

Professionalization and Public Health: Historical Legacies, Continuing Dilemmas

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Professionalization in public health reflects wider institutional and political forces. Depending on the historical context in different countries, public health has developed as a medical specialty or as an independent field, entirely within the state or in mixed public-private institutions, closely or weakly tied to social movements, and in varying relations to fields such as engineering, nursing, environmental science, and the military. In early 20th-century America, the rise of the medical profession and the biomedical model of disease had a formative influence on public health, leading to a different institutional pattern from Britain. Public health in the United States emerged (1) largely outside the medical profession, but under the sway of the biomedical model; (2) without medicine's command of an exclusive jurisdiction and high status; and (3) with a limited role in healthcare organization and planning. Professionalism in public health continues to be subjected to contradictory pressures and uncertainties. Healthcare reform, bioterrorism, and environmental crises could expand its mandate and access to resources, but conflicts with other institutions are likely to result in limits on the capacity of public health professionals to assert an exclusive jurisdiction.

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Public health, as its history in Europe, the United States, and elsewhere shows, has the potential to take a variety of different institutional forms. It can develop as a specialty within the medical profession or as a distinct and independent field. It can grow up within the state or spread among different governmental units and private agencies. It can have stronger or weaker connections with social reform movements. It can assume a

central role in the planning of health services or no role at all. It can develop in more or less proximity not only to medicine but also to other fields such as engineering, nursing, statistics, and the environmental sciences, depending, in part, on the dominant understanding of health and disease. Insofar as it develops within the state, it can become an aspect of public security, associated conceptually and legally with the state's police and military powers. In short, nothing about public health as an institution is foreordained by its functions. The political and economic circumstances, as well as prevailing systems of thought, have affected how those functions are performed in different times and places.

In the United States, the ascendancy of the medical profession by the early 20th century was one of the formative influences on public health. Physicians established the model for professionalism in healthcare, yet their very success made it difficult for other occupations to duplicate what they achieved. This is the peculiar aspect of medicine's exemplary role,

Among the professions, medicine is both the paradigmatic and the exceptional case: paradigmatic in the sense that other professions emulate its example; exceptional in that none have been able to achieve its singular degree of economic power and cultural authority.¹ (pp28-29)

By the time critical decisions emerged in the United States about education and training in public health, physicians were already dominating healthcare, and the biomedical approach to disease enjoyed a corresponding power in the domain of ideas. These influences were partly in tension with each other so far as

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public health was concerned: The economic interests of physicians pushed public health away from medicine—to avoid competition, the physicians wanted to keep public health agencies out of medical practice—while the biomedical model brought medicine and public health closer together. Overall, though, the power and prestige of medicine made it difficult for public health to come into its own as a profession.

Whether public health *should* have followed the model established by physicians and become more thoroughly professionalized—or even whether it should try now—is another matter. To be sure, the professional autonomy and status of physicians have their clear benefits and not just from the standpoint of physicians. The prerequisites of medicine have served a public interest by attracting highly qualified students into the field and encouraging them to invest in and endure a lengthy and demanding education. Respect for professional autonomy has also helped protect the integrity of medical research and clinical judgment. Beginning around the turn of the 20th century, however, physicians' success in using licensure and other measures to get stronger protection against competition raised the costs of healthcare. By later resisting controls in healthcare finance, physicians also helped make medical care more expensive and less available in the United States than in other advanced societies. Professionalism has had two sides, and leaders in public health ought to be sensitive to the drawbacks as well as to the advantages.

These two sides of professionalism—positive and negative—have been reflected successively in the sociology of the professions. During the mid-20th century, sociologists tended to see professionalization as a functional and benign response to social needs. Call this the “standard” model. Then, beginning in the 1970s, a younger generation of sociologists cast a harsher eye on the subject, reframing professionalization as the project of self-interested monopolists. Call that the “power” model.

The standard model of professionalization was succinctly summarized by Harold Wilensky in 1964: “Any occupation wishing to exercise professional authority must find a technical basis for it, assert an exclusive jurisdiction, link both skill and jurisdiction to standards of training, and convince the public that its services are uniquely trustworthy.”² As this formulation suggests, sociologists at that time particularly emphasized the following elements as requisites for a profession: (1) a cognitive base, that is, an area of technical, specialized knowledge; (2) normative commitments to a service ideal, often formally expressed in a code of ethics and contrasted with the commercial norms of the market; and (3) an exclusive jurisdiction. In support of their cognitive, normative, and jurisdictional claims, professions have typically developed three interrelated insti-

tutions: professional schools, professional associations, and professional licensing and accreditation systems. Together, these allow for a high degree of collective self-regulation by a profession and instill in its practitioners a concern for the approval of their colleagues—that is, a peer orientation—rather than a concern only to please clients or bureaucratic superiors. Surveying a wide range of occupations that had professionalized, Wilensky identified a standard sequence for the various steps in the process, though he was skeptical about how far professionalization could extend down the occupational ladder. Sociologists influenced by Talcott Parsons³ saw the rise of the established professions as a functional response by society to the growing complexity of knowledge, just as Kenneth Arrow⁴ and other neoclassical economists saw professionalism and other aspects of medicine as rational, welfare-maximizing responses to uncertainty. The basic idea was that knowledge was growing more complex, society needed both to educate people to apply that knowledge and to trust the people it educated, and professionalism represented a solution to those problems.

Like so much of mid-20th-century social science, however, this view of the professions came under attack after the 1960s as insufficiently critical of existing institutions. Where the older generation saw a consensus about values and a commonality of interests between the professions and society at large, the new generation saw a deep conflict. Where the standard model accepted the professions' self-representations, the power approach questioned their claims. According to the power model, much of the professions' specialized knowledge was merely ideology, their service ethic was propaganda, and the mechanisms allegedly established for self-regulation were ways of protecting members of the guild rather than the public. From this standpoint, the professions' insistence that only those with professional credentials be allowed to engage in certain forms of practice—that is, the idea of exclusive jurisdiction—reflected the interests of monopolists attempting to control a market.⁵⁻⁷

The view of the professions as monopolies of both knowledge and markets was the central point of the power model. And interestingly enough, this critique had support on both sides of the ideological spectrum. Some of the earliest economic work critical of medical licensing laws came from Milton Friedman, and by the 1970s other free-market economists as well as legal scholars were arguing that medical care and other professional services ought to be subjected to the antitrust laws and stronger competition to break down the professions' monopoly power. Meanwhile, drawing on the ideas of Marx and Weber, sociologists were arguing that the professions had used their monopoly power to dominate other occupations as well as consumers. This

story also had a gender component: male physicians, feminists said, drove out female healers and controlled women in subordinate occupations. Although the intellectual traditions were different, the thrust in both economics and sociology aimed at shattering the aura of the professions and reducing the power they exercised.

In *The Social Transformation of American Medicine* (1983), I tried to synthesize the standard model and the power approach in the analysis of the professions as well as the work coming out of economics and law. The various perspectives on professionalism, though sometimes overdrawn, give part of the picture. While the standard model is too benign and schematic, much of it is not wrong so much as incomplete. Professionalization does involve power and conflict, but the professions could never have succeeded in raising their status and income if they had not gained support from wider interests in society, though that achievement has to be understood as a political and cultural process rather than simply as a functional response to social needs.

The rise of the medical profession in the United States did not follow a uniformly linear course. In the early republic, the organized profession was divided and weak, the social status of practitioners was insecure, and their earnings were modest. Amid the antimonopoly sentiment and popular suspicion of expertise during the Jacksonian era in the 1830s, states eliminated medical licensing laws, throwing medical practice and training open to a wide array of practitioners and medical sects. Toward the end of the century, however, the tide began to shift, the regular profession developed stronger organization, the public became more receptive to its claims, and by the Progressive era (1900–1920), physicians' status and income were on the rise. Changes in knowledge and technology that transformed everyday life were crucial in bolstering the cultural authority of science and the professions, and it was partly on that basis—that is, on the basis of the belief that medical authority served wider social interests—that physicians obtained stronger licensing laws and other means of controlling the market for their services. Physicians were also able to protect their independence and to limit competition by constraining the development of other healthcare institutions such as hospitals and by limiting efforts by government or private corporations to control their work.

These developments had repercussions for public health and its development as a profession. The timing of change in America was critical. In Britain, the key steps in the creation of public health organization and training took place in the latter half of the 19th century, whereas in the United States those developments did not come until the second decade of the 20th century. British physicians, many of them economically insecure, saw opportunity for advancement in

public health, and, partly as a result, public health developed as a specialty within the medical profession. In America, however, physicians were doing so well in fee-for-service practice by the early 20th century that they had little incentive to go into public health and invest in additional training in that field. As a result, recruitment into public health in America had to come not just from medicine but also from a variety of other fields as well.⁸

The delayed professionalization of public health in America also affected other aspects of public health training, including the model of disease institutionalized in the curriculum. By the second decade of the 20th century, bacteriology had transformed the understanding of public health, and the emphasis in what was called “the new public health” was on the control of microorganisms rather than on environmental factors in illness. Furthermore, in the United States, the key decisions about both medical and public health education were made by a private foundation and not by the federal government, which at the time had little role in either medical services or public health. If Congress had made the decisions, it would likely have given greater priority to western and rural interests (as it had in the land-grant college system). But by default, the initiative in national policy on medical and then on public health education fell to the Rockefeller Foundation's General Education Board under the leadership of Abraham Flexner. Flexner's 1910 report on medical education called for fewer but better medical schools with full-time, research-oriented faculty, endorsing a reduction in the number of schools and graduates that was already in progress because of higher state licensing requirements that made medical education more costly. The impact of the cut in medical graduates would be felt as early as the 1920s, when complaints about vanishing physicians began to emerge from rural and small-town America. The shrinkage would also affect the relation of medicine to public health.

In 1914, the Rockefeller Foundation convened a landmark conference on training for public health and later produced a report that, despite some internal dissent, called for a medical- and laboratory-oriented approach to education in the field. One of the papers for the conference envisioned public health as a three-tiered field. At the top would be the university-trained administrators and planners; then would come experts in specific disciplines, also university-trained; and finally there would be the foot soldiers who did most of the fieldwork and received a limited amount of training emphasizing practical skills. The foundation concerned itself with education for the top two groups, and it channeled its resources disproportionately to elite institutions concentrated in the northeast. The first school of public health that it financed, at Johns Hopkins under William H. Welch, reflected the laboratory-oriented,

biomedical vision, as did the other early schools that followed. Flexner and Welch expected that physicians would enter public health, but by helping reduce the supply of physicians, they undermined their own conception. Not only did relatively few physicians pursue public health as a career, but also the physicians who took posts in public health often had no public health training.⁹

The results for the professional project in public health were mixed. On the one hand, the shortage of physicians forced public health to rely on people with more diverse disciplinary and career backgrounds than was the case in Britain. On the other hand, it was difficult for public health to claim an exclusive professional jurisdiction—to insist that only those with the proper credentials in public health be allowed to do certain kinds of work and make certain kinds of decisions. In the early 19th century, physicians had been unable to control entry into their field because of general popular distrust of expertise and suspicion of monopolies. In the 20th century, professionals in public health were unable to control entry into their field because other kinds of preparation were regarded as equally legitimate.

The problem of exclusive jurisdiction also reflects the inherent difficulty of defining the boundaries of public health. In 1920, one of the field's leaders defined *public health* as

the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.¹⁰

It was an admirable ideal, but this conception is so far-reaching in its implications that it puts public health into tension, if not outright conflict, with a wide range of American institutions and beliefs. More recently, the Institute of Medicine defined public health's mission as "fulfilling society's interest in assuring conditions in which people can be healthy."^{11(p7)} While more concise, that definition also suggests so vast a jurisdiction for public health that it cannot possibly claim it as exclusive.

Professionalism in public health is unavoidably subject to contradictory pressures. While professionalism calls for peer-oriented self-regulation, most work in public health has government as its immediate client and demands strict compliance with bureaucratic rules. Yet the democratic state requires professionalism. As the military illustrates, professionalism within the state

has long been a way of inculcating high ideals of responsibility, depoliticizing certain kinds of decisions, and assuring that the officials elected by the public have the authority to determine the mission. The military analogy has had direct application in public health at the national level (the term "surgeon-general" nicely encapsulates the use in public health of both medical and military frames of authority).

Despite the inevitable tensions with American beliefs in individual autonomy and limited government, public health has benefited from several deep trends in the past half century. As understanding of the environmental and behavioral sources of disease has grown, Americans have come to accept changes in lifestyle and new forms of public health regulation. The growth in health costs has encouraged more serious efforts at disease prevention and interest in the role that public health can play in rationally allocating healthcare resources. September 11 and the subsequent anthrax panic reawakened understanding of the integral role of public health in public security.

As in the past, public health still has the potential to change institutionally. If healthcare reform brings a larger share of medical costs into the public budget, it may lead to closer integration of public health and medicine. Future acts of terrorism could lead to a greater emphasis on a national security conception of public health. Environmental crises could redefine the mission of the public health in yet another way. Each of these developments would affect the public health workforce and professional ideals. No matter what happens, the sheer breadth of public health will make it difficult for professionals in the field to exercise any kind of exclusive jurisdiction. Conflicts with the medical profession, private industry, and politics are guaranteed. Professional careers in public health are likely to expand, but the career of public health itself will not be an easy one.

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