus on four essentials: the need for a workable information infrastructure, strategic planning at the community level, encouragement of primary care, and public support of lifelong learning for physicians through “maintenance-of-certification” programs. Achieving these would enhance quality of care by better aligning the advantages of medical specialization with the needs of consumers searching for physicians with top-notch skills and expertise, the latest technology has to offer, and the most effective treatments.

## **Specialization in U.S. Medicine**

Why do we have such a complex and confusing array of specialists? Partly because patients have long been complicit in the rush toward specialized medical

practice. “Between us we have 10 or 12” specialists, reported an eighty-three-year-old Medicare beneficiary in Florida in 2003. His list included a pain specialist, neurologist, cardiologist, pulmonologist, rheumatologist, and urologist. His wife’s experts were likewise defined by body parts, conditions, and diseases (Kolata 2003).

Historically, three social forces have combined to encourage specialization in the United States: the definition of medicine as a science that advances through the subdivision of effort; belief in the superior skills of experts; and competitive (rather than collaborative or bureaucratic) medical practice, supported by private and public health insurance. The managed care movement of the 1980s and 1990s promised to limit direct patient access to specialists by imposing a generalist or “gatekeeper” but roundly failed, attacked by both providers and consumers.

Specialization is an intrinsic, formalized aspect of American medicine. The medical profession is much more formally stratified than the legal profession; for example, and unlike law, which is largely state regulated, medicine is intensely subject to private regulation. Specialties do not just happen. The system that produces and credentials medical specialists is owned and operated by professional organizations, in the time-honored process of public deferment of responsibility. As I will show, specialties are based on demarcations negotiated among major associations. Those groups, working together, are now attempting a major expansion of specialty certification into a system of lifelong learning for all physicians.

For the individual U.S. physician, successful specialist practice requires favorable market conditions, including an available and willing patient base and supportive insurance programs. However, in our legalistic society, successful practice also requires some formal validation of experience that stands up to marketplace challenges such as denial of hospital privileges and malpractice insurance, that is accepted by third-party payers, and that is convincing in the case of costly lawsuits. For the U.S. medical profession and the public, the persona of a “specialist” may suggest success, expertise, and enhanced fees, but for practical purposes this persona must be accompanied by years of education, usually capped with examinations and the resulting certificates on the doctor’s office wall. The credentials embedded in those certificates—ranging, alphabetically, from adolescent medicine to vascular surgery—are almost always those the medical profession has validated through its formidable specialty network: medical school departments and divisions in designated fields, professionally accredited residency programs, and specialty certification.

### ***Specialty Credentials as Essential Standards in a Privately Organized System***

In contrast to the constantly shifting organization and financing of U.S. health care, the production system for doctors runs like a finely tuned machine. Specialty identification and credentials provide a necessary standard for consumers (at least in theory, though often ignored) in America’s competitive health care enterprise.

On a practical level, specialty credentials are important for at least four reasons. First, the MD degree is an intermediate, not a final, credential in a market

where physicians are specialists, and thus the specialty (and increasingly subspecialty) diploma has taken over the role once marked by the MD alone. Second, common standards are essential in a context of decentralized, fragmented services without strong, local institutional controls, and where a physician may have relationships with multiple insurers, hospitals, and other providers. Third, credentials serve as markers for patients shopping for specialty services in a market-oriented system and help define a market niche. And fourth, credentials serve health care providers, auditors, accrediting agencies, bond raters, and insurers, all anxious to maintain standards, acquire prestige, protect patients from harm, and avoid legal difficulties.

In the absence of national, state-based, regional, or even large-scale corporate health services, there is no countervailing authority overseeing the quality and use of health personnel. Government has intervened from time to time to stimulate the overall supply of doctors and subsidize training programs, chiefly research fellowships in subspecialty fields and areas deemed undersupplied, such as (in the past) mental health. Federal "health manpower" legislation of the 1970s made a large impact on the number of doctors, but relatively little on their roles or the distribution of their services demographically and geographically (Weissert and Weissert 1996). Meanwhile specialists have made their career choices based on the training available and their perceptions of the changing health care market (Robinson 1999; Scott et al. 2000). Credentials that attest to residency, specialty, and often subspecialty training provide a gold standard in an otherwise uncertain health care environment.

### ***Organized Medicine: One Voice or a Multitude of Agendas?***

Through decades of debate over how to provide efficient specialty services, national organizations have represented U.S. physicians, but the pattern of representation has shifted significantly. From the early years of the twentieth century through Medicare legislation (1965) and beyond, the American Medical Association (AMA) offered a united front in political debates, successfully claiming to represent the entire profession. The growth of organized specialties, evident well before 1965 but increasingly powerful and activist, shifted physician allegiances away from the AMA. The specialty rather than the general medical society has become the primary allegiance for American doctors. Today the average internist, pediatrician, cardiac surgeon, and interventional radiologist identifies with his or her specialty organization, meetings, newsletters, and journals for both scientific information and policy representation.

Between 1950 and 1990, as organized specialties consolidated their institutional authority, AMA membership fell away. In 1950 almost 73 percent of all MDs were AMA members; in 1970, 64 percent were, and by 1989 little more than 40 percent of MDs were AMA members (AMA 2002). By the late 1990s the AMA was recognizably weak, representing less than half of all doctors, including those in training. Powerful specialty groups have focused on agendas such as child health policy (American Academy of Pediatrics) and a forty-eight-hour minimum hospital stay after childbirth (American College of Obstetricians and Gynecologists).

Specialty groups have also sought congressional support for a national trauma system, claiming that only eight states have well-organized trauma systems (American College of Surgeons) (Hawryluk 2003).

In the political arena, such focusing may make organized medicine more powerful and effective, at least on targeted policy issues. In the professional arena, though, too much fragmentation may ultimately be self-defeating, as medical leaders are well aware. As specialty credentialing has become ever more important, questions regarding common standards have acquired new significance.

For example, what does the array of specialty and subspecialty training programs say about the production of U.S. doctors? Does certification imply quality of services for patients? Are the certifying boards doing a good job? Should government support them more fully in the Herculean tasks they have set for themselves, which include greater coordination? Or can other groups do credentialing better or more economically? These are important questions with major implications for the quality of care, medical standards, professional responsibility and accountability, and the role of regulation. Though they cannot yet be answered fully, debates about health care quality and outcomes, cost controls, and state licensing require a better appreciation of where credentialing arrangements have come from and how they work.

### **The Production of Specialists in the United States**

Twenty-four independent, “approved” boards divide the U.S. medical profession into specialties and subspecialties. An approved board is one formally affiliated with the American Board of Medical Specialties (ABMS), based in Evanston, Illinois. (Since 1999 I have served as one of three public members representing public policy perspectives on the ABMS). Subspecialty status requires that the individual physician first become certified in a primary specialty field. For example, internal medicine, pediatrics, and radiology are designated specialties, each with its own board: the American boards of Internal Medicine (headquartered in Philadelphia), Pediatrics (Chapel Hill), and Radiology (Tucson). Cardiology, pediatric allergy, and interventional radiology are among the formal subspecialties, respectively, of these boards, each responsible for granting subspecialty certificates.

Each board specifies training pathways, via approved residency or fellowship programs, and administers examinations. Approved training requires completion of residency programs accredited by a group parallel and related to the ABMS, the Accreditation Council for Graduate Medical Education (ACGME). An individual doctor leaves medical school with the MD degree, enters an approved residency program in a specialty for three to six years, and eventually becomes certified in that field. Those who are certified are called “diplomates.”

Together the boards granted thirty-seven basic specialty certificates and ninety-two types of subspecialty certificates in 2003, with more subspecialty categories on the way (ABMS 2003a). In 2000 alone, almost twenty-four thousand physicians became diplomates. The “biggies” were internal medicine, which

granted 29 percent of all primary certificates; family practice (15 percent); and pediatrics (11 percent). These three specialties—together with psychiatry and neurology (which for historical reasons joined together in one board), obstetrics/gynecology, radiology, emergency medicine, and surgery—granted 80 percent of all specialty diplomas in 2000, with the remaining 20 percent scattered across the other sixteen boards. Half of all subspecialties reside in three boards: internal medicine (with sixteen subspecialties), pediatrics (seventeen), and pathology (eleven).

ABMS-affiliated boards now certify 90 percent of U.S. practicing physicians, on a rising trend (ABMS 2003a). Thus these ABMS-approved twenty-four boards and their subspecialty committees define the formal structure of American medicine.

As might be expected, other credentialing groups also exist, perhaps as many as two hundred—there is no formal list. Osteopathic physicians have their own boards that maintain substantial affiliation with ACGME-approved residency programs. Other groups advance the cause of newer specialties not yet covered, in their view, by ABMS-approved boards. (The ABMS, in liaison with the AMA, has a formal process for approving applications from new boards.) Vascular surgeons, for example, though recognized as a subspecialty of the American Board of Surgery, have been pressing—so far unsuccessfully—for acceptance of the American Board of Vascular Surgery as an independent, ABMS-affiliated board (Burton 2003). Leaders of the American Board of Hospice and Palliative Medicine are similarly seeking recognition of end-of-life care as distinct from pain medicine, which is an ABMS-approved subspecialty. This group, too, may eventually seek ABMS approval (Beresford 2004).

Courts have generally upheld the authority of ABMS-approved boards. The American Academy of Pain Management brought an unsuccessful suit against the Medical Board of California for prohibiting physicians from advertising that they are “board certified” unless they meet certain requirements. These include certification by an ABMS-approved board or the “equivalent,” as determined by the Medical Board or by completion of approved postgraduate training. Physicians certified in other ways, such as by attaining the academy’s credentials for multidisciplinary pain practitioners, may not advertise in California that they are board certified. In upholding the Medical Board, the U.S. Ninth Circuit Court of Appeals noted that “‘Board Certification’ is a term of art that the ABMS popularized among physicians and has come to designate a certain level of qualification.” The court also noted that the state has given the term “board certified” a “special and particular meaning,” and that the plaintiffs’ use of “board certified” was “inherently misleading” and thus not protected speech, as the plaintiffs had claimed (U.S. Court of Appeals 2004).

Such challenges push approved boards to recognize their public role, to ask what this means regarding quality of care, and to make major attempts to coordinate their efforts. The legal system thus provides a useful goad to responsible self-regulation.

### ***The Origins of Specialties***

The specialty board structure arose out of a long, negotiated history. Multiple professional associations typically organize a specialty board once they have become motivated to seek credentialing. Not surprisingly, these groups found boards at different times for different reasons. The first medical specialty board—for ophthalmology—incorporated in 1917 amid turf battles with well-organized optometrists, who were also seeking professional credentials (Stevens 1971). The newest specialty board is Medical Genetics, approved in 1991, affirming medical jurisdiction when many investigators in the field held the PhD as their primary credential.

The basic pattern was set in the 1920s when otolaryngologists followed the ophthalmologists with their own board (1924), thus making an effective claim for that field, too, as requiring expertise beyond that of the general practitioner. However, specialty boards blossomed into a movement with the economic pressures of the 1930s. By 1944, when sociologist George Rosen published a classic study of medical specialization, self-styled specialists outnumbered general practitioners, making specialization an “essential feature of modern medical practice” (Rosen 1944, 1). Specialism seemed tailor-made for the American public, with its faith in experts and the cachet accruing to those who charged high fees and offered esoteric treatments. As Rosen also observed, specialization intensified the U.S. view of medicine as an economic transaction, becoming a natural partner to and developing alongside market-oriented health care (Rosen 1944, 77).

The specialization movement proved a double-edged sword for the medical profession. As long as general practice remained its actual—or even symbolic—core, the training and recognition of specialists could remain at the margin of organized medicine. Specialization reinforced the profession’s commitment to innovation based on an elite cadre working in science, technology, and clinical advancement in medical schools, while specialists could work as consultants to average practitioners without considering their demographic distribution. However, as the balance shifted toward an entirely specialized profession, the opportunistic and public policy aspects of specialties came more firmly into view.

The formation of the American Board of Family Practice in 1969—amid vocal concern about the decline of general practice and rousing calls for new roles for “personal physicians” and “primary care”—made generalism a “specialty” (Lee et al. 1976; Stevens 2001a). Somewhat similarly, emergency medicine achieved its own certifying board in 1979 following intense public interest in reforming emergency medical services. But by encompassing family and emergency medicine, the certifying boards acquired *de facto* responsibility, however unwillingly, for the design, specialty training, and evaluation of the entire medical profession. Equally, all physicians were now specialists.

At least in theory, the collective influence of the certifying boards, their associated specialty groups, medical school departments and sections, and the residency system on the structure and standards of medicine is now as great as that of universities. However, collective influence implies some cross-specialty collaboration so the profession has a unified voice, and this process is still in its infancy.

For the certifying boards and their associated specialty societies, the key question is whether, now that they have acquired the opportunity for power and influence, they can overcome their history of professional separatism.

### ***Problems with Specialties***

Rivalries across fields, encouraged by competitive practice, make it difficult to determine how well the specialty structure helps patients find the right expert for a specific condition. Surprisingly little research has been done on this question. Preliminary studies for the ABMS suggest lack of public awareness of the specialty boards, their standards, and their formal specialty and subspecialty delineations (ABMS 2003b). Left to her own decision, a patient with annoying back pain might decide to take it easy and self-medicate with over-the-counter preparations, consult her primary physician, or seek out a general orthopedic surgeon or one with additional spinal expertise. Or she might ask friends for advice and receive an enthusiastic recommendation for a specific neurologist—or rheumatologist, sports medicine specialist, or pain subspecialist with a background in anesthesiology, neurology, or physical medicine, each offering a different professional perspective. The patient might also try herbal remedies, acupuncture, and massage.

These consultations might produce recommendations ranging from exercise through behavior modification, prescribed medications, laminectomy, and spinal fusion. Becoming a wise consumer is difficult in such circumstances. Nevertheless, the U.S. system, based on free-standing groups of specialists, assumes that the consumer is competent to do so. Indeed, direct access to specialists requires that patients act not only as sophisticated and sensible first-line diagnosticians but also as general contractors for their care. In seeking (or avoiding the need for) specialists, many patients clearly need an intermediary, a role that may be performed by doctors, nurse practitioners, physician assistants, the Internet, or someone or something else.

The Internet may play a powerful role for some patients in initially diagnosing symptoms and matching them with appropriate specialists. But that process may be risky. “Primary care” has long recognized the beneficial role of a knowledgeable generalist who has the patient’s interest at heart. Nevertheless, despite efforts from the 1960s through the managed care movement to designate a specific service role for primary care, no one “specialty” plays that role. Primary physicians may be family physicians, general internists, or general pediatricians, each with their own specialty board and associated subspecialties. Many subspecialists also act as primary care practitioners for their patients.

The field of sports medicine, for example, a formal subspecialty of family practice, internal medicine, pediatrics, and emergency medicine, will naturally appeal to patients primarily for sports injuries. Similarly, practitioners of endocrinology, oncology, and nephrology—among the subspecialties of internal medicine and pediatrics—are likely to draw patients with specialized rather than general needs. Yet these and other specialists may take on primary care roles for at least some of their patients. For example, an obstetrician/gynecologist may serve that

role for a woman, while a child psychiatrist may do so for a child with behavioral problems. The U.S. health system makes no direct connection between the training and credentialing of physicians and the clinical roles they play.

### ***Turf Wars***

Market and policy conditions ranging from managed care and Medicare reimbursement through varying competition among specialties and the relative burden of malpractice rates (heaviest for surgeons and obstetricians) affect clinical roles. The AMA designated seventeen states as in “tort crisis” over medical liability insurance rates in 2003 (Albert 2003). Meanwhile, physicians have looked for income opportunities outside their own specialties. To “limit economic shortfalls and to expand boundaries,” primary care physicians have reportedly been offering fee-for-service cosmetic procedures and dermatology, adding their own laboratories and imaging and bone density equipment, and setting up physical therapy programs (Reece 2003). Investment in imaging centers serving privately insured patients by physicians who are not radiologists has evoked public concern, “pitting radiologists against other doctors, and hospitals against free-standing centers, in a fight for health care dollars” (AP/*Dallas Morning News* 2003). Cosmetic surgery may endanger patients when performed by inadequately trained practitioners in unregulated facilities, yet it has been a steadily growing field for men as well as women (Haiken 1997).

Two movements are occurring simultaneously: the encouragement of health care as a market commodity allows patients relatively unfettered access to specialists while muddying specialty roles. Since the 1990s, market forces have stimulated competition between physicians practicing in the same specialty (such as rival groups of orthopedic surgeons), fanned turf wars between specialties, and fostered a decline in multi-specialty practice in favor of single-specialty groups and centers. “As HMOs and hospitals have seen their profit margins narrowed,” wrote one analyst in 1999, “entrepreneurs have turned to niche industries” such as ambulatory surgery centers, eye care companies, oncology, and cosmetic services (Kuttner 1999).

Medicare has also encouraged single-specialty practice by abolishing separate payment codes for the same procedure performed by radiology and internal medicine, for example. Medicare fees for family and general practitioners also rose much faster than for specialties such as ophthalmology, cardiology, gastroenterology, and urology in the 1990s, while fees for some specialized procedures such as cataract removal and insertion of a lens dropped significantly (Iglehart 1999). The Medicare Payment Advisory Commission and its predecessor effectively encouraged interests to lobby for (or against) specialty fields and procedures. A large multispecialty group had thus become “too unwieldy,” claimed members of such a group in Charlotte, North Carolina, as it disbanded. In contrast, a single-specialty group cited an “alignment of incentives” regarding reimbursement and few inter-specialty tensions (Page 2000).

In a competitive, single-specialty system, the patient cannot rely on doctors in different fields to provide comprehensive, coordinated care. Many Americans

do have primary physicians in one specialty field or another whom they trust to manage their care. Many patients, though, make their own choices from a list of specialists who are part of their insurance network or who participate in Medicare. No one is directing the patient to the physician who can best meet the patient's needs.

Better information on clinical results among specialty practices in different communities would greatly help consumers. In a consumer-oriented system, patients should have access to standard information. The simplest way of providing such information is to work toward standardized, computerized patient records with firewalls to ensure confidentiality. If the relatively impoverished National Health Service in England is able and willing to establish a universal health care database over the next two years, entertaining bids for contracts from global corporations such as IBM, why can't the United States (Naik 2003)?

### **Cooperation across Specialties**

Paralleling these market trends are two promising signs of cooperation. The first is joint planning among subspecialties, and the second is a move toward life-long learning and evaluation of physicians, known as maintenance of certification.

Cooperation is important in designing innovative cross-specialty training and evaluation to advance the quality of care, standardizing credentialing, providing consumer-friendly information to help patients choose specialists, and assuring life-long commitment to learning and quality improvement. Cross-specialty alliances are also essential in enabling the medical profession to play a significant role in health care policy (Stevens 2001b).

The human urge to protect and extend one's property applies to organizations as well as individuals. As with primary boards, the creation of subspecialties tends to have a domino effect. One board's creation of a new subspecialty sparks similar moves by other specialties interested in the same field. Oncology is an early case in point. The ABMS approved oncology as a subspecialty of internal medicine in 1972, of pediatrics in 1973, and of gynecology in 1974, following applications from each of these boards. The growing importance of critical care has similarly led to subspecialties in six different boards (anesthesiology, pediatrics, internal medicine, obstetrics/gynecology, neurosurgery, and surgery). Newly visible fields such as geriatrics, sports medicine, toxicology, pain management, adolescent medicine, head and neck surgery, and neurodevelopmental disabilities have sparked the interest of more than one board. Five boards offer immunology as a subspecialty, while four boards offer sports medicine. Part of this movement reflects the fact that clinical medicine and market opportunities continue to shift.

The subspecialty movement has made the specialties less rigid than in, say, the 1960s. Sometimes painful negotiations precede a move toward integrated standards. Recent fights between otolaryngologists and plastic surgeons over the subspecialty of head and neck surgery resolved only after years of negotiation involving the ABMS and two ABMS boards, the American Board of Plastic Surgery and the American Board of Otolaryngology. The latter two were undoubtedly energized by the American Board of Facial and Reconstructive Surgery (ABFRS) and the

American Board of Cosmetic Surgery, neither of which the ABMS recognizes. The potential of state licensing boards to preempt professional standard setting was also clearly an ingredient. Licensing boards in Florida, Colorado, and California recognized the ABFRS as “substantially equivalent” to the ABMS boards in the 1990s. State boards usually work with ABMS-approved boards to set standards for licensing and advertising, but that could change, particularly in areas with “non-approved” specialties, such as physicians without board certification who perform cosmetic surgery in Florida.

Negotiations between otolaryngologists and plastic surgeons within the ABMS were difficult. An editorialist for a major plastic surgery journal wrote in 1996 that “it appears that the old embers of suspicion and distrust still glow too hot to permit closure of this issue” (Neale 1996, 223). Nevertheless, the groups did reach consensus: the ABMS approved a subspecialty program for each board, administered jointly. The otolaryngologists received their approval first, in 1999.

All twenty-four ABMS-approved specialty boards also recently agreed to develop requirements for all physicians to maintain their certificates throughout their careers, thereby spurring “continuous quality improvement” (ABMS 2003a). This move, if successful, will represent a giant step toward integrated education and evaluation of physicians from medical school through their entire careers. The boards are also working with the ABMS and related specialty societies to develop tools for teaching and evaluating physicians in patient communication, professionalism, and systems improvement as well as knowledge and skills. How this commitment plays out will determine the influence of specialty organizations in U.S. health care and health policy. It will also determine whether those groups can meet challenges from state licensing boards, thus maintaining a national credentialing process rather than fifty or more separate ones, and whether public or private entities such as a national quality board, health insurers, or hospitals supercede self-regulation.

### **Avenues for Change**

One could argue that the physician production system is exquisitely attuned to the diffused American health care marketplace, meeting the demands of both doctors and patients. While some evidence shows that physician incomes are declining as managed care, Medicare, and Medicaid fees tighten, few physicians are unemployed. Physicians have become adept at responding to perceived signals in the market. This is not surprising in a climate that encourages consumer choice and specialty proliferation, and where the average doctor is an owner or participant in a clinical corporation.

Proponents of market approaches in the 1980s and 1990s suggested that shaking up the health care system would spur innovation, and, indeed, entrepreneurial medical specialists and many patients enthusiastically embraced innovations (Robinson 1999). These included the rise of single-specialty medical groups and the buying and selling of lucrative specialty corporations, such as orthopedic groups and organ transplantation teams by hospitals and health care systems. Other

innovations included the development of specialty hospitals (such as heart hospitals) and the rise of decentralized specialty office procedures (sometimes unlicensed, such as cosmetic surgery). With or without ABMS approval, newly defined subspecialty fields such as back surgery, sleep medicine, and Alzheimer's disease were part and parcel of the larger redefining movement.

However, assuming a totally free market in health care would be naïve—and blatantly ahistorical. We have long lived with the benefits and distortions of major public insurance programs (notably Medicare), tax subsidies (to employers providing workers with health insurance), federal grants (to states for Medicaid and other programs), federal assistance (for research and university-based postdoctoral training in new fields), and national policies that encourage organizations deemed socially important, such as cancer centers. States have also been a vital resource, funding training programs for family physicians. The policy question is not whether subsidy and regulation of the complex, specialized U.S. system will continue, but how, for what purposes, and by whom.

How best can we improve the overall quality, effectiveness, and efficiency of patient care? Does it make most sense—politically and operationally—to try to regulate the behavior of consumers so they seek services more prudently? Are there practical ways to improve information for consumers in a direct-access system, or to provide incentives for collaborative practice in corporate systems? Or to reform Medicare via compelling incentives for private corporations to establish new systems and for Medicare beneficiaries to participate? Or to change the behavior of specialists as providers? And at what point does it make sense for government to preserve valued social institutions such as hospitals serving the poor, medical teaching institutions, and professional organizations?

These questions have no simple answers. However, some avenues for change appear promising. First, the quality movement is off and running. The U.S. population, steeped in direct access to specialists, is unlikely to flock to HMOs that restrict access, however good their care may be. Quality data may eventually show real advantages to patients in organized health systems or through primary care. Databanks of comparable evidence from competing systems can make a compelling case for consumers attuned to making their own, often intuitive decisions in the marketplace for specialty care. Here is a strong argument for establishing a compatible, national clinical information infrastructure based on automated patient records, and for providing trustworthy analyses that can advance medicine for the public, professions, and health care organizations. The automated medical record—as a basis for public accountability—may even be a necessary precondition for effective Medicare reform.

A second positive sign of change is the apparent willingness of Congress to consider planning and regulating health care, as expressed in the eighteen-month moratorium on new starts of physician-owned specialty hospitals in the 2003 Medicare law (Section 507). This legislation specifically mentions hospitals devoted primarily to cardiac or orthopedic surgery, but the secretary of health and human services may also designate other specialties under the moratorium. The law also restricts such hospitals from adding physician investors, expanding beyond the main

hospital campus, extending services into a new specialty, and increasing the number of beds. Meanwhile, the Medicare Payment Advisory Commission (MedPAC) will study the financial impact of physician-owned hospitals on local full-service hospitals. MedPAC is already studying free-standing centers for plastic and other forms of outpatient surgery to establish Medicare payment rates. The relative value of different forms of medical service is likely to become more prominent in public debates.

The reasons are obvious. “Specialty niche” has become a common health care term, but it is a potential bombshell in its policy implications. Heart and orthopedic hospitals have shown that these specialty centers can be lucrative, but they threaten to strip services and reduce quality in neighboring general hospitals, with potentially serious implications for their bottom line. Not surprisingly, hospital associations lobbied vigorously for Section 507. However, communities also face splintering services and rising costs of care without added value (and perhaps with negative value). Common sense alone suggests that quality will decline when a community sees its general hospital lose its leading cardiologists or orthopedic surgeons.

Hospitals facing competition from new specialty hospitals, particularly those started by their own medical staff, face difficult choices. These range from launching an aggressive campaign of their own—perhaps involving expensive recruitment of another specialist team—to pressing the state legislature and regulatory agencies to limit specialist services to high-volume facilities. The first scenario involves added expenses and duplicated services; the second, expanded state and federal regulation (Devers, Brewster, and Ginsburg 2003). Community benefit and protection of well-established general hospitals may become more powerful considerations in health policy debates as efforts to curb “cream skimming” of patients yield public payoffs.

The need to coordinate and improve access to medical care can also spur strategic planning across traditional specialties. A cancer center offering multiple services, for example, may include subspecialists in radiology, surgery, gynecology, colon and rectal surgery, internal medicine, psychiatry, and pediatrics. The cancer center coordinates the efforts of professionals who come to oncology with diverse training. The concept of bringing multispecialty skills within a larger hospital or health system to patients with identifiable conditions may extend to areas such as Alzheimer’s disease, healthy aging, and stroke.

A third promising movement stems from calls by family physicians and others for renewed attention to the advantages for patients of a “medical home.” To be successful, such a movement may require substantial investment in consumer education regarding the value of primary care and (again) coordinated patient records, so both the primary doctor and the patient can discuss their options and make good decisions. A renewed market for primary care would prompt more medical students to become residents in family medicine, internal medicine, and pediatrics. The move away from such general fields is a rational economic response to present conditions, but these are not immutable. Here again public policy may seek to intervene.

Finally, the move toward maintenance-of-certification programs should attract broader policy attention. The most intense policy focus on physicians now stems from the Medicare payment system. However, except for the studies of specialty hospitals and ambulatory surgery, this focus is narrow, and it encourages specialties to compete to maximize their fees rather than set standards for the entire profession. In this instance public policy is divisive. At the very least, policy analysts need to know how U.S. physicians are being educated and in what fields, how they are evaluated by their professional organizations, what changes are under way, and how that process can advance the broader quality movement. A possible physician shortage, shortages in specific fields, quality of care, patient safety, and computerized patient records and ordering systems are best addressed in conjunction with—rather than in opposition to—specialty organizations, whose members may otherwise be reluctant to move ahead.

Overall, for the past twenty-five or thirty years, coinciding with the shift toward market-oriented health care, hospitals and physicians alike have been seen as self-interested competitors rather than guardians of the public interest or worthy of the public's trust. This dominant perspective views specialty organizations as fighting for turf, new revenue sources, and status. Fight they do. Yet they also pursue more altruistic activities. As noted, ABMS-approved specialty boards are trying to improve standards for communication with patients and peers, professionalism, and effectiveness under the maintenance-of-certification program, which all boards have endorsed. Representatives of the ABMS and the Council of Medical Specialty Societies have been meeting to expedite the program. I speak from experience as a public member representing ABMS in that group.

The broader policy question is whether health professions as well as medical schools and hospitals will be regarded as merely self-serving or as invaluable, irreplaceable social institutions. The former assumes a hostile, confrontational political and regulatory context; the latter, self-regulation to serve the public good. I hope the policy tide will turn from the former to the latter. Government and the medical profession should work together. Absent organized health care on a major scale, it is difficult to see an effective alternative.

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### *References*

- Albert, T. 2003. Tort Crisis Spreads, Few Signs of Abating. *American Medical News* 8 (December): 1.
- American Board of Medical Specialties (ABMS). 2003a. *Annual Report and Reference Handbook*. Evanston, IL: ABMS Research and Educational Foundation.
- . 2003b. Unpublished reports to the Executive Committee.
- American Medical Association (AMA). 2002. Personal communication.

- AP/Dallas Morning News. 2003. Imaging Centers: Physician Investment in Facilities Examined, December 1. As reported by *American Healthline*, December 3.
- Beresford, L. 2004. Doctors to the Dying: The Growing Specialty of Palliative Care Attracts Physicians Who See It as a Noble Calling. *American Medical News*, January 26.
- Burton, T. M. 2003. The Surgery Your Doctor Shouldn't Perform: Vascular Surgery Carries Greater Risks When Done by General Surgeons. *Wall Street Journal*, December 30.
- Devers, K. J., L. R. Brewster, and P. B. Ginsburg. 2003. Specialty Hospitals: Focused Factories or Cream Skimmers? Issue brief. *Center for Health Systems Change* 62 (April): 1–4.
- Fye, W. B. 1996. *American Cardiology: The History of a Specialty and Its College*. Baltimore: Johns Hopkins University Press.
- Haiken, E. 1997. *Venus Envy: A History of Cosmetic Surgery*. Baltimore: Johns Hopkins University Press.
- Hawryluk, M. 2003. Surgeons Push for Federal Funding for Trauma Care. *American Medical News* 23 (June): 8.
- Iglehart, J. K. 1999. The American Health System: Medicare. *New England Journal of Medicine* 340: 327–332.
- Kolata, G. 2003. Patients in Florida Lining Up for All That Medicare Covers. *Wall Street Journal*, September 13, A1.
- Kuttner, R. 1999. The American Health Care System: Wall Street and Health Care. *New England Journal of Medicine* 340: 664–668.
- Lee, P. R., et al. 1976. *Primary Care in a Specialized World*. Cambridge, MA: Ballinger.
- Ludmerer, K. M. 1985. *Learning to Heal: The Development of American Medical Education*. New York: Basic Books.
- . 1999. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York: Oxford University Press.
- Naik, G. 2003. England Plans Major Revamp of Health Care. *Wall Street Journal*, December 3, B1.
- Neale, H. W. 1996. ABMS-ABPS-ABO to Negotiations: Where We've Been and Where We Are Now. *Annals of Plastic Surgery* 36: 221–223.
- Page, L. 2000. N.C. Clinic Abandons Multispecialty Trend. *American Medical News* 24 (April): 15–16.
- Pisacano, N. J. 1964. General Practice: A Eulogy. *GP* 19: 173–181.
- Reece, R. L. 2003. Observing Health Care: Realities and Boundaries in Revitalizing Primary Care, Part I. *HealthLeaders News*, December 3. Available at [www.healthleaders.com/news](http://www.healthleaders.com/news) (accessed December 3, 2003).
- Robinson, J. C. 1999. *The Corporate Practice of Medicine: Competition and Innovation in Health Care*. Berkeley: University of California Press.
- Rosen, G. 1944. *The Specialization of Medicine with Particular Reference to Ophthalmology*. New York: Froben Press.
- Scott, W. R., et al. 2000. *Institutional Change and Healthcare Organization: From Professional Dominance to Managed Care*. Chicago: University of Chicago Press.
- Somers, H. M., and A. R. Somers. 1961. *Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care*. Washington, DC: Brookings.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books.
- Stephens, G. G. 1979. Family Medicine as Counter-Culture. *Family Medicine Teacher* 11, no. 5: 14–18.

- Stevens, R. 1971. *American Medicine and the Public Interest*. New Haven, CT: Yale University Press. Reissued 1998, with new introduction. Berkeley: University of California Press.
- . 2001a. The Americanization of Family Medicine: Contradictions, Challenges, and Change, 1969–2000. *Family Medicine* 33, no. 4: 232–243.
- . 2001b. Public Roles for the Medical Profession in the United States: Beyond Theories of Decline and Fall. *Milbank Quarterly* 79, no. 3: 327–353.
- U.S. Court of Appeals for the Ninth Circuit. 2004. *American Academy of Pain Management v. Joseph*. No. 01-15764. DC No. CV-96-02108-LKK. Filed January 2.
- Weissert, C. S., and W. G. Weissert. 1996. *Governing Health: The Politics of Health Policy*. Baltimore: Johns Hopkins University Press.