

Doctoring in Australia: A View at the Bicentenary

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MY LOCAL DOCTOR RECENTLY HAD HIS CAR STOLEN. The court case to prosecute the young person responsible was held in the country town where the vehicle was found. The doctor took the day off from his practice in order to appear as the complainant. On conviction of the offender the matter arose of the doctor's costs (travel, fees forgone, etc.). Because the offender had no money, the magistrate awarded only witness fees—a token amount which would not even cover travel costs—adding the gratuitous remark to the doctor that “you might not be able to afford the usual caviar on your bread tonight, but you should be able to afford some jam.”

This article reviews the debate, outlined in the earlier part of this issue, on how best to make sociological sense of the changing social position of the medical profession (henceforth doctors) in the specific geopolitical context of Australia. As outlined, the debate broadly has three positions—deprofessionalization, proletarianization, and the maintenance of the phenomenon of professional dominance. What's happening to Australian doctors in relation to this debate?

As with the other articles in this issue, the caveat is necessary that evidence on these specific matters is difficult to gather. Evidence on changes affecting Australian doctors exists, but it is an issue of interpretation as to what these mean for the debate in question. The

interpretive argument to be made in this article is, broadly speaking, that the maintenance of professional dominance argument has greatest salience, though its form and mode of operation is changing.

The Debate

In order to situate the Australian evidence to make this argument, it is necessary first to review briefly the conceptual debate. The position to be outlined here to make sense of this debate takes, as central conceptual ingredients to the analysis, class relations and the capitalist state. This analysis draws upon earlier work (Willis 1989a).

Deprofessionalization

The conceptual confusion with the terms profession, professionalism, and professionalization has been considerable. This confusion is reproduced specifically in the debate about the deprofessionalization of the medical profession. Therefore, deciding whether deprofessionalization as a social process is occurring and is the best means of understanding sociologically what is occurring to doctors may revolve around what professionalization is considered to be. The traditional sociological approach reflecting a Durkheimian legacy was that professionalization was a process of acquiring the necessary attributes to justify professional status. This approach has long since been superseded by an insistence that professions and professionalism were concerned with power and control. For Johnson (1972), for instance, professionalization was a process, the end point of which was professionalism, a form of occupation self control. In the several sociological histories of the medical profession which followed this reorientation (Berlant 1975; Parry and Parry 1976; Larson 1977) professionalization was a process aimed at collective upward social mobility through social closure and monopolization. For Larson, in addition the process has an ideological component; what professions have in common is an occupational ideology staking a claim to autonomy in the performance of their work and in regulating their affairs. All stress that the process of professionalization can only be understood in relation to the development and maintenance of the class structure, though the nature of that relationship varies according

to the broad sociological tradition within which their accounts are situated. The key claim (the "sacred cow" for Freidson) is to autonomy in the performance of work. Such autonomy, as Johnson (1977b, 29) argues, is based upon the historical process whereby occupationally generated definitions of professional service ("health") become "official," state-patronized ones. The process of professionalization toward professionalism as a mode of occupational control (for Johnson, the institutionalization of colleague control in medicine), "took place in the nineteenth century when social conditions associated with the rise of 'private' capitalism were conducive to 'professionalism' and occupational definitions of client need" (Johnson 1977a, 229). Professionalism is, therefore, both a material practice and a set of ideas that justify that practice—in short, an ideology. The ideology legitimates autonomy for the doctors themselves. As Freidson (1970a, 80) argues, it is a deliberate rhetoric in the political process of lobbying, public relations, and other forms of persuasion to attain a desirable end—"full control over work." But it has wider ramifications as well, reproducing aspects of the dominant ideology and promoting bourgeois hegemony which, as Gramsci (1971) argues, provides the basis for bourgeois rule in monopoly capitalism. The ideology of professionalism does not operate in a straightforward, even way but in a complex, uneven way, so it would be an oversimplification to view the ideology of professionalism as a microcosm of bourgeois ideology. What professionalism does do, however, is to reproduce what Habermas (1970) calls the "ideology of expertise"—the emphasis on technological rationality, on the claim to effectiveness, and on individualism—all of which leads to the claim that "knowledge is beneficent power," yet legitimates inequality and elitism as Larson (1977, 241–43) has shown for a number of capitalist countries.

From this point of view then, deprofessionalization would be represented as a historical process in which state patronage of professionalism has declined both in the sense of autonomy and the set of ideas which legitimate it. Contrary to this, I would argue that, in Australia at least, the ideology of professionalism has been more stridently expressed, particularly by that segment of the medical profession losing out. It takes the form of an ideological rearguard action to preserve the position of the medical profession in the face of challenges to its position.

Proletarianization

As already outlined, the proletarianization thesis argues that the development of capitalism, in particular the concentration and centralization of capital, has led to a polarization in class terms. In the case of doctors, this has been taken to mean that the petit-bourgeois class location of doctors is increasingly under threat, as evidenced in a number of ways. The argument to be made here is that such a proletarianization thesis makes most sense within an orthodox Marxist position. What that position does not take adequately into account is the continued existence, even flourishing of an intermediate class location in advanced capitalist societies between the major historical classes of capital and labour. For this reason a distinction is needed between an old or traditional middle class (small business persons, family farmers, etc.) and a new middle class comprised of major professional groups. Proletarianization has occurred mainly to the former group. In the latter group, as Freidson (1977, 28) has argued, self employment or employment status per se is less important as an analytical issue than the process by which control over work is established and maintained. Doctors, as important members of the new middle class, have not been proletarianized, because of their involvement in the maintenance of ideological hegemony. Rather, following Gramsci, doctors must be seen as organic intellectuals who have emerged in association with a new dominant class in advanced capitalism "exercising the subaltern functions of social hegemony and political government" (Gramsci 1971, 12). They are what Merrington (1968, 154) calls "experts on legitimation." They rationalize and provide a justification for the nature of that society, thus acting "as the mediators of the realities of capitalism into values" (Davidson 1968, 45). In the specific case of doctors, the basis for state patronage lies in the role of doctors in the reproduction of labor power, mediating relations between individuals and their bodies, on one hand, and the state, on the other. This is, after all, how medicine acts as an institution of social control.

From this point of view, evidence for proletarianization of doctors would be sought in the decline in their role as organic intellectuals to the dominant class and in medicine as an institution of social control.

Professional Dominance

This position in the debate, as developed in Freidson's (1970a) seminal work, accords doctors a position of dominance in the health sector which is based upon dual functions. One is esoteric knowledge, the other state patronage to recognize and protect that knowledge by according a legally supported monopoly over practice. As I have argued elsewhere however (Willis 1989a), the problem with the original formulation of this position is that it is inadequately located in a theory of class relations central to an analysis of autonomy and professionalism. Freidson (1970b, 72) identifies the maintenance of professional dominance by medicine as based upon the "protection and patronage of some strategic elite of society which has been persuaded there is some special value in its work." As McKinlay and McKinlay (1977, 465–66) have shown, Freidson leaves many questions unanswered about relations between these elites, the state, other professions, and the nature of the special value of the work. Following Frankenberg (1974), these elites are more usefully analyzed as a class—the dominant class defined by private ownership and control of productive resources. For those reasons, in earlier work, while acknowledging the insightful analyses provided by Freidson, I have referred to the phenomenon as medical dominance in attempting to deal with those questions left unanswered by Freidson (Willis 1989a). For the purposes of this article however, my interpretation of what evidence is available on the changing social position of doctors in Australia is that it is best analyzed sociologically within the professional dominance tradition. What I have called medical dominance is sustained at three levels: first, at the level of control over their own work, doctors are not subject to direction and evaluation by other health occupations. This level I have called *autonomy*. The second level is that of *authority* over the work of other health occupations: either directly supervising and directing the work of others or indirectly by medical representation on registration boards or denial of legitimacy. The third level, what I have termed *medical sovereignty*, involves the sustenance of medical dominance in the wider society: doctors are institutionalized experts on all matters relating to health. For a decline in medical dominance to have occurred, a discernible diminution in the control of doctors at each of these levels should be apparent.

The Historical Process

Having considered the conceptual background to the debate and outlined a position in relation to it, we can now examine the specifically Australian evidence. First, however, it is necessary to provide some brief historical background to the provision of health services in this country in order to make the changes being discussed more intelligible. Medical dominance is after all the end point of a long historical process of the establishment of control. Since the arrival of white settlers, reluctant or otherwise two centuries ago, health services in Australia have been provided on the basis of a mixture of public (i.e., state funded) and private suppliers. In the nineteenth century, the English tripartite medical system of apothecaries, surgeons, and (a few) physicians was transplanted to Australia. Consolidation into a recognizable medical profession occurred in 1862 in the State of Victoria, for instance, with the passing of a registration act modeled on the 1858 English act. Until early in the twentieth century however, state patronage for doctors was relatively limited. Internal divisions promoted disunity. A general lack of effectiveness in treatment meant that early doctors had difficulty distinguishing themselves in other than status terms from homeopaths, their main competitors. In addition, an ideology of *laissez-faire* individualism prevailed consistent with the economic times, rendering unsuccessful several legislative attempts to ban "unqualified" medical practice in the late nineteenth century.

From the early twentieth century however, consistent with a general trend in many western capitalist countries toward the beginnings of a transition from *laissez faire* to monopoly capitalism, the state began to adopt a more interventionist role in regulating the affairs of Australian society. A significant step in the state of Victoria, for instance, was 1908 legislation according greater state patronage for doctors than had previously been the case. The supply of doctors became more easily regulated; "foreign" registration was effectively ended, and homeopathy and other modes of medicine effectively controlled. The medical board established in the 1862 act was given partial autonomy, able to act as an internal regulatory body in certain cases. All this, it should be noted, occurred in the absence of clear evidence that the new "scientific medicine" was effective in reducing the incidence of mortality and morbidity.

From 1908 however, doctors who had achieved a position of dominance

in the health division of labor went on to consolidate that position through state patronage as the state became increasingly interventionist. The second decade of the century saw a major struggle to control the terms and conditions of practice. To do this, doctors had to gain control over the demand for medical services in the marketplace and achieve professionalism as a form of control over work. Friendly societies or lodges, again based upon the English model, were the major alternative entrepreneur of medical care, employing doctors on a salaried rather than on an individualized fee-for-service basis. In lodges, doctors experienced a mediated form of work control, thus limiting their autonomy. Industrial action through local branches of the British Medical Association led to a Royal commission following which the friendly societies caved in (see Pensabene 1980; Green and Cromwell 1984).

So, by the 1930s the professionalization process achieved "professionalism" as the form of control over work. In 1933 in the state of Victoria, further legislation granted full autonomy for internal regulation to the profession through the medical board with the passing of an infamous conduct clause. By such means doctors were able to supervise the professional behavior of its members without recourse to outside authority.

Since World War II, the tendency toward state intervention in health care has increased, particularly under social-democratic-type Labor political governments. An attempt in the late 1940s to introduce a national health service broadly along English lines was prevented only by a High Court ruling that such a scheme would involve civil conscription of doctors, something the Australian Constitution proscribes. The long period of conservative government in the 1950s and 1960s saw health care funded through private health insurance companies, a development initiated by the doctors themselves in conjunction with the government to preserve their autonomy. This period arguably represents the heyday of medical dominance.

In the mid-1970s however, the reformist Whitlam Labor government, in the teeth of medical opposition, introduced a national health insurance scheme called Medibank. It reimbursed a substantial proportion of medical fees but did not interfere with autonomy or fee-for-service payment for medical services. This scheme was wound-down with a return to private health insurance under the Fraser Liberal-National Party coalition in the late 1970s and early 1980s, but reintroduced

in a slightly modified form by the Hawke Labor government on its election in 1983. Now called Medicare, the scheme again refunds part of the fee paid to doctors without affecting their autonomy.

The Evidence

Having considered the conceptual and historical backgrounds to the debate on the changing social position of doctors, it is now possible to assess the changes. Here the argument made is that what evidence there is available supports the contention that medical dominance, broadly speaking, thus far at least, is being maintained, though its form and mode of operation is changing. Each of the three analytical levels of autonomy, authority, and sovereignty will be examined.

At the level of autonomy first, there appear to be a number of changes which might be considered to represent a decline in the social position of doctors. The growth of a consumer movement, particularly the women's health movement, has been important in questioning the unbridled autonomy which doctors have historically enjoyed. Consumer representatives have been appointed to state bodies pertaining to doctors, including research fund allocation committees. Indeed, the Victoria state government is reported to be planning legislation to get a consumer representative on the medical board of Victoria: the citadel of professional autonomy. Consumer representatives have also been incorporated within state health authorities themselves, serving alongside medical officers, etc. Arguably though, these changes, so far at least, are fairly token actions. Certainly, little evidence is available of any substantial impact thus far. One area of impact, however, is a decline in the impact of the ideology of professionalism, particularly as it involves the "doctors know best" ideology of expertise. The political experience of organized medicine's strident opposition to the introduction of the Medibank and Medicare health insurance schemes was to reinforce the notion that the organization of health services was essentially a political phenomenon in which doctors didn't necessarily know what was best for the rest of the populace.

Insofar as the autonomy of doctors has been affected, this is arguably more the result of intra-occupational changes rather than involving outside bodies. What appears to be occurring in the Australian health

system is a concentration of power in the hands of academically oriented specialists and away from general practitioners, on one hand, and even private specialists, on the other. This trend has been apparent for a long time, but appears to have accelerated more recently. Very few general practitioners do any surgery other than in fairly remote rural areas: as in other countries, general practitioners are increasingly becoming a screening device for referral to specialists for the management of most health conditions. In the specialty fields, the social relations of the increasingly sophisticated medical technologies such as randomized control trials, increasingly concentrates power in the hands of academic, salaried specialists backed up by technicians of one sort or another (including biostatisticians) and away from specialists engaged in private practice who rely on the academically oriented specialists and technicians to interpret the meaning of the studies involved.

Another perceived threat to the autonomy of doctors was the national health insurance schemes of Medibank and Medicare. Effective record keeping, it was considered, would make doctors vulnerable to charges of overservicing patients. Experience has shown, however, that, while there have been some prosecutions for blatant overservicing, the autonomy of doctors could not reasonably have been said to be affected. Where the more effective statistical picture of servicing patterns has made an impact is in pointing to regions of the country where some procedures are performed as much as seven times more often than others. In sum then, at the level of autonomy, while some changes are evident, the level of personal autonomy which individual doctors experience does not seem to be greatly affected.

At the level of *authority* vis-à-vis other health occupations, some changes are also evident. Most particularly, the idea of team approach to patient care, for so long mainly ideological rhetoric, does appear to be occurring rather more often, though the doctor remains very much as captain of the team and there is considerable variation between rural and urban areas. In this respect, I agree with Freidson's (1977, 28) contention that "interdependence does not necessarily corrode dominance." There has been a marked growth in militancy among paramedical groups, particularly nurses. The last few years have seen nursing largely abandon professionalism as the strategy for occupational advancement, and adopt trade unionism as the preferred strategy. The consequences of such a change were reflected in the state of Victoria in a seven-week nursing strike at the end of 1986. What has thrown doctor/nurse relations into sharp relief has been the process of tech-

nological innovation. One of the nurses' grievances has been that they don't get consulted about which technology is introduced or how it is used, yet they are often required to operate it and deal with patient discomfort, etc. Certainly, it appears that the traditional role of nurses as "handmaidens" to doctors has been eroded and, to that extent, the doctors' authority has diminished. Many doctors spoken to will report that they are aware of needing to be much more "careful" in their relations with nurses than previously. Authority changes in relations with other health occupations are also apparent, though perhaps to a lesser extent than with nurses. A concrete result of some decline in authority and growth of interdependence of doctors with others (lamented by many doctors) is the loss of privileged parking access for medical staff at some city hospitals, meaning that doctors have to take their chances with the rest of the health work force.

Another area where it could reasonably be said that medical authority has declined is with patients vis-à-vis alternative or preferably complementary medicine. Utilization of complementary practitioners—such as chiropractors, osteopaths, natural therapists, and practitioners of traditional Chinese medicine—has been growing rapidly (Willis 1989b) even in spite of, or even perhaps because of, medical opposition. Chiropractic is a good example, now having statutory registration in every part of Australia and within the state-funded tertiary education system. The legitimation of chiropractic, both legally and clinically, has long been opposed by organized medicine, even though it is clear that individual referral relationships have existed for a long time. Medical opposition to the statutory registration of chiropractic did not prevent it occurring, largely because of the gradual process of the separation of medicine and the state. Whereas traditionally legitimation was dependent upon medical approval, complementary modalities have increasingly looked directly to the state for legitimation.

Yet, this decline in medical authority should not be overstated. Practitioners of complementary health care modalities have so far been unsuccessful in gaining access to the hospital system, either public or private. Furthermore, a number of recommendations by government inquiries for research monies to be made available to investigate properly the efficacy of these complementary modalities have fallen on the deaf ears of medically dominated research funding bodies (see Willis 1989b).

The other health occupation sometimes considered a threat to medical dominance involves health administrators who are not also medically qualified. Certainly, there has been a trend toward requiring chief executives of hospitals both public and private to be nonmedically qualified administrators, though this varies. Likewise, there has been a trend towards corporatization of private hospitals identified elsewhere, with the entry of several American multinational hospital companies into Australia. The question is whether such changes of ownership and direction have led to a decline in medical dominance. My argument would be that the form of dominance has changed from overt to (relatively) subtle. Medical committees within hospitals remain very powerful. Administrators may be able to implement budget cuts of one sort and another, but the medical committees have a powerful say in how this occurs. The size of the budgetary cake to be divided up might be smaller as a whole, but that does not mean a redistribution in the relative size of the slices.

The same might be said of the decline in medical dominance of the state health bureaucracies. In the Victoria health commission, for instance, a policy of administrative regionalization was recently implemented. All but one of the regional directors are currently nonmedically qualified. Yet, they remain heavily dependent upon medical advisory committees and limited in their ability to effect changes of a distributive nature.

This raises the issue of the third level of medical dominance; that referred to as *sovereignty* at the level of the state. As in most Western capitalist economics, the fiscal crisis of the state has led to attempts, under pressure from dominant classes, to reduce government expenditure in "social areas" such as health and welfare. The capitalist state has indeed been increasingly interventionist in the era of monopoly capitalism in Australia, as elsewhere. Attempts to reduce government expenditure on health care have been seen in the removal of "cosmetic" surgery items in the schedule for which Medicare benefits are payable. The close identification of doctors with the state has in the past been based upon class affinities, the compatibility of medical knowledge and sympathetic governments occupying the legislative arm of the state, all of which provided the basis for medical dominance having reached its peak in the 1960s. Since that time however, the changes outlined earlier in this article have meant that the state has increasingly become a terrain on which struggles over social expenditure have taken place.

In the struggle to maintain their position, the possibility at least has emerged of coalitions between doctors and patient groups to preserve social expenditure in the face of dominant class pressure to reduce it.

For now however, at the level of the state, medical sovereignty largely continues. Medicine retains its role as an institution of social control. Indeed as a number of observers have noted, its influence may be increasing with increasing secularization. Nonmedical representation on state health bodies remains at this point largely a token one, and medical certificates from doctors are required to legitimate all sorts of state benefits in the health arena. Only in the area of legitimation of absence from work for sick leave purposes has there been some erosion, with some employers accepting certificates from practitioners other than doctors.

Status

Deprofessionalization, proletarianization, or the maintenance of medical dominance is, of course, only one means of addressing the issue of the changing social position of doctors. Other relevant evidence which might be considered is the status of doctors themselves. If status is taken as the indicator of the social position of doctors, as measured by public opinion polls, then the situation is changing very little. While other occupations have regularly received a higher or lower ranking of public esteem over time, doctors have maintained their position at the top of the list. In the latest available assessment of public opinion carried out by the Gallup method in 1986, 74 percent of Australians placed doctors at the top of the list when asked to nominate the five occupations they held in highest regard. When the last poll was held in 1984, doctors topped the list for 63 percent of Australians (Australian Public Opinion Polls 1986).

Conclusion

Within the limits of a general paucity of available evidence, this article has argued that the most useful way to make sociological sense of the changing social position of doctors continues to be the professional dominance tradition of explanation, albeit modified and referred to

here as medical dominance. Such medical dominance, the end point of an historical process of the creation and maintenance of medical control, probably peaked in the 1960s in Australia and has been waning since. At the same time, the decline in medical dominance has not been sufficient to suggest that either deprofessionalization or proletarianization has or is occurring. Instead, medical dominance has changed its form and become more subtle and indirect than previously. Changes in the form of medical dominance does not mean changes in its applicability as a whole. Indeed, drawing upon the argument made by Larkin (1981, 26) in the United Kingdom, I would argue that the evidence presented in this article represents "no more the end of dominance than imperial withdrawal is the remoulding of international economic relationships." Many third-world countries continue to be dominated economically by their former imperialist masters, despite political independence.

But while, in the Australian context, medical dominance remains most useful sociologically to explain the position of doctors as the country enters the third century of white settlement, the historical process continues. If the extent of medical dominance peaked in the 1960s and has declined since then, further declines appear likely. A number of the trends in doctoring identified earlier in this issue, especially in the United States, are not apparent or only beginning to be apparent to anything like the same extent in other countries. If the first 150 years of white settlement of Australia were characterized by an alignment with the United Kingdom, in the last fifty years a realignment toward the United States, reflected by a whole variety of measures, especially economic and defence links. In this situation the third century of white settlement is likely to see an ever-increasing "Americanization" of Australian life and trends identified in the social position of doctors in the United States increasingly reflected here.

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