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The strategic defense of physician autonomy: State public health agencies as countervailing powers

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ABSTRACT

Advances in genetic testing and the aggressive marketing of genetic tests by commercial diagnostic laboratories have driven both consumer demand and the need for unbiased information about how tests should guide healthcare delivery. This paper uses the countervailing powers framework to explore the role of state public health agencies as arbiters of quality and safety, specifically through their efforts to encourage physicians to follow evidence-based recommendations for screening for hereditary cancers. Social scientists have often viewed actions by the state to regulate cost, quality, or safety as a threat to physician autonomy. This paper draws on case studies from two US states—Michigan and Connecticut—to better understand the specific role of state public health agencies, and especially whether their activities to encourage adherence to evidence-based recommendations bolster or subvert the interests of other parties in the healthcare arena. We find that lacking authority to compel provider to follow evidence-based recommendations, they improvised ways to foster compliance voluntarily, for example, by emphasizing the role of the physician as gatekeeper, thus affirming the importance of physician autonomy and clinical judgment. Both states also used public health surveillance data to make rare diseases visible and illustrate gaps between recommendations and practice. Finally, they both showed that following evidence-based recommendations could align the professional and market interests of healthcare stakeholders. Both states employed similar strategies with similar effects, despite substantial differences in the regulatory climate and organizational capacity. Taken as a whole, their activities orchestrated a countervailing response that checked the profit-seeking motives of commercial laboratories. Our findings demonstrate that rather than eroding physician autonomy, state action to monitor healthcare quality and encourage adherence to evidence-based recommendations can actually reinforce physician authority.

1. Introduction

The high expectations for personalized medicine that dominate the post-genomic era and the aggressive marketing of genetic tests by commercial laboratories have created the need for unbiased information on how to use genetic tests to improve healthcare delivery. To promote healthcare quality and ensure the appropriate use of these genetic tests, expert panels have issued evidence-based recommendations on using genetic tests to identify patients who may be at especially high risk for disease. Efforts to direct healthcare quality—whether through issuance of evidence-based recommendations or alternative mechanisms—do not, however, influence healthcare delivery as rapidly as we might expect (Greenhalgh et al., 2014; Timmermans, 2010). In the United States, federal and state public health agencies have launched educational programs, surveillance projects, and policy initiatives to monitor and promote appropriate use of genetic testing, viewing these projects as related to their mission of improving overall population health. In doing so, they have positioned themselves as an "honest broker," to disseminate unbiased information about the appropriate use of genetic tests (Bowen et al., 2012; Khoury et al., 2011).

These efforts by federal and state health agencies provide a new vantage point for understanding how efforts to monitor healthcare quality may trigger conflict in the healthcare arena—especially

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longstanding tensions between physicians (who view themselves as professionals and who therefore expect autonomy and respect in their professional clinical judgment), and governmental regulatory agencies (who have, with increasing regularity, exercised state power to ensure healthcare quality and control costs). Medical sociologists and health policy scholars have drawn upon Light's (1991) countervailing powers framework to understand both conflict and cooperation in the healthcare arena; this line of research has often viewed innovations such as evidence-based recommendations as mechanisms for curtailing professional autonomy. In this paper, we apply the countervailing powers framework to identify the strategies that public health agencies use in promoting healthcare quality. To date, medical sociologists have largely ignored the role of public health agencies in the healthcare arena. We argue that the countervailing powers framework could be applied to this phenomenon, and even be expanded in two ways. First, we argue that sociologists should view the state as a multifaceted entity made up of organizations that occupy specific bureaucratic niches (e.g., agencies that license or regulate healthcare practitioners vs. others that monitor and promote public health). Specifically, sociologists should recognize that public health agencies generally wield less power in the healthcare arena than agencies that issue licenses or pay for healthcare services, and may therefore need to adopt a cooperative, rather than conflictual, stance in relations with physicians. Second, we argue that sociologists should examine variations in organizational capacity across states, which might produce variations in health policy and clinical practice in different regions of the US.

To address this gap, we present case studies of two state public health agencies—Michigan and Connecticut—and analyze the repertoire of activities they have developed to promote compliance with evidence-based recommendations for genetic testing, specifically for hereditary breast and ovarian cancers (HBOC). HBOC screening is an interesting application that straddles both the clinical and public health realms. Since the discovery of the BRCA1/2 genes in the mid 1990s, patients and providers have had to negotiate the utility of genetic testing in directing clinical care for individual women, i.e., whether a woman could benefit from early screening or surgical intervention. Over time, various professional societies have issued recommendations to regularize HBOC screening for high-risk women, at least for women with a family history of the disease (U.S. Preventive Services Task Force, 2013). Because early action on HBOC screening has preventive potential, however, it is also relevant to public health, and public health policymakers have begun to promote adherence to evidence-based recommendations for HBOC screening as a means of reducing overall breast cancer morbidity and mortality (Khoury et al., 2011; U.S. Preventive Services Task Force, 2013). This paper addresses three research questions: first, what strategies do public health agencies use to promote adherence to evidence-based recommendations; second, do variations in organizational capacity across states necessarily lead to different strategies to promote evidence-based practice; and third, how do state health agencies align their own interests with the interests of other stakeholders in these endeavors.

2. Background

2.1. The countervailing powers framework

Medical historians and sociologists have documented the complex and variable relationship between the state (writ large) and the medical profession. These narratives often depict the early decades of the twentieth century as a 'Golden Age of Medicine,' when physicians exercised complete discretion over clinical decision-making (Freidson, 1970; Starr, 1982). During this era, the state played an essential role in enhancing medical professional authority by granting physicians an exclusive right to practice through licensure. The state also curbed competition by disreputable practitioners, regulated the patent medicine industry, and limited healthcare delivery in public health clinics (Starr, 1982). This endowed physicians with tremendous power and allowed the profession to pursue its professional and economic self-interests unchecked for decades, unfortunately resulting in variable healthcare quality and escalating healthcare costs (Light, 2000). These problems led to what Light and others have described as the 'Buyer's Revolt,' or a rebalancing effort by other parties in the healthcare arena (especially purchasers such as the state or private insurers, most visibly with the passage of Medicare in the 1960s) to influence clinical decision-making and thus improve patient outcomes and curtail costs (Light, 1991, 2000).

In response to these fluctuations in physician autonomy, Light's (1991) countervailing powers framework was developed to explain shifting power dynamics among actors in the healthcare arena. This framework has generally depicted physicians as increasingly embattled, with external actors—especially the state—posing escalating demands for accountability, cost effectiveness, and quality of care, potentially encroaching upon medical authority and eroding professional autonomy (Hafferty and Light, 1995; Light, 1991; Starr, 1982). Fields or arenas are, however, inherently dynamic. The healthcare arena has become populated by a growing number of organizational, professional, and institutional entities: not only healthcare professionals and state regulatory agencies, but also third-party payers, patient advocacy groups, and pharmaceutical or biotech companies.

A key element of the countervailing powers framework holds that as one party accumulates power, other actors will "muster their forces in an attempt to control the first" (Light, 1991, p. 500). The goals and interests of these actors sometimes meet and sometimes diverge, allowing for "significant alignments," which may be coincidental or deliberate (Light, 2000, p. 203). For example, recent work has shown that various actors in the healthcare field, including physicians, state regulatory agencies, medical professional societies, medical schools, and medical journal editors have orchestrated a countervailing response to curb abuses by the pharmaceutical industry (e.g., influencing physician prescribing practices by offering commercial inducements or ghost-writing articles that position their products favorably in medical journals; Angell, 2000; Relman, 2007; Studdert et al., 2004). But although recent scholarship has applied the countervailing powers framework to study conflicts and allegiances between the medical profession and the pharmaceutical industry (e.g., Busfield, 2010), medical sociologists have largely ignored the role of public health agencies in the healthcare arena. And because public health activities in the US are directed at the state level, we also do not know how state-level variations in public health policy may produce regional variations in healthcare quality.

2.2. Evidence-based guidelines as a means of promoting healthcare quality

In addition to understanding power relations within the healthcare arena, the countervailing powers framework may also be used to understand the types of systemic dysfunction that produce substandard care and lead to poor health outcomes, as well as the quality improvement initiatives that have sought to eliminate medical errors and improve healthcare quality (Zuiderent-Jerak and Berg, 2010). Quality improvement research has often examined efforts to standardize healthcare, sometimes through the imposition of specific performance metrics and other