BOOK REVIEW

WHITHER HEALTH CARE?


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Lawyers reading this excellent social and historical analysis of medical care in America might well suppose its subtitle should read "Eat Your Heart Out, Counselor!" The importance of the law to our nation—to our cultural arrangements as well as our institutions—has not been matched by an intensity of interest among social scientists comparable to that shown in the social and historical evolution of medicine.¹ This imbalance may of course be due to the fact that health care consumes an ever-expanding part of our economy. But there is more—for the fascination that sociologists and historians have with medicine also results (as it does for the rest of us) from awe in the face of birth, pain, and death, and from wonder and admiration at the interventions of physicians that save lives and alleviate suffering.

A related source of intraprofessional envy lies in the history recounted by Professor Starr, particularly in the first half of his book, which he labels "Book One: A Sovereign Profession." Would not any lawyer be jealous of the progress the medical profession in the United States has made in transforming itself from a disorganized, disre-

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¹ Regrettably, Professor Starr himself does not remedy the imbalance. Despite some use of comparative data (especially in showing differences between developments in the medical profession in the United States and those in England and Europe), he fails to compare and contrast the legal profession with the medical profession. He does, however, make very good use in his book of previous studies of medicine, including a number by leading scholars from the University of Pennsylvania such as Renee Fox, Charles Rosenberg, and Rosemary Stevens. R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST (1971) is particularly influential, along with E. FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE (1970); E. FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (1970); W. ROTHSTEIN, AMERICAN PHYSICIANS IN THE NINETEENTH CENTURY: FROM SECTS TO SCIENCE (1972); R. SHRIOCK, MEDICINE IN AMERICA (1966), and the classic writings of Weber, Parsons, and Merton among others.

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spected, and generally disdained calling as late as the end of the nineteenth century into the country's most highly regarded and prosperous profession, possessed of enormous economic significance and political influence? Despite their relative affluence and ingrained role in society, lawyers are not able today to lay claim to cultural authority or occupational control comparable to that of their medical counterparts.

Yet the real reason that readers of law reviews should also be readers of *The Social Transformation of American Medicine* goes well beyond one's motivation to lean on the fence and wonder how one's neighbor gets such a green lawn. In the corporate field, for instance, lawyers will find that health care is of great concern because insurance premiums are a major part of employee benefits (and hence part of the cost of every product). Moreover, many lawyers work for corporations directly involved in one of the many facets of health care. Lawyers involved in government regulation on both state and federal levels will find the book fascinating, not only in its technical but also in its political aspects. And all Americans should be concerned with a segment of modern life that has repeatedly posed crises not only for the nation's pocketbook but also for its conscience. We lawyers claim to be concerned with questions of justice. What kind of a society, however, scrupulously observes the niceties of due process for the few that come before its courts yet fails adequately to provide for care of the many who have need of its hospitals and healers?

I.

Professor Starr sets out to demonstrate, in Book One, that the privileged and powerful position of medicine in America today was not foreordained by either historical position or the rise of science. Rather, Professor Starr argues, the origins of power of the medical profession are a function of political, economic, and cultural forces that are all at work in the health care and medical professions. It is true that patients in need of care are in a dependent position; but such dependency does not lead inevitably to great power or to a unified profession. Consider the relationship between the members of another ancient profession and

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2 For example (and on the simplest level), the National Institutes of Health and the Health Care Financing Administration, unlike the Supreme Court, are not parts of our basic constitutional structure, although of course it is merely historical fact and not a requirement that the Justices (like most judges on inferior courts) are lawyers.


4 Professor Starr notes how "[p]hysicians offer a kind of individualized objectivity, a personal relationship as well as authoritative counsel. The very circumstances of sickness promote acceptance of their judgment." *Id.* at 5.
their supplicants: not all sinners in need of salvation go to the same church, nor do they expect ministers to exercise broad social authority.

In earlier times, Americans may have been as preoccupied as they are today with health and well-being (as demonstrated by a long-term attachment to popular movements such as those concerned with diet and exercise), but they sought it through a variety of healers other than those trained in medical school. And with good reason, for many people with medical degrees actually had little formal education and possessed only meager skills. Even the most respected and learned physicians (who typically had studied in England and Scotland, or on the continent) had to rely on such a primitive body of knowledge and such a small bag of remedies that their major function was to provide comfort and consolation. The ancient admonition—primum non nocere (above all, do no harm)—was wise counsel: the physician was likely to be of greatest assistance by intervening as little as possible and by merely supporting the patient, while nature resolved the illness.

But all of this did little to endow medical doctors with the God-like aura that they possess today. In many ways, physicians were in no better position to help their patients than were the various “lay healers,” who did everything from prescribing botanical remedies to setting bones. The relative lack of helpful skills meant that the profession faced substantial barriers to establishing its own legitimacy in the eyes of the community. Its fractionation into competing schools of thought and the wide variation in social class and education among its practitioners also lent it short of a consensus about its goals and identity.

Beginning in the colonial era, American physicians had departed from the three-part structure that had prevailed in England. At the top of the English hierarchy were physicians, a small, elite group of Oxford-educated gentlemen, who did not physically intervene in cases (they only observed, speculated, and prescribed), followed by surgeons (who engaged in manual tasks and had been members of the same guild as barbers until 1745), and, finally, by apothecaries, the most

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6 Professor Starr writes:

Since the 1830s . . . the United States has been swept by a series of popular movements concerned with improving health variously through diet, exercise, moral purity, positive thinking, and religious faith. Today . . . Americans [are] jogging in parks, shopping in health food stores, talking psychobabble, and reading endless guides to keeping fit, eating right, and staying healthy . . .

*Id.* at 7.

6 See *id.* at 47-49 (lay healers included botanic practitioners, midwives, cancer doctors, bonesetters, inoculators, abortionists, and sellers of nostrums).

7 See *id.* at 37-38.
numerous group, who could charge for drugs but not for their advice. Even when a movement began in the 1760's to create a stronger identity for the profession—such as by the establishment of the first American medical school in 1765 at the University of Pennsylvania§ (then the College of Philadelphia)—the predominant mode remained democratic and competitive, with the result that by 1850 France had three medical schools, while the United States had forty-two.°

Throughout most of the nineteenth century, this lack of legitimacy and cohesion kept the medical profession from gaining much authority. Indeed, developments in the larger society conspired to retard physicians' attempts to improve their positions. Professor Starr shows how the century's characteristic "double movement"—the expansion of the free market into every sphere of social life coupled with "social protectionism" that tried to counteract the resulting harsh consequences for traditional institutions—played out in medicine: on the one hand, the nascent (and largely ineffective and unenforced) licensing laws were attacked by economic liberals, who wanted people to be free to obtain treatment from whomever they wished, and, on the other hand, charity and government intervention (in the drug area, for example) increased, as many perceived a growing need to protect people from harm.

Eventually, of course, the medical profession improved its position. Once again, Professor Starr attempts to discredit many of the conventional explanations for the eventual change in the profession's fortunes. For example, he points out that the famous report on medical schools by Abraham Flexner" played more the role of reporting changes already underway than of initiating them. By the time it was published in 1910, the proprietary medical colleges, which accounted for a large portion of the 162 schools then in existence, were already facing severe pressures from state licensing boards setting higher standards for the length of education and the requisite quality of laboratory and clinical facilities.12 Moreover, a clear alternative had emerged in the university-affiliated medical schools, which were requiring more extensive prepar-

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§ See id. at 40-41 ("By establishing medical schools on American soil, physicians hoped to create a profession in the European image. . . . If physic was to be a learned profession, it had to have a seat of professional learning.").

° See id. at 42. A medical education encompassed two years of three to four months' study each, and until 1850, the second year consisted solely of repeating the courses given in the first. See id. at 43.

10 Professor Starr refers to K. POLANYI, THE GREAT TRANSFORMATION 61 (1944) for an articulation of this phenomenon.

11 See P. STARR, supra note 3, at 118-21 (citing and discussing A. FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA, Bulletin Number Four (1910)).

12 See P. STARR, supra note 2, at 118-19.
atory education and longer training.\textsuperscript{13}

In place of the conventional explanations, Professor Starr points to the power that the medical profession slowly accreted because of "institutionalized forms of dependence."\textsuperscript{14} He shows that, even when they were managed by nonmedical boards, hospitals were increasingly forced to rely on physicians for business—namely, the admission of patients—as the hospitals were transformed from dispensers of charity (almshouses) to institutions of medical science.\textsuperscript{15} Even more interestingly, Professor Starr traces changes in the authority of physicians to other developments in society at large, such as improvements in transportation and communication, which made the practice of medicine more efficient. Once physicians were able to schedule appointments in their offices and to respond quickly to emergencies (with the growth of the telephone after 1870), they could organize their time more economically. As rapid transportation became readily available, patients could more conveniently visit their physicians, and physicians’ schedules were consequently less disrupted since they no longer had to go out to see patients. Whereas summoning a physician to the home of a sick person had once been an arduous process (on both sides)—with the result that a physician, travelling long distances by horse or wagon, might see only a few patients a day—the growth of cities and the availability of automobiles made it easier for patients to come to physicians at the office or hospital.\textsuperscript{16}

A part of the improvement in the position of physicians thus seems to have sociological roots. Physicians arriving at their patients’ homes are in a less powerful position (however grateful the patients may sometimes be) than when the patient makes the trip and visits the physician on the latter’s turf. Furthermore, the ability of a single physician to care for a larger number of patients not only increased the physician’s income, but also gave her practice a broader base and freed the physician from having to rely on the patronage of a few rich patients (the only route previously available for the ambitious doctor).\textsuperscript{17}

\textsuperscript{13} When it opened in 1893, Johns Hopkins University became the first school to require a college diploma and a four-year medical program. See id. at 115. At Harvard Medical School “[t]he academic year was extended from four months to nine; the length of training needed to graduate rose from two years to three. . . . Students henceforth would have to pass all their courses to graduate.” Id. at 114. The University of Pennsylvania followed Harvard’s lead and extended medical training from two to three years. Id. at 115.

\textsuperscript{14} Id. at 144.

\textsuperscript{15} See id. at 147-69.

\textsuperscript{16} See id. at 65-71.

\textsuperscript{17} Further, many of the new patients came from the middle class, so that most physicians could now presume both social equality to and (in most instances) educa-
In emphasizing such factors, however, Professor Starr downplays a little too much another traditional explanation for the greatly enlarged authority of physicians in the twentieth century: the growth in the scientific basis of medicine.\(^1\) Admittedly, this factor has probably been credited with playing too large a role in explaining the spectacular increase in the influence of the medical profession in modern America. But the growth of scientific knowledge greatly increased the powers of the trained professional to do things that were beyond the ability of the ordinary mortal limited to common sense or folk customs. This seems to me an absolutely essential underpinning to the other factors that Professor Starr so rightly emphasizes, such as changes in the broader society. One wonders, for example, whether a patient would have been equally impressed with the medical profession when visiting the physician's office were it not for all the visible accouterments of scientific medicine found there. Evidence of scientific gains reinforced the patient's sense of awe as effectively as whatever the practitioner actually accomplished by way of cure. This is not to say that Professor Starr ignores the effect that scientific developments and increased clinical sophistication had on the practice of medicine and on the creation of a collective identity for the profession, merely that he underplays it.\(^2\)

As Professor Starr makes clear, the eventual transformation of the medical profession into a powerful and rather cohesive group by the 1920's cannot be regarded as the unfolding of some inevitable process. Rather, the profession—particularly its organizational and academic leaders—skillfully used each new attribute of power to gain more power. They dissuaded "ethical" drug companies from dealing directly

\(^{1}\) See P. STARR, supra note 3, at 6 ("In the world today, not all societies with scientifically advanced medical institutions have powerful medical professions. . . . The growth of science . . . does not assure physicians broad cultural authority, economic power, or political influence . . . .")

\(^{2}\) For example, in discussing the increase in office practice, Professor Starr claims that a "very deep-run current to segregate pain and illness as private events reinforced the desire of more prosperous families to receive physicians in the privacy of their own homes," rather than in offices and hospitals, which carried "a mark of lower status." Id. at 75-76. Yet his description of the factors that changed patients' attitudes is vague (indeed, almost circular): "It is a measure of the changing position of the profession and medicine's success in overcoming the feelings of delicacy accentuated by the Victorian sensibility that this stigma was gradually overcome." Id. at 76. What, then, caused such a powerful change in the profession's position? And what fueled "medicine's success," in light of the fact that many of the expanding number of patients were from the middle class, the very group most imbued with "Victorian sensibility"? Could it be that this group was the most impressed with the scientific trappings of the profession, which justified treating medicine increasingly as a fit subject for commerce, to be purchased in its own marketplace, rather than as a form of ritualized hand-holding to be dispensed at the bedside by a kindly old man with a small bag of ancient potions?
with the public, fought all forms of the "corporate practice of medicine" by insurance companies and hospitals that wanted physicians to serve as employees rather than as independent practitioners, and—perhaps most to their own discredit and to their communities' harm—they constructed barriers to public health reform. What is remarkable about the power that physicians obtained, as Professor Starr writes, is that it was gained through "belief rather than force, . . . the success of its claims to competence and understanding rather than the strong arm of the police." Nonetheless, the growing cultural authority of the profession (which aided physicians in resisting the efforts of both the state and the corporations to control health care) was itself a product of other factors, particularly the ever increasing powers of biomedicine, that not only placed physicians in a pivotal role as the common person's link to advanced science but also provided an acceptable basis and rationale for collective solidarity.

II.

The description of the profession's "Escape from the Corporation," as Professor Starr entitles the final chapter in Book One, provides an excellent bridge to Book Two, "The Struggle for Medical Care." The chapters in this part have two purposes: first and foremost, to trace the growth of outside powers over medical care, and second, to anticipate the increasing role played by "for-profit" corporations in this field.

The first of these subjects could well be described as a slowly maturing Faustian bargain. Looking over the past fifty-five years (from the inauguration at Baylor University Hospital in 1929 of a program of prepaid hospital care that grew into the Blue Cross system), one would have to conclude that physicians have done extremely well by this bargain. Not only did the plans for hospital—and later physician—insurance (Blue Shield) protect (indeed, greatly enhance) physicians' earnings, but by satisfying the needs of many consumers, they served as a bulwark against cooperative health plans, commercial insurance companies, and compulsory, state-mandated (or even state-run) health insurance. The success of this development confounded the experts, because it violated actuarial principles and other accepted insurance practices; eventually, however, the very success of the medically

20 Id. at 229.
21 See id. at 295.
22 Actuaries feared that the inadequacy of available statistics would result in unpredictable losses. Others feared open-ended policies because they were "like blank
initiated insurance plans proved their undoing. Physician control of the system meant not only that physicians’ interests were given priority, albeit with public obeisance to consumers, but that the system grew rich. This made it attractive to entrepreneurs and vulnerable to outside controls when times got hard.

Ironically, the very power and influence gained by the profession may have been its Achilles’ heel. For example, physicians’ authority was sufficient to require Congress to make certain compromises when federal financing was legislated on a large scale in the mid-1960’s. In order to get the program enacted, reformers gave in to the American Medical Association (AMA) and other lobbyists and agreed that the federal government would not become directly involved in supervising but would instead funnel its funds through the existing insurance plans, in the role of “financial intermediaries” that would supervise disbursements. Thus, billions of dollars were poured into a system whose “cost-plus” mode of operation virtually ensured that any competent health care administrator could turn a profit.

This financial lure attracted profit-making firms (in increasingly large chains of institutions rather than single hospitals) run by people used to setting performance targets and marshalling resources (including personnel) to meet those objectives. Moreover, as the groups who really pay the piper (both the federal government and private employers) became concerned by the spiral of medical prices, they decided that they wanted to call more of the tunes. As the terms of the programs became less generous, nonprofit institutions also felt forced to exercise tighter management controls and to provide incentives in order to alter the behavior of health care personnel, particularly physicians.

For example, C. Rufus Rorem, who as an expert for the American Hospital Association presided over the birth of Blue Cross, opposed the single-hospital plans that were first developed on the ground that they interfered with subscribers’ “freedom of choice.” As Professor Starr points out, however, it is unclear why subscribers would have had less choice if they could choose from a variety of plans offered by hospitals in their community. The AHA did not encourage community-wide plans in addition to single-hospital plans, but instead of them. In this respect it denied consumers the choice of contracting with a single-hospital plan and possibly securing a more favorable price.

Id. at 297.

See, e.g., Capron & Gray, Between You and Your Doctor, Wall St. J., Feb. 6, 1984, at 24, col. 3 (discussing profit-sharing plans established by hospitals to reward physicians who help reduce costs).
consultants, imposing increasingly explicit controls on physicians’ decisions, and even setting up profit-making subsidiaries. All in all, the health care industry (and that now seems the appropriate term) is one of the most rapidly evolving in the entire economy.

Today, as the goose seems at risk of choking on its own golden egg, it is interesting to remember that physicians foresaw from the beginning the very things that have come to pass. In the mid-1930’s, the AMA insisted, for instance, that the only acceptable restrictions on treatment were those “formulated and enforced by the organized medical profession.” Furthermore, the AMA initially insisted that all insurance payments go directly to the patient, so that physicians would not become subject to the dictates of an organized payer. Similarly, many physicians, “like those who wrote the [Committee on the Costs of Medical Care] minority report, suspected . . . that any financial intermediary would ultimately impose controls on their incomes.”

Plainly, this oversimplifies a complex story. Yet I think that, for all the exceptions and side roads taken by health care (and traced by Professor Starr), the predominant trend remained. The great storehouse of collective authority that had been slowly accumulated by the medical profession was cashed in for a reimbursement system that for a time added further to physicians’ power, in part by adding immensely to their wealth. But eventually the system grew too large and complex and became too entwined in the economy and the government for medicine to continue to control it.

As a consequence, medicine today is entering an environment that is reminiscent in many ways of that at the turn of the century. Again, for example, physicians (particularly those just entering the profession) are taking employment with hospitals, health plans, free-standing clinics, and private companies; employers, concerned about the expense of health benefits, are placing limits on the types or setting of care for covered employees, thus promoting competition among health care providers; and, generally, physicians are having to relinquish some of the extraordinary control and power they have amassed during the past

25 Minutes of the Eighty-Fifth Annual Session of the American Medical Association, Held at Cleveland, June 11-15, 1934, 102 J. A.M.A. 2109, 2201 (1934) (recommending that there be “no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession”).

26 Today a major means of asserting control over physicians’ practices is to insist that they accept “assignment”—meaning that their charges are limited to the amount paid directly to them by the insurance program.

27 P. Starr, supra note 3, at 299.

28 Physicians’ interests in research and in improvements in their institutions, particularly acute-care hospitals, were also amply supported by the government and private philanthropy. See, e.g., id. at 338-351.
sixty years.

Many of these changes are beneficial. The financing of health care, in particular, needs to be shaken-up. If greater competition among health care providers promotes greater information for consumers, that too is good. Even the entry of profit-making institutions may have a positive effect, particularly if it brings additional sources of capital into the system at a time when the federal government is reducing its commitment.29

But some distinctly worrisome features are also emerging in the health care industry, as the second part of Professor Starr's work makes clear. From my viewpoint, the most disturbing of these features is the diminished access to health care among the poorer members of society. Tens of millions of people still lack adequate health care, despite the billions of dollars being expended by the federal government (to say nothing of private funds).30 Few nations spend a larger proportion of their GNP on health care than America does, yet many can claim better health care statistics (in terms of infant mortality and adult longevity, for example).31 One cannot simply dismiss such comparisons by asserting that the health of a population depends on more than medical care—of course that is true, but in this country the heavy emphasis on physician-mediated acute health care (at the expense of public health and preventive measures) is a cardinal feature of the very "triumph" of the medical profession, as recounted by Professor Starr.

The increasing role that for-profit institutions in health care (especially hospitals, walk-in "urgicenters," and nursing homes) are playing underlines the subtle contextual changes that are occurring. Medicine is moving further and further away from being an altruistic calling, often practiced in charitable settings, toward being a sale of a commercial

29 One unusual recent development was the transfer of Dr. William C. DeVries' artificial heart implantation program from the University of Utah to the Humana Heart Institute in Louisville. The promise of Humana, Inc., one of the largest "for-profit" hospital chains, to fund 100 heart implants (estimated at $250,000 each) dwarfs the funds that the University of Utah was able to raise for this research. See Altman, Surgeon's Move Highlights Controversial Trends, N.Y. Times, Aug. 7, 1984, at C3, col. 2. Humana is not a charitable institution, however. A 1980 Fortune magazine article cited by Professor Starr quotes a Humana official with respect to an uninsured heart attack patient's transfer (after one day's treatment at a Humana hospital) to a public hospital where he died: "These-freebies cost $2,000 or $3,000 a day. Who's going to pay for them?" Kinkead, Humana's Hard-Sell Hospitals, FORTUNE, Nov. 17, 1980, at 68, 81 (quoting Dr. Karl Fazekas).


31 Professor Starr notes that Americans have "higher infant mortality rates and lower life expectancy than most Europeans." P. STARR, supra note 3, at 382.
product in the marketplace.\textsuperscript{32} Needless to say, this development has raised concerns for many people, most notably Dr. Arnold Relman, editor of the prestigious \textit{New England Journal of Medicine}, who wrote in 1980 of the problems with a “new medical-industrial complex.”\textsuperscript{33}

Professor Starr identifies five dimensions of the phenomenon. Among these, he emphasizes the shift from nonprofit and governmental organization to for-profit companies and the concentration of ownership at the regional and national (rather than the local) level.\textsuperscript{34} Professor Starr reports that although the nonprofit chains account for many more beds than those in the profit-making organizations, the latter have grown much faster\textsuperscript{35} (even though their easiest period of growth—through acquisition of certain attractive, locally run proprietary or voluntary hospitals—is behind them). For-profit companies will unquestionably have a significant impact on the organization and delivery of health services, particularly because this segment of the industry is concentrated in fewer, larger organizations than is the nonprofit sector. If we are going to respond well to these developments, we will need to know the effects of a corporate-style profit motive on physicians’ behavior, on the costs of care, on access to care, and on the overall “system” of health care in each community.

Yet, in some ways, I believe the emphasis on the profit-making side of these organizations focuses the spotlight on that aspect of the change that is less important, although perhaps more controversial. Professor Starr is right when he observes that, although physicians and hospitals have been preoccupied with government regulation, “they may be on their way to losing their autonomy to another master.”\textsuperscript{36} But in explaining that the for-profit chains have introduced “managerial

\begin{itemize}
\item \textsuperscript{32} Plainly, this is no ordinary market, because patients often do not (and sometimes really cannot, due to their limited knowledge) act like ordinary “consumers,” and health insurance has profound effects on decisions about “purchases.”
\item \textsuperscript{33} See Relman, \textit{The New Medical-Industrial Complex}, 303 \textsc{New Eng. J. Med.} 963 (1980) (discussing the recent and unprecedented rise in new industries that supply health-care services for profit, such as proprietary hospitals and laboratory services, and its impact on economic efficiency and national health policy). The “old” medical-industrial complex refers to the linkages between doctors, hospitals, and medical schools and the health insurance companies, drug manufacturers, medical equipment suppliers, and other profitmaking firms. Their interests seemed so closely interlocked that they constituted . . . a common front for a particular style, structure, and distribution of medical care.
\item \textsuperscript{34} \textit{Id.} at 429.
\item \textsuperscript{35} \textit{Id.} at 430.
\item \textsuperscript{36} \textit{Id.} at 428.
\end{itemize}
capitalism into American medicine on a large scale,\textsuperscript{37} he emphasizes the capitalist component; I think the managerial mode itself is at least as significant.

Thus far, the nonprofit chains have been less quick to replace local boards with central ones and to vest authority with managers rather than with boards. But under the mounting pressures to ensure institutional solvency in the face of new payment formulae, the need to protect against malpractice liability, and requirements for data to fulfill governmental and accreditation rules, one can be sure that the managerial style of the nonprofits will move even closer to their for-profit siblings. One way or another, rules will be prescribed, power will be given to managers and committees, and the discretion of individual physicians will be increasingly limited.

This loss of discretion and control does not necessarily mean less effective care for patients. It might, if bureaucratic convenience and institutional objectives replace medical judgment. But if better management leads to more efficient use of physicians' time (for example, through division of labor and better materials for communication with patients) and elimination of certain perverse incentives (for example, the greater financial reward to physicians that now comes under most forms of insurance in doing something, rather than in observing and inquiring), better management could mean better care. Moreover, the dominance of institutional objectives over patient needs—which is now being lamented—is actually nothing new; the change is that, in the past, institutional interests were congruent with those of the medical profession, which controlled most health care institutions. In other words, the shift in power, to the extent it is occurring, is from physician to manager, not from patient to manager. Thus far, the greater role for nonphysicians in health care has merely resulted from corporate planners stepping into the void created by physicians' keeping public planners at bay. If a greater role for institutional officials also opened the door to greater public accountability, then it could ameliorate what Professor Starr characterizes as one of the greatest failings of the health care system as it evolved in this century.

But reducing physicians' authority could also have some undesirable results. Much of the private law of physician-patient relations in the past quarter-century has involved a struggle (waged by lawyers in what often seems to be a half-hearted fashion) to increase patients' autonomy at the expense of physicians.\textsuperscript{38} Would it not be ironic if the

\textsuperscript{37} Id. at 431.
\textsuperscript{38} See J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, LAW, SCIENCE AND MEDICINE 353-415 (1984) (discussing informed consent and other uses of private con-
legal rules that have emerged were to undermine the physician's emerging role as the advocate for and protector of the patient in her relationship with health care institutions that may have strongly conflicting interests of their own? This does not mean that the gains made for patients in these cases need to be disavowed, merely that those responsible for the continuing evolution of the law in this area should be sensitive to the important but subtle changes that are taking place in the settings in which care is provided and decisions are made. They should be joined in this enterprise by the true leaders of the medical profession, who will realize that the best buttress for physicians' legitimate authority is their clear demonstration that the needs and interests of their patients take precedence over all else, be it their own convenience or preferences or, more disturbingly, the financial benefit of third parties.

I trust that Professor Starr will be among those contributing to an analysis of the changes in health care brought about by the organizational developments that he outlines at the end of his book. Because the rest of the volume is so good, it would be ungrateful to complain that the final chapter is too brief and superficial. Better to say that, judging from The Social Transformation of American Medicine, any contribution he chooses to make will be informative, careful, sweeping but sufficiently detailed, and very readable. I recommend the present volume to anyone who wants to know not only whence health care in America has come, but whither it is going as well.

\textsuperscript{trol exercised by individuals over medicine and science); J. Katz, The Silent World of Doctor and Patient 59-84 (1984) (discussing the history and legal status of the informed consent doctrine and the "symbolic significance of the call for patient self-determination").}