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Professionalism: An Archaeology

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Abstract

For more than two decades, classes on "professionalism" have been the dominant platform for the non-technical socialization of medical students. It thus subsumes elements of previous foundation courses in bioethics and "medicine and society" in defining the appropriate relation between practitioners, patients, and society-at-large. Despite its importance, there is, however, no clear definition of what "professionalism" entails or the manner in which it serves various purported goals. This essay reviews, first, the historical role of the vocational practitioner in society, and second, the introduction of "professionalism" as a newly constituted, core value in teaching. The structure of the paper is as an archaeology, a Foucauldian term for an investigation of seemingly separate but related antecedent contexts and ideas whose result is a perspective or point of view. The goal thus is an attempt to precisely locate "professionalism" within the greater history of medicine and its contemporary role in medical socialization.

Keywords Bioethics · Hippocratic Oath · Medicine · Professionalism · Burn-out

Almost 30 years after "professionalism" was introduced into medical discourse as a means of promoting the "integrity of internal medicine" (Edelman and Byszewski 2014), nobody is quite sure what the noun means or the precise nature of the integrity it seeks to advance (Swick 2000). And yet, since "Project Professionalism" was launched in 1995, professionalism as a general, foundation course in medical schools has been adopted internationally (Holden et al. 2012). Its referent is not technical competence or accountability, areas of expertise supervised by bodies of clinical practitioners (Cassel and Holmboe 2008). Rather, as *Merriam-Webster Dictionary* puts it, the noun thus generally describes "the conduct, aims, or qualities that

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characterize or mark a profession or a professional person" in "a calling requiring specialized knowledge and often long and intensive academic preparation" (*Merriam Webster* 2018).

What those aims or qualities should be in medicine—and how they might be promoted—has long been a subject of considerable debate and uncertainty (Pellegrino 1979). Are they grounded in a metaphorical social contract never actually negotiated with the greater society (Cruess and Cruess 2008) or in a practical perspective promoting the long-term maturation and satisfaction of the practitioner (Cohen 2007)? Do they advance a specific "virtue" ethic governing practice and, if so, what are the principles underlying that ethic (Brody and Doukas 2014)? Or, perhaps, the referent is to a kind of efficient, entrepreneurial approach to clinical practice (Hafferty and Castellani 2010).

Are all those possible definitions consistent or conflictive and, if so, can the conflicts between them be resolved? If professionalism is somehow *all* these things how can their relative importance be ordered?

To unravel these competing skeins of meaning, I employ a kind of Foucauldian "archeology" in which a noun's various referents are assessed so their contemporary influence can be revealed. From this perspective, medical professionalism, as it is understood today, is a means to solidify a redistribution of ethical and practical resources from medicine's traditional focus on the practitioner's care of the person to the economics of care. This shift continues an attack on traditional, Hippocratic medical ethics of care by moral philosophers, bioethicists, who beginning in the 1970s successfully sought to insert themselves as principal adjudicators of medical decision making and social policy.

Michael Foucault

For those perhaps unfamiliar with Foucault's writing, a brief introduction may be helpful. A twentieth century social critic and historian, he sought "to assist people in finding new ways to conceive of their relationships to themselves and with each other, and their imbrications in relations of power…." (Tremain 2005, p. 1). In attempting to construct a "history of the present," Foucault advanced what he called an "archeology of knowledge," seeking antecedent ideas that together created the "genealogy" of otherwise taken-for-granted ideas. The result, when successful, is a kind of intellectual "archipelago" in which a series of seemingly distinct but in fact related ideas and their histories creates a single, integrated cognitive structure (Foucault 1980, p. 68). The result is a system of social rules based on antecedent histories whose result always is contingent rather than inevitable. As such, it is therefore malleable (Gutting and Oksala 2018).

A principal focus of Foucault's writing was "biopolitics," a noun first coined by Swedish political scientist Rudolf Kjellén, to describe the intersection between politics and life (Esposito 2008, p. 16). This focus has more commonly been used to identify the means by which marginalized populations are first defined and then socially discounted. Its application here to physicians, while unusual, implies modern professionalism and its bioethical antecedents represent a marginalizing force

that reduced rather than enriched the ethics of medical practice, shifting its focus from patient care to an economic vision of a greater, social good.

While medicine has always had economic and political dimensions, the argument will be that professionalism enshrines a business-education model of medical socialization and supervision in which acceptance of and conformity to an economically focused, bureaucratic social agenda dominates (Reid 2011).

Profession: The Beginning

The *Oxford Living Dictionary* defines profession first as any "paid occupation, especially one that involves prolonged training and a formal qualification" (Oxford dictionaries.com 2018). Professionals, therefore, are simply those assumed to be "competent, skilful, and assured" in a particular practice. It is in this sense that one talks of a "pro" who is not only accredited as competent but is also recognized as technically expert. Beneath and antecedent to that definition is the idea of profession as a statement of beliefs and allegiances that define the relation of the practitioner not only to his or her area of expertise but to and in society at large. The Latin root here is *profiteri*, to profess or declare publicly and came, in Middle English, to describe vows made on entering a religious order. In this sense, professions are bodies of persons sharing both a skill set and a defining, declared moral perspective governing its application.

Hippocrates

The first profession, in this sense, was the medicine advanced by Hippocrates of Cos (460–370 BC) (Koch 2012, pp. 23–31). The Hippocratic Canon was a systematic ordering of medical knowledge that included a covenant defining the ideals of its practice. Central to that was the now famous Hippocratic Oath sworn by all students at the beginning of their studies and one to which, as practitioners, they ever after expected to bear allegiance. The Oath received neither theological endorsement nor state acceptance but instead was, as Sherwin Nuland put it, a "pledge of trust rather than a priestly document" (Nuland 1995, p. 27). The trust it professed to engage was that of the individual patient, and through him or her, that of society-at-large irrespective of a patient's economic standing or social position.

The Oath begins with an introduction followed by three distinct but related parts. It first invoked "all the Gods and Goddesses" of the Greek Pantheon to witness the covenant. In effect, that evocation can be understood as simply "by all we hold holy" and not a vow to any specific deity or pantheon. At varying times Christian, Jewish, and Muslim versions have removed that reference, substituting others, but otherwise held closely to the original text (Jones 2003). In modern versions recited today, the early evocation is generally abandoned in favor of other, more contemporary ecumenical values. That said, The Oath remains today a widely recited incantation repeated not at the beginning of medical studies but in graduation ceremonies at medical schools around the world (Markel 2004).

In subsequent sections and until recently, the Oath presented an ethic that remained largely unchanged even as medical practice changed, country to country and century to century. The Oath committed practitioners to a respect for their teachers and thus for the medical knowledge they sought to impart. It then articulated as the *summum bonum* of medicine the care of persons as the principal vocational virtue and the primary obligation of all practitioners. Third, the Oath promoted a collegiality among Hippocratic physicians. Even then, as Hippocrates knew, no one physician could know it all. The care of persons required the shared knowledge of other practitioners.

"The distributive logic of the practice of [Hippocratic] medicine seems to be this: that care should be proportionate to illness and not to wealth (Waltzer 1943, p. 86). Care of the person was advanced as a communal virtue enacted by practitioners rather than as an entrepreneurial opportunity. And because Greek society did not distinguish absolutely between the person and the community-at-large–one was indivisibly linked to the other—care of the person was understood within a context of a greater social good. While physicians presumably were paid for their services, The Oath makes no comment on remuneration, promising only that those who fulfilled their covenant would enjoy a satisfying life and the gratitude of fellow citizens. This became what sociologists call a "foundation myth" defining "a common persona for those collectively engaged in a singular activity through the expression of a specific expertise" (Parsons 1951, p. 22). The result was a vocational imperative to care irrespective of all other considerations. Foucault, for his part, called it a kind of "technology of the self" by which a person constitutes him or herself in an active manner that reflects a specific ethic, ideal, or social perspective (Hancock 2018).

Professionalism: Histories

Biopolitics is nothing new. Physicians have always existed in society, not apart from it. They have thus necessarily been to some extent influenced by social values and their bureaucratic imperatives. What is permitted and what is forbidden—abortion, forced sterilization, or medical termination, for example—have always been subjects of social as well as clinical debate. Similarly, medical officials and political representatives always have been joined in the conception and implementation of public health measures from the Roman aqueducts, perhaps the first public health project, to the battling of epidemic incursions. Simply, individuals exist in society and their health is in part dependent on shared social perspectives and political initiatives.

Still, within this complexity, medicine as a vocational service remained largely independent. In its focus on patient care, the physician was enjoined to consider first a specific rather than a general public good, the health and care of the individual seeking their help. The trust this promoted was focused upon the duties of the practitioner to a patient and on, secondarily, to society at large. The result endured as the ethical heart of medicine for more than two millennia across a remarkable range of societies.

In the late Middle Ages, other technical groups developed skills-based craft guilds tasked with the training of new members and a general supervision of their

performance. These were typically recognized by and granted license by the governments of the day and thus more or less beholden to them for their existence. Guild charters typically lacked a moral declaration of caring service similar to medicine's, however. Exceptions were acolytes who, entering religious orders, swore vows of obedience to church hierarchies and military inductees who swore obedience to superiors and thus to their rulers. Only law, as it evolved, included a statement that set those "called to the bar" to a higher purpose: allegiance to and a defense of the ideal of law itself.

In the late 1700s, the Hippocratic injunction to care was interpreted by some as a call to civil participation and social activism. These physicians were in the main sanitarians who believed that the health of their patients and more generally all fellow citizens was adversely affected by the lack of clean water and efficient sewage disposal in the evolving urban environment. In the United States, some like Dr. Benjamin Rush, a signer of the US Constitution, sought political office as a way to advance Hippocratic goals of care (Koch 2017, pp. 34–36). Others, like New York City's Dr. Valentine Seaman, would join then new, local health boards to help cities and states address the challenge of emerging epidemic diseases like yellow fever (Koch 2017, pp. 26–33).

It is likely that a tension between the entrepreneurial aspirations of individual physicians and the social ethic of Hippocratic care was always evident in practice. During plague epidemics in England and elsewhere, for example, some physicians fled to avoid contamination while others remained to serve their patients. That said, a "technology of self" grounded in The Oath gave a popular grounding to the ideal of medicine as a specific vocational service focused on patient care and, secondarily, the health of society-at-large.

Gradually, tensions erupted in England and then elsewhere as "the placement of the old aristocratic system" based on hereditary privilege and land ownership was replaced by a "meritocratic civil service" composed of managerial and professional experts in increasingly capitalist societies (Perkin 1989, p. xiii). The older system relied on social standing as the primary credential for scientific credibility as well as for bureaucratic authority. The Royal Society of London, for example was founded in 1660 as an "invisible college" of "natural philosophers" and physicians. Its motto, *Nullius in verba*, expressed a determination to verify all statements by an appeal to facts determined by experiment.

It was assumed, however, that only those of the landed class would be capable of studied, technical and thus verifiable advances. So, when eighteenth century carpenter and watchmaker John Harrison created a watch sufficiently accurate to be used in longitude at sea, officials were reluctant to award him prize money set aside for this achievement. He was, after all, a commoner: just a watchmaker (Brown 1956, pp. 807–819).

During the increasingly industrial nineteenth century, however, a meritocratic system came to dominate. Universities spawned departments dedicated to individual scientific and social enterprises whose graduates would be the new bureaucrats and recognized authorities in emerging disciplines. Here, to make a long and complex history impossibly short, ideas about professionalism in its modern sense were born.

The result was two opposed perspectives (Perkin 1996). Some experts advanced economic growth as the principal focus of an evolving capitalist, industrializing society. Medicine in this new order would necessarily bow to that agenda. Thus, for example, some argued that the importation of cholera in the 1830s was preferable to quarantines resulting in expensive trade restrictions (Lancet 1831). Others argued social justice and social cohesion should be the primary ideals that governed both medicine and society. In this context, patient care would remain a preeminent vocational goal. Not for the last time, the necessities of public health and patient care were challenged by those who believed cost accountancies were the primary goal, a new virtue in itself.

Both perspectives can be found in Edmund Chadwick's monumental 1842 *Report on the Sanitary Condition of the Labouring Population of Great Britain*. It included the testimony of physicians who argued strongly for civil health care reforms to fight the systemic poverty adversely affecting their patients, and more generally, public health in general. Vocational care was from this perspective a matter not only of individual obligation but of social medicine writ large. As one physician, Dr. John Ferriari, put it, "The safety of the rich is intimately connected with the welfare of the poor… minute and constant attention to their wants is not less an act of self-preservation than of virtue" (Hamlin 1998, p. 70). Thus, a focus on patient care would answer, at one remove, the needs of the greater society.

In service of individual patients, and in conformity with the Hippocratic ideal, some physicians billed their parishes for "ample doses of mutton, ham, and wine" they prescribed to the poor (Hamlin 1998, p. 95). Managerial, economically inclined officials saw this as inappropriate if not also illegal. Others, however, like the General Registrar Office's medical statistician, apothecary William Farr, insisted physicians were obliged to use all available means to promote the health of their patients and thus of communities-at-large.

The continued independence of medicine from officialdom meant physicians were free to act not only as advocates for health reform but also as critics of officialdom. Rudolf Virchow's famously withering report to Prussia's King Frederick Wilhelm IV is but one example. Virchow was assigned by his monarch to investigate a horrific epidemic of typhus in Silesia. What was supposed to be an officially sanctioned, technical report became a blistering condemnation of state policies that, Virchow concluded, resulted in the poverty that was the base cause of the subsequent ill-health of the Silesians. "Medicine is a social science and as the science of man," he declared, "has a duty to perform in recognizing these [structural] problems as its own" (Nuland 1995).

Twentieth Century: The Turn

The Hippocratic ideal sat at the heart of this "social science" until the 1980s when US President Ronald Regan and British Prime Minister Margaret Thatcher promoted a neoliberal agenda emphasizing economic growth, profit, and system efficiencies as the principal goals of government (Peck 2010). "The true terror of this new order has to do with its being ruled—and observed to be ruled—by the sheer concatenation of

profit and loss, bids and bargains: that is, by a system whose focusing purpose or compelling image or reutilization is of that purpose" (Clark 1999, p. 7).

Bioethics

This shift in focus from care of the citizen to a general economic focus was embraced in medicine by a then new managerial class: bioethicists. To gain organizational acceptance, most embraced the new neoliberal, economic order. As a former president of the American Society for Bioethics and the Humanities, Mark Kuczewski (2010) put it: "To solidify their position, bioethicists had to align themselves with money and power."

Bioethics began as a response to a series of technical advances—from dialysis to organ transplantation—which raised questions of allocation in a context of scarcity (Jonsen 2004). Bioethicists argued that medical practitioners were unschooled in disciplines that might prepare them to make complex decisions on allocation in a context of scarcity. The ethicists' training in principled, moral philosophies presumably provided them with the expertise required to direct and supervise both social policies governing health care and to adjudicate controversies arising in medico-legal disputes. Practically, this new biopolitic ignored the traditional Hippocratic ethic, insisting instead on a set of general virtues (autonomy, beneficence, non-malfeasance) somehow to be enacted within the context of an economic vision of social constraint. Clearly, however, for bioethicists the collective good overshadowed care of the individual patient. Co-founder and director of the Hastings Center, Daniel Callahan, for example, chastised physicians for their focus on the individual patient. They should instead, he argued, focus on "the common good and collective health of society, not the particularized good of individuals" (Rothman 1992, p. 33).

To promote this agenda, Callahan and others (for example, McCullough 1983) devaluated the status of physicians as anything but technical experts whose knowledge base was insufficient to order medical services in a neoliberal society of limits. Vocational responsibility for patient care thus became necessarily secondary to institutional priorities (those of insurers, pharmaceutical companies, etc.) and political agendas. The real hero of this new biopolitics—and here the Foucauldian noun is precisely correct—was not the caring professional but "the risk taking entrepreneur who creates new jobs and better product" (Peters 1983).

Although bioethicists promoted patient autonomy as a principal virtue (Beauchamp and Childress 1979), what persons might wish was in practice usually an at best secondary concern. Bioethicists applauded as "rational," for example, 1990s British physicians who, faced with cost restrictions imposed under National Health Service guidelines, chose to triage treatments based on a patient's age (Thomasma 1987, p. 249). More generally, the dominion of economic ends over the primacy of patient autonomy and need was the motive force for what now are sometimes called "tissue economies" (Waldby and Mitchell 2006), in which questions of treatment answer first to the priorities of pharmacological, research, and other corporate medical interests and objectives (Fisher 2009).

There is irony here. Many bioethicists advanced their own engagement with a recitation of the excesses of research physicians experimenting on patients without their consent or knowledge. These included those treating indigent syphilis patients in the Tuskegee experiments (Vonderleht 1936); the hepatitis infection of intellectually challenged students at Willowbrook State School (Lysaught 2009); and the general use of medically needy poor patients as research objects in medical research (Skloot 2011, pp. 29–30). These sorry events were submitted as evidence that, as a class, practitioners required oversight and civil restraint. Those violations of traditional Hippocratic values arose not in the arena of general practice, however, but within the context of research agendas bioethicists themselves later embraced and promoted.

In recent years, for example, a pantheon of bioethicists have argued for an enforceable, civilian obligation to participate in pharmaceutical company human research trials irrespective of an individual patient's wishes (Koch 2012, pp. 201–203). They argue the future good potentially achieved—for both pharmaceutical companies and the public—must trump an individual's freedom to refuse participation. Irrespective of a physician's recommendations, patient's "best interests" thus would become subservient to the needs of industry and its research agendas. Not inconsequently, the call for mandatory participation would require practitioners to act as shills directing patients to research programs seeking test subjects, a practice in place today in the U.S. where treatment for some is dependent on participation in one or another research protocol (Fisher 2009).

Professionalism

Since its earliest days, bioethics has been criticized by some as a "leftist enterprise" and by others as a commercially grounded abandonment of a traditional ethic of care (Koch 2012). Critiques from both left and right have at various times disparaged its narrow conceptual framework, its understanding of the realities of medical practice, and the refusal of many bioethicists to acknowledge divergent points of view. More generally, bioethicists focus is not on a patient's clinical outcome. Rather, they ask, "How effective is this bioethical approach" intellectually and within an institutional framework of priorities (Dopken 2018, p. 46). As another author said, in a riff on Mahatma Gandhi's famous comment on democracy, a true bioethic is a grand idea we should, someday, consider (Koch 2008).

What became clear was that bioethicists, typically trained in moral philosophy, typically lacked not only clinical experience but, more importantly, economic and managerial training. It therefore became necessary to fold its perspective into a broader instructional curriculum that would serve the emerging, new neoliberal economic ethos. Professionalism, an instructional model based upon corporate, management-science programs, was the result (Lave and Wenger 1991). The clear goal was the "professional identity formation" (socialization) of young practitioners (Holden et al. 2012) and eventually medicine at large, to a perspective in which patient needs and practitioner satisfaction were bounded by a conformal, "socially negotiated" (or dictated) value set (Daniels 2008). It was conformal in the sense that

while it advocated physicians embrace a series of bioethical and social virtues it took as given bureaucratic, economic, and political contexts that might impede their inaction but which themselves were neither challenged nor questioned. And, too, at worst, in the words of one physician, "At every level, dissenting voices are actively suppressed and differing views are misrepresented and demeaned" (Cottle 2018, p. 12).

In promising to institutionalize the "highest behavioral and ethical standards" of practitioners, proponents suggested the new professionalism simply followed upon the ethical tradition first articulated in the Hippocratic Oath (Sohl and Bassford 1986). That, however, was clearly incorrect. Traditional medical ethics were neither contractual nor negotiated but solely vocational, setting the caring relationship of patient and physician apart from economic agendas and political priorities. But like bioethics, professionalism from its inception has been a pragmatic response to and an embrace of "the pressures of the marketplace" (Hendelman and Byszewski 2014) in a society that increasingly defines "all human relationships… as business arrangements" (Brody and Doukas 2014, p. 981). Indeed, a new book on teaching medical ethics, employs a teaching model developed for business students, one which is short on ethical ideals and focused on workplace pragmatics (Bedzow 2019).

Outcomes

Historically, disaster has been the near inevitable result when traditional medical values were superseded by economic or political priorities. The forced sterilization of mostly poor, illiterate women following the 1927 U.S. Supreme Court decision *Buck v Bell*, was one example. In his majority opinion, Justice Oliver Wendell Holmes argued its necessity for the economic well-being of the state. Another was the participation of German medical practitioners in the genocide ordered by Nazi officials on ethnic and racial grounds in World War II. A modern echo of that horror was the participation in recent years by military and civilian medical personnel at U.S. torture sites like Abu Ghraib. This was certainly an "oath betrayed," a violation of codes of medical conduct and principles (Miles 2006). But in practice, those engaged were beholden first to military directives originating with the U.S. President rather than ethical medical values. To refuse participation would have resulted in severe personal consequences, from dishonorable discharge to extended incarceration (Koch 2006).

In the same vein, the integrity of medical conscience and its vocational values is now under attack from those who insist physicians accept the dictates of legal and social agendas irrespective of conscientious (and clinical) objections. "Licensing bodies for physicians and other health care professionals are mandating that we 'check our morality at the door' and provide, or at least refer for, any legal service that the patient wants—even if we have reasonable evidence that the so-called 'service' might harm our patient" (Cottle 2018, p. 12). Bioethicists like Great Britain's Savulesqu and Schüklenk (2016), see little problem with this, insisting it is "unprofessional" for practitioners to refuse a service.

The problem is fundamental and reflected in the language distinguishing commercial services from clinical treatments. If physicians are mere technicians, then their reservations and recommendations can be safely discounted in the provision of this or that commercial service. If, however, medicine is a vocation that professes an ethical standard of engaged care, then a practitioner's view of the best care for a patient becomes desired, defensible, and protected.

Moral Distress

Nineteenth century tensions between medicine as a business and as a humanist, patient-centered vocation thus were revisited at the end of the last century with a vastly different outcome. As a direct result, "The 3000 year old tradition, which bonded doctors and patient in a special affinity of trust, is dying as caring is supplanted by managing" (Rich 2018). While in theory professionalism seeks to instill traditional trust-generating virtues, as Brody and Doukas (previously cited) assert, the promotion of those vocational perspectives increasingly is lost in the realities of practice.

There is no simple metric to assess the effect of professionalism as it has overtaken traditional vocational medical ethics. In theory, it promotes the long-term maturation and satisfaction of practitioners (Brody and Doukas 2014). But at least for some, and perhaps many, "The re-engineering of healthcare to give precedence to corporate and commercial values and strategies of commoditization, service rationing, streamlining, and measuring of 'efficiency,' is demoralizing for health professionals and students" (Austin 2012).

What some have called a "hidden curriculum" disavowing vocational goals in favor of other priorities is a reported source of moral distress among medical students whose vocational expectations are confounded by the realities of contemporary medicine in a neoliberal environment (de Carvalho-Filho 2018). As a foundation medical student in Great Britain reported, real patient engagement and the satisfaction that comes from it is sometimes discouraged as "unprofessional" even when it has a clear therapeutic rationale (Koch and Jones 2010).

Others have argued the distance between vocational values and practical constraints on care contribute to drop-out rates among students and either "burn-out" or early retirement among practitioners. The result is less "burn-out"—a kind of ennui—however, than a moral injury implicated by some in the high rates of suicide among practicing physicians since the 1990s (Talbot and Dean 2018). In the United States, physicians are more likely to commit suicide than U.S. military veterans (28-40 versus 20.6 per 1000,000) (Anderson 2018). Compared to the general population, physicians are nearly twice as likely to commit suicide than their patients, 1.87 times higher than the average American (Hoffman and Kunzmann 2018).

Discussion

The interlinked islands of this historical archipelago of ideas can now be seen and with it the genealogy, in Foucault's language, of professionalism in medical education. Historically medical education, ethics, and science were closely associated in an island chain called "vocational medicine" that was independent of but broadly linked to the greater bodies of political and social interests. In the last half of the twentieth century, integrity of this island set was breached as economic priorities came to dominate the politics of patient care. This tectonic shift was encouraged by bioethics, a new managerial island. It has been, in its turn, enfolded into a separate entity, "professionalism."

While the system may advance entrepreneurial aspirations and the goals of corporate interests, it does so with only token support for the ethical focus of traditional vocational medicine. It certainly does not promote long-term satisfaction of physicians whose goal is the increasingly "lost art of healing" (Lown 1999) or the primacy of care as a practical good. While retaining both legal and moral responsibility for the care of persons, the duty and right of physicians to act in the best interest of this or that patient has thus been diminished. Power without responsibility is dangerous; responsibility without power is vacuous. That is the dilemma of the Hippocratic professional today.

Perhaps the greatest damage of the new reality is that it inhibits the tradition of physician advocacy, both for the patient and in society at large. The metaphorical social contract presents the status quo as an accepted element and one therefore not open to modification and certainly not to contractual negotiation (Reid 2011). It reduces the formerly dominant ethical obligations of practitioners to a conditional agreement dependent on bureaucratic accountancies and directives.

The argument that this is economically necessary is false. Because resources are not infinite does not mean they need to be limited. The relationship between corporate entities seeking profit and the needs of the citizenry is malleable. Resource allocation need not favor the first over the second. But within the contemporary neoliberal framework the assumption of limits is assumed, corporatism is a given, and the need for priorities beyond patient care thus becomes inevitable. Similarly inhibited are the legitimate interests of any who might argue that a rebalancing of priorities would be at once less expensive, more efficient, and more likely to permit the kind of vocational ethics that in theory professionalism accepts but does not promote, not really.

Essential to the Foucauldian perspective is the conclusion that the historical result of socioeconomic forces are not inevitable and therefore are not immutable. Archaeologies and genealogies tell us how we got here and imply we are free to change direction if we wish. A reformation would start with a rejection of the ideal of a metaphorical social contract that was never negotiated and assumes ethical expectations and an economically grounded politic easily coexist (Harris 2017). That said, a discussion of potential levers for change and the means by which a reformation of the role of the Hippocratic physician in society could be achieved is beyond the limits of this paper. At the least, however, one can now

point to professionalism's dubious history and at best equivocal performance in fulfilling its stated goals. The hope is that this paper will invite critical discussion and a strenuous evaluation of a still ill-defined professionalism and its role as a counterproductive centerpiece of medical education and thus eventual medical practice.

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