Research in the Service of Ideology: the Israel Medical Association according to the Kohelet Forum

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It is not clear how one should relate to the Kohelet Policy Forum. On the one hand, the forum calls itself a “research institute.” This finds expression, for example, in its use of conventional rules of writing in the world of research, such as footnoting. What is more, professionals who self-identify as researchers affix their names to its publications. Conversely, Kohelet pursues an explicit economic agenda that it calls “deepening the principles of the free market.” What this really means, as review of its publications shows, is dismantling the welfare state, the state reneging on its responsibility for its citizens, and doing away with trade unions, viz., imposing an extreme version of market economics on Israeli society. But how does scientific objectivity fit into such a blatant ideological tilt? Well, it does not fit in and cannot fit in, because there is an unbridgeable contradiction between the two. The inevitable outcome is research in the service of ideology. This emerges clearly in the Kohelet Forum’s policy paper, “The IMA on the Operating Table—the Role of the Israel Medical Association as a Link in the Healthcare System.”

Fire first, sketch the target later

The main thesis in the paper is composed of two mutually supportive arguments. First, the Israel Medical Association (IMA) is *“one of Israel’s strongest labor organizations in terms of the number and strength of its powers.*” Second, the IMA uses its power in a way that inflicts harm on the healthcare system. The allegation of IMA’s excessive power is based on the fact that the IMA engages in diverse areas of activity and does not meet the definition of an “ordinary” labor organization—a feature that the rapporteur calls the Association’s “multiple hats”[1]. There is no disputing the nature of the IMA as, simultaneously, (a) a labor organization, (b) a body that regulates its area of specialization; (c) an umbrella organization for scientific associations. However, the interpretation of these “multiple hats” as something that gives the IMA excessive power, and the charge that the IMA uses this power in a way that harms the healthcare system, deserve critical examination.

The question of what “professional power” is and how it can be estimated is one of the most complex and fascinating in the social sciences. The multiplicity of facets in the concept of power, as well as the complexity of reciprocal relations between the professions and elements in the public sphere, government, and the business sector, make it very hard to offer an unequivocal answer to questions pertaining to the power of professions. This is all the more true when it comes to the medical profession. As evidence, in 2020, the selfsame organization—the Kohelet Forum—put out a policy paper dealing with the power of the Israel Bar Association [2]. To substantiate the allegation concerning the Association’s exceptional power, the author of the paper carried out an interesting comparison with other professional organizations in Israel, including the IMA. The upshot of this comparison is that the IMA is on one plane with most of the organizations, such as the Association of Certified Public Accountants, the Tax Consultants Bureau, and so on. This means that it does not have exceptional authority and therefore, also does not enjoy aberrant power.

How can it be that the same entity publishes, within two years or so, two publications that contradict each other? The answer is quite simple: first open fire and afterwards sketch the target. When the target is the Bar Association and its ostensible power, then you portray the Association as something that dwarfs all other entities, including the IMA. But when the spotlight is focused on the IMA, you inflate its importance to imaginary magnitudes. Unfortunately, this is easily done by putting the evidence to selective use. Consequently, the answer to the question of the extent of the IMA’s power depends on the elements that the researcher chooses to focus on or filter out—a tactic known in academic jargon as “cherry picking.”

For the author of the policy paper, the profusion of the IMA’s hats is a key to understanding the Association’s power and influence over the healthcare system, in disregard of the multiple regulatory aspects that point, contrarily, to the limitations to its power. As Green noted in his comparison of the IMA and the Bar Association: first, membership in the IMA is voluntary, meaning that a doctor need not belong to it in order to practice medicine. Similarly, the issuance of medical licenses falls into the purview of the Director General of the Ministry of Health in accordance with the Medical Practitioners Ordinance, and not to that of the IMA. The IMA is responsible for awarding expert certifications by means of its scientific council, but only because the Minister delegated their authority to it. Even so, the council is only an advisory body; the authority to certify belongs to the Ministry of Health. The Minister of Health, and not the IMA, also has the power to apply disciplinary sanctions against a doctor up to the suspension of his or her license[2].

In contrast, licensing and registration powers in many countries do belong specifically to the medical association. Furthermore, there are countries that require membership in medical associations in order to practice medicine (e.g., Germany, Austria, and Italy). Medical associations in various countries are responsible for carrying out disciplinary proceedings against misbehaving doctors, to the extent of revoking their medical licenses[3]. Additionally, the IMA has no control over the number of medical students in Israel—the institutes of academic are responsible for this—and least of all over the number of Israelis who attend medical school abroad.

At this point, Yael Yishai’s study is also worth noting. According to Yishai, the IMA does not have, and has never had, a partisan power base; therefore, it has not managed to weave a ramified network of political connections. Yishai adds to this the tendency of doctors around the world, and in Israel as well, to distance themselves from political issues and public activity[4]. In her extensive discussion of this question, Yishai points to the IMA’s decentralized structure as a potential source of weakness and not necessarily one of power due to the threat is poses to the Association’s internal cohesion—a threat that has intensified many times over since Yishai conducted her study due to the tendencies to fragmentation in the medical profession.

For good reason Yishai reached the conclusion that the IMA’s influence on government health policy is limited and that the IMA has no special status in the legislator’s eyes. This is evidenced, as stated, in the analysis that Green provides in his comparison of the IMA and the Bar Association. Similarly, Borow et al. showed that the IMA’s regulatory powers do not deviate from convention among corresponding associations abroad[3]. This is found again by Levi et al. in their international comparison of medical associations, including the IMA, in terms of their involvement in activities for the advancement of quality in the medicine profession[5].

Is the “multiplicity of hats” bad for health?

The “mythical” ability of the IMA to do almost anything it wishes in the healthcare system, as described in the document, is overstated in the best case and chimerical in the worst, to the extent of libeling the doctors of Israel and their organizations. For example, it is scandalously insinuated that the IMA board may order the skewing of doctors’ data that are shared with the Ministry of Health in accordance with the IMA’s interests—a groundless and very grave accusation. Needless to say, medical associations around the world collaborate with state authorities in gathering, monitoring, and processing data from medical personnel, including sharing them with international organizations such as the OECD, it being understood that reliance on government databases alone often yields an insufficient picture of the supply of medical human resources [6]. Should we infer from the policy paper that medical organizations around the world corrupt national and international databases intentionally?

The claim that doctors who hold executive posts at the Ministry of Health are beholden to IMA interests is also groundless. They do, of course, represent the Ministry of Health, but the IMA itself has no grip on the ministry. This argument is tantamount to saying that attorneys should not work for the Ministry of Justice because they belong to the Bar Association and, therefore, are tainted with conflict of interests. Similarly, CPAs—the Kohelet Forum would postulate—should not work in the public sector because they are members of the Association of Certified Public Accountants, and so on. From this standpoint, the Kohelet Forum’s attack on the IMA is actually an attack on the professions at large. Similarly, the allegation of inadequate representation of interns in wage discussions is groundless in view of the wage increases and grants that interns have received in order to attract them to occupations in distress and peripheral areas in the 2011 collective agreement [7].

Beyond all this, even if some concentration of responsibilities in the IMA’s hands exists, it does not constitute a blow to the healthcare system. On the contrary: as for the “first hat,” IMA’s identity as a labor organization, it is the state more than any other party that is interested in having the IMA continue to be a sole bargaining agent in order to prevent the chaos that the healthcare system would face if different doctors’ organizations decided to negotiate with the employers separately. Not for naught did the court rule, about a decade ago, that the IMA is the sole bargaining agent of Israel’s physicians [8]. In this respect, the IMA resembles the British Medical Association, for example [9].

As for the “second hat,” the regulator of medical specialization, the IMA’s responsibility for this field resembles that in Germany and the Netherlands. In fact, the IMA undertakes “voluntarily” to provide a state service of immense importance to Israeli society, as is accepted in other developed countries such as the Netherlands and Germany [3]. As for the “third hat,” the IMA’s role as an umbrella organization for scientific associations, the rapporteur totally disregards the great utility that this form of organization provides, especially for quality-sustaining activities such as writing clinical guidelines, position papers, and consent forms, since it is the IMA body that organizes, navigates, and regulates the creation of these documents for dozens of scientific associations and companies—thus preventing contradictions and conflicts among them.

In addition, the international comparison presented in the paper lacks is totally devoid of context. It makes no reference to the environment and the specific circumstances under which medical associations operate. This is an important dimension of comparative studies, one that may explain a medical association’s modus operandi and place in the political field. In Israel, for example, the aberrant power of the Ministry of Finance and the concentrated structure of the healthcare system—in which the state and two large HMOs (Clalit and Maccabi) are main employers that dominate the labor market—stand out. It follows that the existence of a cohesive and resilient medical profession as a counterweight may serve the public interest well.

Attention to critical questions for the healthcare system, such as developing medical-assistant and nurse-practitioner roles and formulating quality indicators, is an inseparable part of the IMA’s activity. Here, too, the position paper is inaccurate. For example, the rapporteur should have noted that the IMA was the first to place the medical-assistant question on the agenda for discussion back in 2009 [10]. In 2021, a committee tasked with examining the patterns of doctors’ work in hospitals, appointed by the IMA, recommended adding medical assistants to the healthcare system in order to make the hospitals’ work more efficient and facilitate reforms in specialization [11]. As for the nurse-practitioner question, the thesis constructed by the rapporteur totally collapses. The basic assumption in the report is that the IMA wields greater power than do its counterparts abroad. Since the IMA opposes the transfer of powers to the nursing profession, by implication Israel should be the last place where the profession of nurse practitioner should evolve. Amazingly, however, Israel preceded most European countries in passing legislation that would allow prerogatives to be transferred to nurses (and to pharmacists), for reasons associated with the thinking traditions of bureaucratic systems around the world as against professional dominance [12].

The discussion of the doctors’ opposition to quality indicators is also biased and one-sided. It should have left more room for the adverse implications of measuring and publishing personal outcomes in relation to quality of care and patients’ safety [13]. It is for good reason that many healthcare systems around the world are wary of publishing personal indicators, particularly in regard to health outcomes, in order to thwart negative competition between caregivers and healthcare institutions [14].

Hippocrates, not Adam Smith

The social sciences have come a long way in their attitude toward the medical profession. The regnant economic paradigm tends to reduce all human activity, including medical activity, to a profit-and-loss calculus that verges on absurdity, uncoupled from the range of human motivations for action. Over the years, however, other conceptualizations have taken a more sympathetic approach toward the professions generally and the medical profession particularly, emphasizing the importance of the “social contract” between those in the profession and the public at large. These mindsets assign the professions a key role in maintaining the stability of social and economic life and see their organizations as entities that avoid the bureaucratic rigidity of the state institutions, on the one hand, and the pursuit of profit in the business market, on the other [15].

Only more recently have more critical outlooks begun to rule the roost. They analyze a profession in terms of competition, professional insularity and power-hunger, *inter alia* under the influence of the ascent of extreme market approaches such as the one promoted by the Kohelet Forum. These approaches, typical of conservative circles in British and American politics and academia, are usually poorly suited to Israeli society. Truth to tell, one doubts that they are suited to their countries of origin as well. As the president of an American medical association once put it, “Our mentor has always been Hippocrates, not Adam Smith.”

A brief visit to the IMA website might have balanced, however slightly, the demonic manner in which the association is portrayed. Thus the reader might have learned about the IMA’s ramified public activity for the improvement of the public’s health, for example, by legislation to discourage smoking and encourage healthy nutrition, human rights, and medical ethics; advancement of health equity; and advocacy for the public-health system. The rapporteur might have added a “fourth hat,” standing for public activity. Presumably, however, that would not have squared with the agenda of the Kohelet Forum.

It bears emphasis that pertinent criticism of any institution anywhere should always be heard because it may lead to needed reforms and corrections—*a fortiori* in the case of an organization representing a profession that lives and breathes scientific judgment and criticism. What should not be accepted, and what must not become a norm in Israeli public life, is the use of pseudo-science to promote a politico-economic agenda. When an entity that aims to weaken organized activity to the extent of de facto obliteration by placing the representative organization of Israel’s doctors “on the operating table,” the outcome of this medical procedure is foreknown and its failure inevitable. In the world of medicine, such a surgeon would face immediate delicensing and even the IMA, with its three hats and its “egregious” power, could not offer salvation.

References

1. Maane S. The IMA on the operating table: The role of the Israel Medical Association in the ailments of the healthcare system, Kohelet Policy Forum, 2022 [Hebrew].
2. Green Y. Regulation of lawyers in Isreal; Analysis and a proposal for reform, Kohelet Policy Forum. 2022 [Hebrew].
3. Borow M, Levi B, Glekin M. Regulatory tasks of national medical associations - international comparison and the Israeli case, Isr J Health Policy 2013;2:8. <https://doi.org/10.1186/2045-4015-2-8>.
4. Yishai, I. The power of expertise: The Israel Medical Association. Jerualem: Jerusalem Institute for Israel Studies, 1990 [Hebrew].
5. Levi B, Borow M, Glekin M. Participation of National Medical Associations in quality improvement activities - International comparison and the Israeli case. Isr J Health Policy Res 2014;3:14. <https://doi.org/10.1186/2045-4015-3-14>.
6. Levi B. Re-registration and re-licensure of doctors as tools for planning of medical personnel: Why not in Israel? *Marot—Studies in State Control and Investigation of Public Complaints,* 2022:64 [Hebrew].
7. The Israel Medical Association—the 2011 agreement [Hebrew].
<https://www.ima.org.il/InternesNew/ViewCategory.aspx?CategoryId=4360>
8. Town building plan (Beersheva area), Subsection 67451-75-61, OHEL—Organization of Medical Interns Register vs. Assuta Ashdod, Ltd., and Israel Medicla Association (2019) [Hebrew].
9. UK Parliament. Memorandum by the British Medical Association (BMA). <https://publications.parliament.uk/pa/ld200304/ldselect/ldeucom/67/4022502.htm>
10. Israel Medical Association, Preparing for tomorrow’s medicine: an IMA initiative to cope with challenges to the healthcare system, 2009 [Hebrew].
11. Recommendations of the High Committee for Examination of Doctors’ Working Patterns and the nature of duty shifts in hospitals, 2021 [Hebrew]
<https://www.ima.org.il/Main/ViewContent.aspx?CategoryId=17133>
12. Levi B, Zehavi A, Delegation of clinical authority, administrative culture and policy adoption: A comparative analysis. Journal of Comparative Policy Analysis: Research and Practice 2017;19:3: 227-244.
13. Israel Medical Association, Quality indicators in medicine, 2016 [Hebrew].
<https://www.ima.org.il/healthsystembook/ArticleDetails.aspx?aId=9>
14. Rechel B et al., Public reporting on quality, waiting times and patient experience in 11 high-income countries, Health Policy 2016;120(4):377-83. doi: 10.1016/j.healthpol.2016.02.008.
15. Saks M, Professions and the Public Interest, London: Routledge, 2005.
16. Starr P, The Social Transformation of American Medicine, New York: Basic Books, 1982[2017].
1. Israel Medical Association. [↑](#footnote-ref-1)
2. Dalla Lana School of Public Health, University of Toronto. [↑](#footnote-ref-2)