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**FROM THE EDITOR**

## Unifying Medicine

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What is the future of medicine in the public sphere, as expressed through its professional organizations? Will the profession continue to be just one of many competing interest groups, whose influence will continue to wane? Or is there a basis on which the professional organizations of medicine might assume a new position of moral leadership in American health care? This latter question is seldom asked, perhaps because the answer seems preordained by our understanding of the recent past and projection of that past into the future. Notwithstanding its direct stake in many health policy questions and its perennial ranking near the top of political contributors, organized medicine has become conspicuous politically by its marginality among a cacophony of players, demoted from center stage and seen as just another self-interested player.[1]

To many scholars and commentators, the inability of medical professional organizations to transform themselves in the face of uncertainty and chaos seems intractable. With a less cynical critique of medicine's past, Rosemary Stevens, professor of history and sociology of science, argues that organized medicine's future in the public sphere greatly depends on the ability of physicians to develop and sustain relationships inside and outside the profession. Medical professional organizations can reclaim their public voice, she suggests, by leveraging their historical achievements in establishing clinical, educational, and ethical standards to create institutional discourse based on participatory power, rather than on the current conflict model of inter-organizational relationships.

While Stevens' organizational theory provides neither an exact roadmap nor a guarantee that the destination will be reached, organized medicine has come to an historical crossroads where its future credibility and influence will be determined. Organized medicine (for those who don't know) comprises the American Medical Association and the specialty, state, and county medical societies. To many observers, this federation of medical professional organizations is oftentimes less organized than its label implies. Confronted with member societies who have competing and conflicting interests and priorities, the federation's efforts to get doctors to agree on an issue calls to mind the cliche "trying to herd cats." Thus, it has become difficult for organized medicine to speak with one coherent and unified voice.

How, then, do we redesign organized medicine to better herd the cats? First, it must be noted that there are strong ties that continue to bind all physicians—our common heritage and shared experiences. As a profession, medicine has a history grounded in a set of ethical principles, and, while no code of professional conduct is monolithically accepted and comprehensively enforced, all those who enter medicine appreciate the importance of the profession's ethical underpinnings. Similarly, independent of time, geography, or specialty, medical students and residents share a process of socialization that prepares each generation of physicians. As an internist, I feel a certain collegial bond whenever I meet a new physician, and I hope and suspect that feeling is mutual. Any solution to reunifying organized medicine should draw upon these ties that bind us as physicians.

In my opinion, any intra- or inter-organizational solution that is meant to unify member societies requires clarification of professional medical organizations' roles and priorities vis-a-vis the interest of patients, physician members, and the profession as a whole. Patients and physicians share fundamental interests. Some mutual interests, such as protecting patient confidentiality and securing informed consent, are apparent. Other interests, such as efforts to reduce administrative burden and other hassle factors for physicians, may seem professionally self-serving, but from an important practical and patient-relevant perspective, frustrated and burned-out physicians are probably poorer communicators and less empathic with their patients.[2-7]

But what happens when the interests of patients and physicians conflict? When, for example, a physician's need for personal or family time coincides with a patient's need for the same time. Even when interests are not in direct conflict, professional medical organizations have to decide how to spend their time and resources among issues that may be more important to dues-paying physician members than to the profession as a whole or to patients and the public. Presented with these realities and choices, some have advocated for separate organizations—one that negotiates and lobbies solely for the interests of physicians and another that advocates on behalf of the profession in the public interest. In countries such as Canada and England that have single-payer systems, this organizational division of labor and responsibilities exists. In the US, with its multi-payer, public and private health care delivery system, an organizational solution designed to create a national collective negotiating unit for all physicians seems less likely to succeed. More importantly, though, a solution based on an organizational division of labor, while structurally "cleaner," undermines the ability of medicine to speak with a unified and coherent voice, and conveniently but artificially compartmentalizes pressing challenges that confront the financing and delivery system of health care in this country.

In keeping with our nation's political philosophy of checks and balances, an alternative, though messier solution (workable solutions are oftentimes messy) is a national physician organization that forces debate, discourse, and ultimate decision on important and potentially conflicting interests and priorities. In order to achieve this organizational resolution, leaders and members of the profession must decide

which interests among the primary constituencies of a national physician organization are paramount. Only after organizational clarity is achieved can more rational, but still imperfect, decisions be made when leaders are confronted with issues of resource allocation and conflicting interests. Only then, will organized medicine stand ready to speak with a unified and coherent public voice.

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