

A Re-examination of the Hypothesis of Physician Deprofessionalization

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OVER 20 YEARS AGO, IN 1964, HAROLD WILENSKY sounded a note of warning in a paper entitled the "Professionalization of Everyone?," about the common sociological belief of the day that all occupations were becoming professionalized, and we were on the verge of a professionalized society. Wilensky was reacting to claims such as that of Nelson Foote (1953), who argued that even blue-collar workers were becoming professionals. We have forgotten how widespread the enthusiasm was for this idea, which had the golden glow of wiping out status differences. As Wilensky (1964) argued, professions—unlike other occupations—called for esoteric knowledge acquired through long training, along with a dedication to selfless service as the professional norm. Professionalization involved a process of securing these characteristics, to be validated by university degrees, exclusionary legal licensing, and the adoption of ethical codes. The result was "extraordinary autonomy—the authority and freedom to regulate themselves and act within their spheres of competence" (Wilensky 1964, 146). Not every occupation, he argued, could be successful in struggling to gain these characteristics.

Wilensky's counterview had little effect, however. Seven years after his paper was published, Eliot Freidson (1971), in the editorial foreword to a special issue of the *American Behavioral Scientist*, forecast a "professionalized" society. In 1968, Daniel Bell was making similar predictions for the "post-industrial" society. And if my memory serves,

this is what we were teaching students in the introductory sociology textbooks of the 1960s. These beliefs were rationalized by the knowledge explosion in science and technology that was occurring at the time, since it was held that mastery of increasingly esoteric knowledge would become a general occupational requirement. Meanwhile, Paul Halmos (1970) in Britain was predicting that the service ethos of the professions would be generalized to society as whole. Consequently, “concern, sympathy, and even affection for those who are to be helped by the professional” would be the societal order of the day (Halmos 1970, 14).

It was revulsion to these syrupy ideas about the future of our industrial social system, with its multitude of inter- and intra-occupational conflicts, that resulted in my first article on these themes in 1973. It was entitled “Deprofessionalization: An Alternative Hypothesis for the Future” (Haug 1973). I underscore the word hypothesis, because contrary to some critics of the concept, my goal was not to argue that deprofessionalization was the order of the future, but to evaluate it as an alternate to the popular professionalization argument, which was actually also a hypothesis. Such an evaluation, of course, required some definition of the outcome variable that was to be changed—namely profession. And here we get into the dreary round of arguments as to what characterizes this particular type of occupation.

Even before Wilensky wrote, Becker (1962) had tried to prick the euphoric predictions by declaring that profession was only a folk concept, a semantic technique for winning occupational status and minimizing occupational constraints. Profession, in a word, was in the eye of the beholder—the public. There is a lot to be said for this perspective, but it escapes precise operationalization for the purposes of this article. More amenable to evaluation of the deprofessionalization hypothesis are the factors of monopolization of esoteric knowledge, autonomy in work performance, and authority over clients. Another imputed professional characteristic—the service ethos—is perforce omitted, not only because differentiating myth from reality is difficult, but also because identifying departures from the formal ideal applies to individual practitioners who have fallen from grace, while the ethical code of the profession as a whole can remain intact.

Accordingly, in what follows, I will try to identify and assess past and current trends that appear to be undermining monopolization of

knowledge, work autonomy, and practitioner authority. In so doing, I will limit my remarks to the profession of medicine. In my more cynical moments I have wondered if sociologists' romance with medicine is related to hope or envy: hope that some of the physicians' status and income will rub off, or envy of these attributes, considering that understanding and treating the ills of the body seems easier than understanding and treating the ills of the social order. In any event, the discussion from here on in will apply solely to doctoring as a profession.

What is Happening to Knowledge Monopoly?

In this domain one must distinguish between the monopoly attained by the profession as a whole and the slice held by the individual practitioner. By limiting access to training, leaders of the medical elite have generally sought to contain the spread of their fund of esoteric knowledge, keeping it from the unqualified and uninitiated. This endeavor has only been partially successful. Despite the continued discovery of new techniques and medical breakthroughs, the media have popularized a great deal of the increasing fund of medical knowledge, and made it accessible to a public whose rising educational level permits many people to grasp it, at least in its main outlines.

Does this mean that everyone can be his or her own doctor? Not always, but certainly some people sometimes can, as the spate of medical how-to books flooding the middle-class market demonstrates. Furthermore, the range of knowledge maintained by the individual physician can vary widely. At one extreme is the physician impaired by alcohol, drugs, or declining cognitive ability (for a doctor, senescent forgetfulness can never be benign). At the other extreme are the academic specialists in a particular body organ or physical function, whose fund of information exceeds that of the average doctor. Shorter (1985, 188) even argues that by the time they are in practice most doctors have forgotten the basic sciences they learned in medical school. They have forgotten not only the chemistry, but also the anatomy and pharmacology that they crammed to pass exams.

Experience in diagnosis and treatment as a result of time in practice is an important component of medical knowledge. It is not irrelevant that hospitals and surgeons who do the most operations of a particular type have the lowest operative death rates. But patients also have

experiences, particularly of everyday illnesses and chronic conditions, and may have accumulated information that comes close to that of newly minted physicians. The mother of seven may know more about treating colic than the pediatrician fresh from residency. And one pediatrician has recognized that parents of very ill children may know more about the disease than many M.D.s (Klass 1987).

All of these remarks may be irrelevant, however, in the face of the greatest threat of all to knowledge monopoly, and that is computer technology. Already available are schemes for computerized diagnosis, and computer evaluations of decision trees that indicate the course of treatment most likely to be successful. In a period when second graders are operating PC's in school, the time may be coming when the issue will not be who has the knowledge in her brain, but who knows the technique for extracting it from computer memory (Haug 1975, 1977). Nobody currently knows the extent to which computer developments will replace medical judgment. Since anything that can be codified can be "input," even the results of experience can go into the machine's memory bank. Currently, computer access is limited to persons with the key, and there are problems of confidentiality. In light of the uncertainty that pervades medical decision making (Reiser and Anbar 1984), of which more later, one should not overestimate the potential effects of computerization of medical knowledge on its monopolization. The problem seems to be that its effects are currently underestimated. If computers can play chess, and if artificial intelligence is in the wings, what is the future of physicians' monopolization of medical knowledge?

The Erosion of Authority over Patients

What we do have is information on the unwillingness of many patients in the Western industrialized world (and perhaps elsewhere) to give unquestioning obedience to the doctor's authority. Whereas previously such disobedience was covert, in the form of noncompliance, it is now overt, in public demands for participation in decision making (Haug and Lavin 1981). The evidence is everywhere—in scientific journals, the media, and popular books aimed at the general public. Patients are exhorted to demand and get their rights. For example, according to one writer, they should insist that doctors talk in plain,

understandable English (Cohn 1987), not use words to obscure and mystify, one frequently used technique for maintaining physician authority (Waitzkin and Stoeckle 1976).

In the magazine of the multi-million member American Association for Retired Persons (AARP), older people are urged to fight for their rights as patients. In line with growing public assertiveness with respect to any authority, members are described as no longer as willing to take a doctor's word on faith as they used to be, and are urged to assert their rights to be involved in medical decision making (Demkovich 1987). These popular views are reflected in empirical data that show that considerable sections of the public, particularly the younger and better educated, are indeed challenging physician authority (Haug and Lavin 1981, 1983).

Doctors themselves recognize that times are changing. Bernie Siegel (1987, 51) in his immensely popular book (weeks on the New York Times best-seller list) points out that patient participation in the decision-making process in medicine speeds healing. An article in a journal of a regional medical association asserts that patients' attitudes have changed: "No longer the day of acceptance without questioning the advice, treatment, prescription, etc., given by the family physician" (Steiner 1987). The erosion of unwavering trust in the doctor is lamented by Shorter (1985) because the decline of the practitioner's authority has eliminated the placebo effect generated by patients' belief that they would be helped. Similarly, involving the patient in decision making, while recognized as "a popular concept among both medical professionals and the general public," is seen as having negative aspects since patients may press for a technological answer to medical uncertainty (Bursztajn, Hamm, and Gutheil 1984). And the reason for this decline of professional authority is the emergence of a "more educated and more egalitarian society" (Pellegrino 1977).

The doctor-knows-best attitude may still be more widespread than was the case in the early nineteenth century when all a doctor knew how to do was to give purgatives and emetics, and to bleed the patient. The discovery of new and effective curative drugs and of antiseptics and anesthesia, making safe surgery possible, skyrocketed the authority of the physicians for a time. But among what Shorter (1985, 228) calls postmodern patients, he finds increasing mistrust of formal physician care, and a "revolt against medical authority."

No one, either in the popular media or the scientific literature, seems to disagree that there has been a decline in patients' unquestioning

acceptance of physician power, although not everyone couches the changes that are occurring in terms of diminishing physician authority, agrees on their extent, or accounts for them in the same way. The evidence of the new character of the doctor/patient relationship is so pervasive that even Freidson (1986, 65), who has been most critical of the deprofessionalization concept, recognizes that changes are occurring and that there is “an increasingly questioning attitude toward medicine and health care issues.” The disagreements that do exist concern the meaning, implications, and permanence of the changes that are occurring in physician authority.

Threats to Autonomy

Whereas physician authority concerns legitimated power over patients, physician autonomy refers to freedom from control either by peers or by organizational constraints. In this domain changes are also beginning to appear, but in less publicly recognized forms than is the case with respect to authority. Freidson (1986, 67) argues cogently that formal procedures to review “both the technical propriety of the everyday decisions of physicians and the moral acceptability of their activities” are changing the milieu of practice. Although physicians might have taken some comfort from the fact that their reviewers were their peers—also physicians—who supposedly would sympathize with the vagaries of an inexact science, that consolation has been shortlived. Last May a dispute flared between eight Boston area hospitals and a state medical licensing board that had been authorized to monitor physician performance on the grounds that colleagues were not doing the job adequately because they were reluctant to discipline impaired practitioners. The hospitals charged that a board consisting of five doctors and *two lawyers* could not comprehend the particulars of a medical case and would be apt to infringe on doctors’ rights. According to the *New York Times* (1987), the dispute reflects an unresolved national debate on the preferable way to monitor and discipline doctors.

Another factor that affects autonomy is the trend toward the establishment of health maintenance organizations (HMOs) or group practices, in which physicians are at least theoretically subject to bureaucratic constraints. Clearly impinging on practice autonomy are

the diagnosis-related groups (DRGs), which define reimbursable lengths of stay for patients whose hospital costs are paid by Medicare. Peer review organizations (PROs), mandated by Congress a few years ago, are charged with evaluating quality of care and appropriateness of hospital admissions and discharges, a specific intrusion on physician autonomy with respect to patient care (U.S. Congress Special Committee on Aging, 1987).

A particularly revealing indicator of the slippage of physician autonomy is a recently advertised book, *Managing Doctors*, published by Dow Jones-Irwin. The blurb claims the book will help management influence and motivate physicians in their organizations, and show management how to win their physicians' "loyalty and devotion" [sic]. Whether the volume will live up to these expectations is less relevant than the audacity of entitling it *Managing Doctors*, a clearcut statement of intent to contain autonomy and manipulate physicians for the benefit of the organization.

One of the additional signs of the times are the stringent rules governing the use of patients in research. The implication of these government regulations, which are enforced by committees representing disciplines other than medicine, is that physician autonomy may be dangerous to the patient, and must be subject to oversight and public scrutiny.

Is the Deprofessionalization Hypothesis Retained or Rejected?

My 1973 article (Haug 1973) ended with the following paragraph: "The deprofessionalization hypothesis is, as any prediction, only a hypothesis. The thrust of this paper is that it is as viable as the professionalization hypothesis. Both will be tested by history, the macrodata of sociology." Over fifteen years have passed since that paragraph was written. Although there is considerable evidence favoring the hypothesis, the findings do not, to date, appear sufficient to retain it with 95 percent confidence. But certainly there is no evidence favoring rejecting it either. The main imponderable, in my view, is the future effect of technology, particularly computer technology. I once argued that technology could destroy the monopolization of knowledge and lead to the obsolescence of the concept of profession

(Haug 1976). That has not come to pass, at least not so far. We do know that the old authority-based superordinate role of physicians vis-a-vis patients no longer holds as widely as it once did. Finally, new government regulations and organizational forms hedge physician autonomy in many aspects of their work, as a result of what Starr (1982) warns is a far-reaching transformation and corporatization of the delivery of medical care.

Perhaps in order to test the deprofessionalization hypothesis we must hope that the world will still be around in another twenty years. Then we can assess, in about the year 2009, whether knowledge control, authority, and autonomy of physicians have been so eroded that both in the eyes of the public and in the papers of sociologists the practice of medicine as an occupation has been "deprofessionalized."

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