

The Erosion of Professional Authority: A Cross-Cultural Inquiry in the Case of the Physician

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The extent to which the erosion of professional authority observed in the United States is also occurring in the United Kingdom and the U.S.S.R. is examined in the case of the primary care physician. Informal interviews with health practitioners in these diverse societies revealed that the model of the professions which bases physicians' autonomy and authority on the occupational characteristic of a monopoly of specialized knowledge is subject to some revision. Education of the patient emerged as a critical factor in eroding physician authority in both countries, while patient age affected authority relations differentially in the two societies. Despite variations in the level of bureaucratization of health care, the role of the physician, as gatekeeper to non-medical benefits, served to counteract the erosion trend in both. The legacy of deference to the upper classes in Great Britain and in the U.S.S.R., an ideology of health as a citizen's obligation plus the "mothering" ambience of a largely female personnel are varying societal characteristics which also affect physician authority.

Theoretical Issues

One of the phenomena which seems increasingly to characterize relationships between professionals and their clients in the United States is an unwillingness on the part of the client to accept without question the authority of the professional. The "revolt of the client" (Haug and Sussman, 1969), and the demand for accountability (Reiff, 1971) signify a growing public suspicion that neither the expertise nor the good will of the professional are to be taken on trust, at face value. While this trend can be observed in the United States, having been noted by writers with respect to medicine as well as other professional fields (Reeder, 1972; Eulau, 1973; Haug, 1975), its occurrence in other parts of the world with differing social, cultural and economic structures and various divisions of labor in the human services, has not yet been systematically studied. The research outlined in these pages represents a preliminary attempt to determine the nature and extent of this phenomenon in the case of the physician, in two different societies, the United Kingdom and the U.S.S.R. Utilizing a

sociological perspective, the study explores the basis of primary care physician authority in the context of two types of socialized delivery system of medical care. The aim is to identify those societal characteristics as well as those individual characteristics of patients and physicians which affect the authority relationship in these diverse national contexts.

Most sociologists in the United States have modeled their definitions of profession on the historic trio of medicine, law, and the clergy, focusing on the command of an esoteric body of knowledge acquired through academic training, and a service orientation, which account both for professional freedom from lay control, i.e., autonomy in work performance, and socially sanctioned power over clients, i.e., authority in the practitioner-client relationship. According to this view, it is the professions' monopoly over knowledge not easily accessible to the public, coupled with a claim to a public service outlook, which legitimates the professional's authority in dealing with clients, and institutionalizes client obligations to trust the professional and comply with his prescriptions (Moore, 1970). Even those who have argued that profession is essentially a folk concept (Becker, 1962) concede that knowledge claims undergird professionals' work autonomy and client acceptance of their authority. In fact it has been suggested that the presence or absence of this power position is what distinguishes professions from non-professions (Freidson, 1970). The sick-role concept (Parsons, 1951), the most widely used sociological interpretation of the doctor-patient relationship, is a derivative of the theory of professions: it is the obligation of the sick to seek expert help in order to get well, and thus to defer to the physician's professional authority. The "competence" gap between doctor and patient justifies the asymmetrical power relationship and the patient's trust, confidence, and norm of obedience.

Implicit in the focus on professional autonomy is the likelihood of conflict with the authority structure of bureaucratic organizations, in which professional work is increasingly located. Indeed, the literature on this topic has been voluminous in recent years (Perrow, 1972). However, the strain between the two power bases may currently be more imagined than actual. In fact, professions often in practice forge a partnership with bureaucracy in organizational work settings, in order to buttress their relations with clients (Freidson, 1970). In this case, the bureaucratic rules

and regulations are used to enforce professional decisions with respect to client actions, whether or not the client has accepted the value stricture that it is in his best interests to comply.

Given these multiple pressures on the client to conform, how does it happen that both the autonomy and authority of the professional are nevertheless being challenged, at least in this country? Explanations for the American phenomenon have been sought in the erosion of the professional's monopoly over knowledge, the sophistication attending rising educational levels of the general public, and new divisions of labor which redistribute expertise in the human service field. Changes in control over esoteric knowledge, as its storage and retrieval are computerized, present a potential threat to the eroding monopoly. Furthermore, aggregation of clients in bureaucratic settings may have the unanticipated consequence of stimulating a form of "client consciousness" of their common fate, leading to social movements which challenge professional power and demand accountability for practitioners' actions (Haug, 1973; 1974).

It is apparent that these developments apply to the physician in the United States. Popular knowledge of health issues is disseminated by the media; health organizations urge people to watch for signs of cancer or heart disease; Dr. Spock is only one of a range of do-it-yourself medical guides, of which a more recent example is *Our Bodies Our Selves* (Boston Women's Health Book Collective, 1973); patients with chronic conditions are trained for self-care; and the fact that the majority of the adult American public has completed more than 12 years of schooling (U.S. Bureau of the Census, 1972: 111) implies not only some basic education in nutrition and hygiene but also potential for skepticism about others' knowledge claims (Wilensky, 1964). The computerization of many aspects of medical services is already an established fact (Schwartz, 1970).

As for changes in the division of labor, these also are characteristic of the medical profession. The extent to which tasks of the physician are gradually being given to paraprofessionals or to those now claiming to be professionals in their own right is well documented (Lefkowitz and Ausmus, 1970). Babies are delivered by a midwife with specialized training, and the nurse-clinician handles many aspects of infant and child care; the intensive-care-unit nurse deals with postoperative crises, and the physician's assistant

takes over tasks previously performed by a doctor. One prominent physician educator has suggested that by 1980 physician's assistants or technicians will be setting simple fractures and taking out appendixes (Geiger, 1972: 109).

A complexity which is most marked in medicine is the sexual division of labor. In the United States, the most powerful role, that of the physician, is largely in male hands, while most persons to whom former physician tasks have devolved, as a result of the change in the division of labor, are female. To the extent that societal values produce differences in acceptance of autonomy and authority on the basis of the sex of the authority figure, this confounds an estimate of the effect of the new occupational mix on patient responses to the claims of expertise.

Moreover, physicians are not immune to the loss of autonomy inherent in demands for accountability, and public rather than peer evaluation. The evidence for this development is more tenuous, and it may be related to factors in addition to schooling increments and the changing labor mix. Thus the well-documented increases in malpractice suits may spring at least in part from a general consumerism ideology. On the other hand, proposed legislation to monitor physician use of human subjects in medical research has political overtones. Organized patient movements for improvements in hospital ambulatory clinic care challenge physician control of service delivery at the institutional level, and offer a portent of future developments when patient care is dispensed in a bureaucratized setting. Each of these is in its own way a sign that the doctor's dictum is not necessarily taken as the last word.¹

In sum, it is suggested here that profound change in authority relations is occurring in which knowledge is losing its role as a

¹It might be argued that the voluminous literature on failures and factors in patient compliance (Marston, 1970; McKinlay, 1972) indicate that not following a physician's advice is a common phenomenon. Although this is undoubtedly the case (Freidson, 1961), compliance and non-compliance as such are not logically equivalent to acceptance-rejection of physician authority. Patients can accept medical authority, that is the right to advise and the obligation to obey, but still fail to fulfill that obligation by complying. Conversely, in terms of the bargaining-negotiating model of the medical encounter (Balint, 1957), it is possible that a patient complies with a regimen because he has bent the practitioner to his will, securing the diagnosis and treatment plan which he was desirous of having confirmed when entering the interaction.

power base as it becomes demonopolized, and that the medical profession may be viewed as a prototype of this trend.

Research Question and Method of Data Collection

But is this an emergent phenomenon peculiar to the United States? Is the professional authority model applicable cross-culturally? Specifically, is physician medical knowledge the explanation for this occupation's legitimated power over patients under varying societal conditions, or are there other factors which structure the doctor-patient relationship? Derivative questions address whether variations in patient acceptance of medical-practitioner authority occur by (a) various *individual* characteristics, for example, level of patient education; and (b) various *societal* characteristics, for example, bureaucratic structure.

Data relevant to these research questions have been collected through informal interviews conducted by the author with medical practitioners and knowledgeable informants in Great Britain and the U.S.S.R. during the winter and spring of 1974. The focus was on general practice, as offering the widest range of physician-public interactions. Great Britain and the U.S.S.R. were selected for study because they varied from each other and from the United States on a number of major parameters.

Although both offer a form of socialized medicine, in Great Britain primary care is still dispensed largely by solo practitioners or small group practices, while the Soviet system provides care in large centers or polyclinics. Educational levels and the sexual division of medical labor in Great Britain are more similar to the situation in the United States, while fewer average years of schooling and a predominantly female medical profession characterize the U.S.S.R. Finally, the British and American concepts of profession are virtually identical, whereas the Soviets have no comparable definition; in fact the Russian language does not even have a word for profession in our sense, using the term "intelligentsia" for a more general category.

There was no attempt at random sampling of interviewees. Instead a *purposive* sample was selected, taking into account geographic location and position in the health delivery system. In Britain key respondents were chosen on the advice of British social scientists knowledgeable about their country's health system, and

practitioners of varying ideological stance. From this beginning a "snowballing" technique was used, in which respondents were selected from persons recommended by those already interviewed as having information germane to the study, including those with different perspectives. In all, 47 persons, including 15 physicians in general practice, were formally interviewed.

In the U.S.S.R., heads of medical facilities were selected on the basis of their availability for interview as determined by Intourist, the official tourist agency. Eleven physicians, in seven polyclinics from Leningrad to Tblisi, were among the 22 interviewed. In both Britain and the Soviet Union, respondents were secured from several geographic areas, and from academic medical figures as well as from active practitioners.

All interviews were reconstructed on tape immediately after the interview, using field notes and recollections. Although the interviews were informal and unstructured, they followed a general format which began with a question about the current characteristics of doctor-patient relationships from the interviewee's perspective, followed by inquiries about recent changes, if any, in the nature of that interaction. Questions about the effect of age, education, and occupation of the patients on the relationship were included, as well as probes about those persons considered easiest and most difficult to treat, and why.

In both the U.S.S.R. and Great Britain the data are chiefly from a medical practitioner's perspective, since no patients' organizations are such were found in the U.S.S.R., and only limited contact was possible in Great Britain with two existing groups, themselves circumscribed in scope. Despite this shortcoming, it was possible to gather indications of developments relevant to the research questions posed and thus with impact on theories of professions, and derivatively on doctor-patient relationships in the sick role.

Research Findings

Several themes emerged from these experiences. First, on a general level, physician authority is currently being challenged, and this phenomenon is by no means idiosyncratic to the United States. Moreover, from the physician's perspective, in both Great Britain and the U.S.S.R., professional authority in the physician-patient

relationship varies with patient education, but patient age also is an important variable. In both countries, despite the differences in the bureaucratization of the medical care delivery systems, health practitioners have similar gatekeeper roles from which they derive power over patients not directly related to their medical expertise, since physicians control access to many non-medical benefits valued by the public. An unexpected finding is the overriding importance of historical developments, cultural traditions, and ideology in explaining the position accorded physicians in the division of labor and public acceptance of their authority. The specific impact of the discovery and the development of technological aids of various kinds is only one of these factors, along with the effects of war, social-class history, and the sex of the practitioner. Each of these themes suggest, from different perspectives, the changing role of knowledge monopoly, and the extent to which factors other than knowledge undergird professional power in general and physician authority in particular.

Individual Characteristics: The age variable

In Great Britain, several informants suggested that older patients are more willing to accept the physician's authority because they are grateful for the "free" medical care, remembering the period before World War II when the fee-for-service system existed and care was beyond the reach of many. As one Welsh physician commented, some of the elderly are very respectful and deferential, "excusing themselves for bothering the doctor, bringing gifts of boxes of chocolates at Christmas, or half a dozen eggs during the year."² On the other hand, another general practitioner, in a Midlands health center, had noted the disaffection of some older patients who "expected the doctor to drop in and have a cup of tea and a chat," as in an earlier, more leisurely time, and were upset when this did not occur. In general, however, British health workers considered the older patients more accepting of the physician's authority than the younger, who, many felt, tend to argue, question, and reject authority. The explanation offered, it should be noted, was not only a habit of deference among the

²Quotation marks represent statements reconstructed from notes and tapes, not always exact quotes, particularly in the U.S.S.R., where respondents were translated.

elderly, but the experiences of this age cohort from a period prior to the establishment of the National Health Service.

In the U.S.S.R. age was also viewed as a meaningful variable, but with a somewhat different focus. Some physicians felt, in the words of one informant, that "the aged, when they are ill, are eager to be cured and so carry out all instructions as carefully as possible, while with the young people it is just the opposite—they refuse to obey." Another theme was more dominant—that the elderly are more demanding, questioning, and unwilling to bow to the doctor's orders. Since they are not working, not busy, they come in more often for small matters, although usually all they need is reassurance. As one woman general practitioner put it, "The retired who have grandchildren to care for do not come as frequently, but if they are not working and have nothing to do, they read *Health*, a popular magazine, or medical columns in the paper, or listen to radio and TV, and come in asking for one pill or another, or insist that they have symptoms requiring medication, or just because they want a social visit with the doctor." Since the primary health care system in the U.S.S.R. is based on a network of regional or neighborhood "polyclinics," easily accessible, at least in the city, to would-be patients without charge, the structural arrangements facilitate "overutilization" coupled with challenges of the physician's advice.

Variation in acceptance of professional authority by client age cohort is congruent with a model of profession based on the occupational characteristic of knowledge monopoly to the extent that the age variable is related to educational level and thus to differential breakdown of that monopoly. Indeed, in the U.S.S.R. this relationship is made explicit. It is because the old have time and inclination to read and listen to health education materials that they develop knowledge claims of their own and challenge the word of the doctor.

Individual Characteristics: The education variable

Education of the client as a critical factor in eroding professional authority emerged clearly in both countries studied, although in Britain it was often expressed in social-class terms, whereas in the U.S.S.R. the differences were formulated in terms of schooling and health education, as well as non-manual versus manual categories. One eminent general practitioner in London pointed out that mid-

dle- and upper-class patients more critical than working-class patients. For them, he commented "the knowledge and skill of the general practitioner in terms of his present training is not too much unlike their own sophistication because they also have university degrees." A Midlands physician said he preferred local poor people, because they are "grateful for any help; but couldn't stand Londoners and middle-class types," who were full of questions and arguments. Indeed a thread ran through many of the British interviews, that patients were growing more knowledgeable, demanding more explanations, and in this sense, for some doctors, becoming more difficult, i.e., less willing to accept authority, a finding congruent with data reported by Mechanic (1970) from an earlier study of a larger sample.

In the Soviet Union, a similar theme was expressed by several polyclinic physicians. As one remarked, "it is much easier to treat manual workers as patients. The intelligentsia and the non-manual workers are educated. They read books, literature, listen to radio, watch TV; when they speak of an illness they give not only the symptoms but also the diagnosis. It is easier for the doctor if the patient does not try to tell the doctor what to do." On another occasion, during a group interview, a male doctor had said that it was necessary to explain everything to neurotic patients because they want to know everything. The researcher then probed about the effect of education and asked, apropos of the fact that the Soviet state had recently set compulsory education at 10 years, what would happen when all Soviet citizens had a university education. The head of the clinic, a woman physician, laughed, and said that "then all patients will be neurotic, there will be much work for the doctor, lots of arguments and different kinds of diseases to deal with."

There was, however, a striking difference between the U.S.S.R. and Great Britain on the education variable. In the U.S.S.R. there was heavy constant emphasis on teaching patients about health matters. Every polyclinic had posters and displays in hallways and waiting rooms about nutrition, hygiene, exercise, care of chronic conditions, infant development, and the like. Available in waiting rooms were varicolored illustrated folders on specific diseases and treatment, some with diagrams of various organs to explain the purposes of medical procedures. In several polyclinics the researcher noticed that physical therapy rooms had large wall

displays with photographs of each piece of equipment along with statements of their purpose and benefits. In each facility visited there was an office responsible for fostering patient education, although much of the material was obviously centrally prepared. The medical staff was well aware of the dilemma involved in educating patients while at the same time preferring them to accept the physician's advice without question. Several explained that the education material focused on treatment, rather than symptoms, because if there was too much information about symptoms, the polyclinic might have an excess of patients with imaginary ailments. On the other hand, some others suggested that a few early symptoms were specified, and not too much about treatment, to encourage consultation with a physician.

There was one point on which doctors in both countries firmly agreed, and that was that patients should *not* have access to their own medical records. As one doctor in the U.S.S.R. put it, "patients should *not*, of course, know everything," echoing a general practitioner in Great Britain who responded emphatically in response to an inquiry about patients' seeing their files, "That's stupid...ignorance is bliss for most." The implication was clear that knowledge should not extend to the point where it would be painful to a person. For the patient's own protection, the doctors agreed, there were some things that only they should know. The paradox in this view was understood by a Soviet cancer specialist, who wondered how patients could be persuaded to trust their doctors, and believe what they were told, when at the same time it is common knowledge that doctors may fail to tell cancer victims what their diagnosis is, or even lie about it.

Societal Characteristics: Doctors as bureaucratic gatekeepers

The gatekeeper role of the physician emerged as a reinforcement of medical power under the British National Health Service as well as the Soviet medical system. In Britain, general practitioners must sign "certificates" which validate illness claims and thus a person's right to paid sick leave if he is off work for more than three days. One informant noted that just before the 1974 miners' strike, surgeries and hospital casualty departments in Wales were flooded with patients—miners claiming they were sick in order to get social security payments during the strike. Many physicians are annoyed by certification duties because they view this as essentially non-

medical dirty work, in which the task involves striking a bargain with the worker as to how much of the desired time off is reasonably justified. In some cases this bargaining job has been sloughed off on nurse or receptionist, but the doctor's signature is still needed on the form. The physician's work is also critical in getting a priority for an elderly patient in "council housing," the publicly supported dwellings for the aged and needy, or a telephone installed for an old or sick person living alone. In rural areas or smaller communities the doctor is still presumed to know people on his patient roster well enough to sign gun-license applications or provide character references for young job hunters.

The British general practitioner's control over access to values in the medical arena is also a buttress to his authority, and indeed one protection against encroachments from paraprofessionals. He provides the only entry through the public system to hospitals, and the consultants, or specialists, located there. He is the only channel to medications on prescription-only lists, such as the barbiturates and tranquilizers. Some practitioners indicated that a large part of their practice consisted of prescribing these drugs to individuals with personal and emotional problems. One unpublished study shows that more than half the British practitioners surveyed believe from one third to two thirds of their consultations have a psychogenic component, and four out of five estimate that 80 percent or more of their patients arrive at the surgery expecting a prescription.³ One physician interviewed estimated that nearly half of his consultations involved psychosocial problems, anxiety, and depression, often of women patients, both young and middle aged, who would come in for tranquilizers. If the doctor tries to deny the prescription the patient will say, "I've got to have them. I can't cope. The children are getting on my nerves," and feeling the patient is in a state, the doctor gives the prescription.

In the U.S.S.R., the medical system is the gatekeeper not only for paid absences from work, but also for continuation on the job, as well as side benefits such as special vacation privileges. The general practitioner in the regional polyclinic certifies workers for sick leave and approves pay for illness. More than this, in order to stay on the job, whether in production industry or in a white-collar

³Personal communication from Martin Bridgestock, Medical Sociology Research Centre, Swansea, Wales.

enterprise, workers must receive an annual, or in some cases, a semi-annual, medical checkup. They must show their "card" at the enterprise to prove that they have complied with this requirement in order to continue employment. These examinations are often given at the "enterprise polyclinic," an all-purpose primary and chronic care medical center attached to large establishments such as factories, merchandising complexes, or universities. These enterprise polyclinics, as distinct from the regional polyclinics which are based on neighborhood subdivisions, also have the special gatekeeper role of deciding which workers will be able to take advantage of the health resorts, spas, and vacation facilities run by the enterprise union. Since space is limited, and the benefits of cut-rate prices at desirable vacation locations are much sought after, the physician's gatekeeper role and attendant authority is by no means inconsiderable. Notably in the U.S.S.R., as in Great Britain, sick-leave certificates and other similar gatekeeper functions are based on striking a bargain with the applicant, in order to maintain the patient's good will and cooperation for the future, and not solely on medical criteria or professional expertise.

Societal Characteristics: Technology and authority

Still another pervasive theme, but stressed mainly in the British data, is the modified role of the medical professional as a result of historical changes in conceptions of the nature of health and illness, following in part from the discovery of new drugs and therapies and the invention of medical technologies, tests, and diagnostic and treatment devices. As one general practitioner in London put it, "There has been a profound change in the last twenty years...The person sees himself as ill at an earlier stage and with fewer symptoms...It is an age in which people are not willing to tolerate anxiety or minor symptoms; they want alterations in their experience of life and they turn to the general practitioner," who has been forced to change his attitudes. "His apostolic function has been reduced. No longer can he say, 'I'm the doctor, do as I tell you.' Now there is a transaction, with the outcomes the result of a collusive effort." Another physician, in a Midlands medical center, also remarked that the concept of illness and medicine has changed, but focused on drug discoveries during and after World War II as explanation. Before that, "doctors had only a bedside manner, colored water, and aspirin." Now patients know about the

new magic of pills and technical procedures, and demand that these services be made available by the doctor. In fact several informants noted that patient requests to be referred for diagnostic tests, as carried out in hospitals, were a way of rejecting the authority of the physician in favor of the authority of technology. And a nursing officer commented that godlike tests were replacing the godlike physician as a subject for obeisance and belief.

Only passing references to these developments appear in the Soviet data, and when they do, the perspective is different. Instead of tests substituting for the authority of the primary care physician they are viewed as reinforcing it. Several polyclinic chiefs announced with pride that their staff had a perfect record—all diagnoses made by the general practitioners without the benefit of the technical apparatus available in hospitals and specialty clinics, had been validated by the tests of the specialists. One chief pointed out that the way new doctors in the clinic gained authority was by having their diagnoses and treatment plans coincide with the recommendation of the hospital specialists.

Thus while new medicines and technologies were seen by practitioners in both countries as affecting doctor-patient relationships, the direction of the effect vis-à-vis professional authority was conceptualized in different ways. The findings suggest that various aspects of a physician's tasks differentially affect his authority image. Uncertain diagnosis diminishes, whereas verified diagnosis enhances, that image.

Societal Characteristics: History, culture, and ideology

Medical history is only one among the set of variables found to affect the physician-client relationship; other historical, cultural, and ideological forces also shape, and perhaps even determine, the meaning of the professional category in the division of labor in these two countries.

In Great Britain, there were repeated references to these factors as of critical importance, particularly with respect to the general practitioner, whose *need* for clinical knowledge and whose *command* of psychosocial knowledge were both seen as limited. One prominent general practitioner said of his colleagues that perhaps the quip was true: they are overtrained for what they do and undertrained for what they are supposed to do. Their authority, then, comes from sources other than body of

knowledge.

The most salient supportive factor is the aristocratic tradition, which still casts its aura over medicine. Despite the absorption of lower-class apothecaries and barbers into the occupation of physician and surgeon, the status of the upper-class incumbents remains dominant. As more than one informant pointed out, until fairly recently upper-class families expected the oldest son to take over the estate, the second son to enter the clergy, and the third son to become a physician. All went to a university, and this fact, more than the specific skills acquired, distinguished them from the common folk, who in the class system in Britain were expected to respect and defer to their betters. In some back-country sections of Scotland and Wales, patients still stand when they come in to see the doctor, and actually or symbolically "touch their forelocks." The giving of gifts at Christmas is another manifestation of this habit of deference.

Furthermore, part of the aristocratic tradition is the lord's obligation for public service, a carryover of the feudal value system in which the lord was presumed to have the best interests of his poor and ignorant serfs at heart. The claim that medicine has scientifically based curative power is a relatively new basis for physician authority, and is grafted onto the earlier and more internalized public belief that the doctor's social position merits faith and compliance. Thus as one informant declared, "Doctors are living on the trust engendered from the earlier model of the physician." And another noted that the doctor's ability to secure non-medical services, like better housing and a telephone, is a hangover from "the old days when their word counted for a lot because of their upper-class position rather than their medical status."

An interacting trend is the spreading ideology of collectivism and socialism in Britain. This orientation contains the notion of obedience, the value of deferring to the common good, and the belief that authority should flow to the experts who have the common good at heart. A curious anomaly is that this belief structure also puts physicians in the role of public servants, whose training is paid for by the public and whose services are a public right. Thus the general practitioner should always be available, night and day, to anyone who asks for his attention. The outcome of this mix of forces was verbalized by one of a group of radical medical students in this way: "There is a tension between the traditional deference of

the working class toward the upper class, and their sense of conflict with them over many vital aspects of their lives. The place where the classes meet is localized to the medical arena. In other circumstances the classes do not meet." As a result of this cross-pressure, the average working person is not comfortable with the physician. He may not openly challenge the physician's authority, but neither may he comply with the medical recommendations after he gets home.

The historical, cultural, and ideological trends which emerged in the Soviet Union were also critical explanatory variables for physician power, but of quite a different sort. Three factors in particular merit attention: the impact of the death and destruction of World War II, the pervasiveness of medical oversight coupled with citizen obligation to attend to his health, and the special ambience attached to the fact that so many primary care physicians are women.

Although the Second World War severely damaged Britain, its land was not invaded, and the rate of civilian casualties was less than that endured in the U.S.S.R. Accordingly the war is still a very salient issue there, at an intensity difficult for the American visitor to comprehend. Mass graves and monuments to war heroes constantly remind the public of the suffering of the period, when there were 20 million dead. An example of the continued concern is the custom for brides in many cities to place their bridal bouquets on the tomb of the local World War II unknown soldier, immediately after the ceremony. During the war, the physicians were literally life savers, and their role in rescuing and treating victims under bombing and artillery fire is remembered by anyone over 40 today. The possibility of challenging a doctor's decision in such situations of danger and stress undoubtedly did not often arise, while the physicians' self-sacrificing attention to the needs of the injured was evident. Attitudes from that period have clearly carried over to the present. For example, respondents to a survey undertaken by one of the regional polyclinics for its district, showed that some of the physicians received high praise because they were "just like doctors in the war: very concerned, very active, very willing to help."⁴

⁴As an aside, the survey showed that complaints of the patients in the U.S.S.R. echoed those reported in the United Kingdom (Klein, 1972): lack of attentiveness, rudeness, hasty care. In both countries even these complaints were rare.

Another facet of the Soviet medical system difficult for Westerners to understand is the all-pervasiveness of health supervision. Children and students must be examined periodically in the schools, through the special maternal and child health clinics. They receive checkups before being allowed to go to summer camp. As for adults, no one who is working can escape. The need for periodic examinations in order to continue employment has already been alluded to. Tourist guides, because they meet all kinds of foreigners and their germs, are given annual inoculations; some of the young women try to get out of it to no avail; the physician comes to the office to do the job. According to several informants, there are medical stations in every area of major industrial establishments, satellites of the enterprise polyclinic, where physicians and "feldshers"—specially trained intermediate health personnel (Sidel, 1968)—are located. They get to know the workers well, check on their health, follow up those with chronic conditions, lecture on health matters, and monitor compliance with safety and sanitary rules. Women workers are given regular gynecological examinations whether they want them or not. One polyclinic doctor stated that in industry every employee has a "sports rating," and the "coffee break" is an "exercise break," with calisthenics for fifteen minutes. This physician noted that some managed to slip away and have a smoke in the washroom instead. Workers who are recalcitrant and refuse to follow the doctor's treatment recommendations, or insist on treatment for ailments which the doctor considers imaginary, will be put in the hospital as inpatients for a complete workup and specialist's examination.

Moreover the regional polyclinic structure permits close health supervision in the neighborhoods. One physician with long experience in one such polyclinic told the researcher about how well she knew her blocks of families. They called her "Aunt M—," she was invited to weddings and funerals, and made social visits as well as house calls. She felt that if she noticed someone not looking well, she would be able to urge him or her to get a medical examination, because everyone in her district trusted her, they knew her so well. Several polyclinics explained the system of patient follow-up. If someone with a chronic condition, for example, fails to keep a regular checkup appointment he is sent a letter or postcard. If this fails to work a nurse visits him, then visits his family, and as a last resort the manager of the enterprise where he works will be asked to get him to come in.

In this all-encompassing atmosphere, many polyclinic doctors interviewed seemed to find it hard to imagine any serious challenge of a physician's expertise, or to view the admitted examples of questioning physician authority as anything but examples of aberrant behavior. At an enterprise polyclinic, the chief of staff said, "The doctor doesn't tell the worker how to work and does not expect the worker to tell the doctor how to take care of his responsibility." The fact is, however, that patients do perceive differences in physician ability and sources of medical care. Thus one informant suggested that enterprise polyclinics were better than regional ones, because both union and management, as well as the establishment's political committee, were concerned with the quality of the medical care. These clinics were able, with union-negotiated funds, to provide better equipment and pay higher salaries, thus attracting more able staff. According to this informant, regional polyclinics catered largely to pensioners, an opinion not incongruent with research observations. Also there is a small private practice sector chiefly in the form of cooperatives of male specialists, in a few cities and in the South, and some of the intelligentsia prefer these services if they are seriously ill.

Public acceptance of the pervasiveness of the medical system is partly ideological. There is apparently a strong sense that maintaining one's own health is an obligation of citizenship. It is a person's public duty to keep well, and if ill, to get well. In this effort, cooperation with the health practitioners is part of the obligation. Indeed this ideology has been incorporated into law, on both a national and individual republic basis. One polyclinic director displayed copies of the legislation for the Ukrainian Republic, whose preamble states that the attitude of a person to his own health is a concern of the state. Thus in the U.S.S.R. the Parsonian conception of the sick role as including the obligation to get well (Parsons, 1951) has been institutionalized in the formal legal structure.⁵

Perhaps another basis for the acceptance of all-encompassing medical attention is social-psychological, and is related to the fact that most primary care physicians, and indeed most physicians, have been women, a statistic true at least since 1940. The constant

⁵For a further discussion of the Soviet health system, with a similar perspective, see James E. Muller et al. (1972).

oversight, the continued concern about health, the persistent follow-ups and reminders about taking care of oneself are reminiscent of a mothering role. This impression grew during the data collection, as polyclinic after polyclinic was visited, and the researcher was introduced to many women physicians—in medical departments, minor surgery, orthopedics, and all the other sections of the medical center—and often they were indeed maternal in appearance and manner.

One non-medical informant actually verbalized the mother ambience by talking about an instance where he had a false reading of high blood pressure, and had quite an argument with the doctor who wanted him to change his entire life style. The doctor talked to him “like a grandmother about all the dangers of not caring for himself and was shocked at his cavalier attitude.”

The evidence is scanty and impressionistic but the hypothesis could be formulated that the acceptance of medical intrusion into so many aspects of Soviet life—work, recreation, education—is related to the fact that mothers are expected to worry about the well-being of their children, even into adulthood. And in many cultures, societal values dictate that at all ages it is a good thing to listen to your mother; as a child you obey; as an adult you at least should try to comply with her wishes. The image of the health-provider as a mother figure is indeed congruent with family health care patterns in many societies, not just in the U.S.S.R.

Implications for the future of physician authority

A first review of the field data has suggested some answers to the queries which initiated this research. Across two quite different societies, individual as well as societal characteristics modify the knowledge-power model of the physician's role. Education of the patient does make a difference in acceptance of physician advice, and in some instances interacts with age to undermine authority. Level of bureaucratization of the medical care delivery systems seems, however, to have less meaning for physician power than the way in which medical workers are used by bureaucratic structures as gatekeepers and enforcers of the system. Although the level of bureaucratization of health care varied between the two social systems, in both cases the practitioner's position was strengthened as a result of his or her control over access to non-medical benefits.

The more salient factors affecting medical practitioners' authority and status were, on the other hand, not included in the original knowledge-power model or reflected in the original research questions. These are the historical, cultural, and ideological variables.⁶ Traditional imputations of power based on social-class position, the impact of experiences like a devastating war, and institutionalized beliefs in individual health responsibility, appear to have major consequences for the role and authority of the physician. Finally, the sex of the practitioner may have a social-psychological meaning unlike that originally expected, for being a woman may undergird physician authority rather than diminish it, by invoking a mother image.

Doctors have been viewed as the prototype of the occupational category, profession, approaching on all parameters the ideal-typical end of the continua of professional characteristics. What then are the implications of these findings for the future relation of knowledge and authority among professionals, and particularly physicians?

Consider first the key characteristic of the physician's autonomy, the right granted by society and validated by licensure to define and carry out his tasks. The expression and realization of this autonomy shifts from the *societal* level to that of *individual* transactions with clients at the point of actual task performance. While at this stage physician autonomy is operationalized as authority over patients, theoretically it continues to be grounded in the characteristics of the occupation. The findings here tend to nullify that contention. Degree of authority over clients depends in part on *client* characteristics rather than occupational characteristics alone, i.e., on age and education of the patients. Although these variables affect authority through the instrumentality of patient claims to knowledge conflicting with and undermining physician claims to knowledge monopoly, the fact remains that client characteristics have not heretofore been included in the core model of profession,⁷ and have been neglected in the concept of the

⁶For a more detailed discussion of these issues with reference to Great Britain, see Haug (in press).

⁷One exception to this generalization is the work of Terence Johnson (1972). In *Professions and Power* he suggests that in the case of corporate clients, authority may flow from client to professional instead of vice versa. Unfortunately, this monograph is little known in the United States, and not too easy to secure.

sick role. Indeed when such characteristics are given weight in studies of compliance with physicians' treatment recommendations, they are viewed as obstacles to obedience rather than source of challenge (McKinlay, 1972).

From another perspective, the critical role of knowledge monopoly is negated by examination of the physician's gatekeeper activities. Professional power is based less on special knowing than on assignment of authority by an organization, and conclusions are reached less on medical than on interactional and bureaucratic grounds. When a doctor is confronted with a worker who has taken a few days off and wants to be paid, the decision to grant the leave has virtually nothing to do with the professional's special expertise. Consideration of his own time pressures at the moment of the request, implications for later requests, the importance of keeping the worker's good will, the possible reactions of the employer, the number of such requests previously granted and their cumulative effect, all enter the decision-making process of the gatekeeper. They equal if not exceed the issue of the actual medical situation of the applicant.

Similarly when a physician becomes a facilitator for housing, phone service, vacations, and the like, he is not as a rule calling up any particular medical expertise. It does not take years of training to recognize that an old lady living alone will need a telephone in the event of an illness emergency. However, the welfare system has been set up to require the physician's validation of a request for this scarce resource, and his power comes from that bureaucratic arrangement rather than from his medical degree.

The variables of history, culture, and ideology are also outside the parameters of the medical model as generally conceptualized. The data on the meaning of traditional class position for compliance with physician authority in Britain reveal that the possession of specialized knowledge is a *post hoc* explanation and justification for a social reality with roots in the past.⁸ The findings that medical technology can have differing impacts on physician power depending on cultural setting—in Britain it is said to detract, in the U.S.S.R. to enhance, a doctor's authority—again imply that it is not claims to specialized expertise per se, but societal in-

⁸Krause (1971:111), one of the few occupational sociologists to include the historical perspective, makes a similar point concerning the medical profession.

terpretations of the significance of these claims which are governing.

As for the ideological variable, there have been a few indications in the recent literature that this is an important factor in physicians' status. The ideological content of the "new professional" movement and attendant demands for professional accountability is quite explicit, as are the deprofessionalization exhortations addressed to medicine in the sparse information out of mainland China (Haug, 1973). The validity of this factor is reinforced by the present research, particularly in the data from the U.S.S.R., where the ideology of citizen responsibility for health maintenance and for illness treatment is the rationale for public acquiescence to a pervasive system of medical oversight, and explains the formal obligation to accede to physician advice. Although not necessarily incongruent with the theory of profession which distinguishes certain occupations as having special knowledge, humanitarian concerns and derivative autonomy, it adds a new dimension to the theory, redefining the circumstances under which the core characteristics provide a meaningful definition of the concept.

It is possible to summarize these findings and their theoretical implications by stating that data from both Great Britain and the U.S.S.R. confirm the American-based impression that professional authority is eroding, at least in part as a result of client education, and that the medical profession is no exception to this development, although the pace of change varies in different societies. Perhaps more important, it can be said that the model of profession and of medicine based on occupational characteristics is at best incomplete and at worst erroneous. Factors such as client characteristics, societal structure, and ideology may match if not outweigh the occupational parameters.

The hypothesis takes shape that the segments of the division of labor currently entitled "profession" in the West are simply a range of occupations which require greater or lesser degrees of training and expertise, and in which clients, also with greater or lesser knowledge of the tasks that occupation performs, negotiate a course of action designed to accomplish some individually or socially desirable end. Factors affecting this negotiation are the bureaucratic structures in which the transactions occur, the ideological themes which place values on different transactional

styles and outcomes, and the historical events and traditions which in various social and cultural settings have patterned practitioner and client beliefs and behaviors. The underlying model is one of expert and consumer, without the moral and evaluative overtones of the professional model. While the data presented here cannot support this hypothesis, they at least suggest the theoretical utility of systematic exploration of its validity.

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