Introduction

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WE ARE WITNESSING A MAJOR TRANSFORMATION of the health care systems of the more developed countries that is without parallel in modern times. These institutional changes have implications for the entire division of labor in health care. While there is general agreement on the fact of change, there is healthy debate over its explanation and implications, especially with respect to the evolving social position of doctors. This supplement of the *Milbank Quarterly* captures some of a lively international debate: what is happening to doctoring, how is it to be explained, and what do institutional changes portend for the future of health workers?

Some of the major changes affecting the overall medical care system, its organization, and the content of services and training, are as follows:

(1) The involvement of large scale financial and industrial capital interests in the business of medicine;

(2) The ever expanding role of government at all levels, particularly through financing and regulation;

(3) Technological changes in the content of care which requires new plants, new equipment, different training, and new categories of workers;

(4) The emergence of a new group of medical administrators (sometimes physician) whose reference group, understandably, is the organization

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and whose actions (again understandably) are always in the interest of the bottom line;

(5) The emergence of an apparently more knowledgeable and questioning public, which challenges traditional medical interests.

(6) Evidence of the modest contribution (marginal utility) of medical care to improvement of the health status of populations (as distinct from individuals).

Other general changes could be added to this brief list. Starr (1982) has described some of the "social transformations" that are occurring in American medicine, but their explanation and their implications, especially for health care workers, remain to be developed. This supplement builds on such work and takes up such questions.

Manifestations of Change

What are some of the manifestations of these overall changes in medical care for everyday doctoring in the United States? A few illustrations should suffice. Physicians are increasingly an unhappy and disaffected group of workers. They complain more and more about bureaucratic encroachments, government interference, the crippling expense of malpractice insurance, and the effect of the threat of litigation on the content of care (defensive medicine). Medical journals regularly contain anecdotal reports from older doctors that medicine today is not like the "good old days." In discussing changes in doctoring with one medical school dean, I was told that he would not pay medical school tuition costs for his own children (although he would support their graduate training in other fields). Many physicians state openly (albeit in professional journals to their colleagues) that, if they had to do it over again, they would not pursue medicine as a career. There is evidence of the development of unionization among physicians; only about one-half of all physicians are members of the American Medical Association. The editor of, and invited commentators for, the *New England Journal of Medicine* have lamented the development of the for-profit motive and how it is eroding the ethical basis of medicine. There are complaints about a decline in real income for doctors (especially for the 50 percent or so who are fully salaried bureaucratic employees) and projections of a relative loss of earning power over the next decade.

Although still hotly argued, there are reports of an oversupply of

physicians—an excess of 150,000 by the year 2000—which threatens their market position. The ratio of doctors to the United States general population is expected to reach 1 to 300 by 1990, by which time there will be 1 health worker for every 14 people in the population. These health workers are encroaching upon the traditional domain of the doctor (albeit in the name of "team work" and "specialization"). College advisors are dissuading highly talented students from choosing medicine because its job market looks so bleak. There is no disputing the fact that medical school applications have declined; students apparently fear a glutted market. Practicing doctors state that their patients do not accord them the respect that they formerly received. Patients are apparently much more assertive or demanding, and threaten to take their "business" elsewhere if the satisfaction "demanded" is not received. Caveat emptor has replaced credat emptor. As bureaucratic employees of health organizations, physicians are required to "keep the customer satisfied" (even though patients can be dissatisfied with technically competent high-quality care and satisfied with technically inadequate care). There are reports that physicians are leaving medicine to pursue more satisfying work in other fields. This brief catalogue of manifestations could be readily expanded.

Occupational Prerogatives

In my own work on modern changes in doctoring (McKinlay 1977; McKinlay and Arches 1985, 1986; McKinlay and Stoeckle 1988), in order to provide operational specificity and to facilitate the collection of useful data, I have listed 7 specific occupational prerogatives that affect the relative position or power of any group of workers. They are based on earlier theoretical work and are as follows:

(1) The criteria for entrance (e.g., the credentialing system and membership requirements);

(2) The content of training (e.g., the scope and content of the medical curriculum);

(3) Autonomy regarding the terms and content of work (e.g., the ways in which what must be done is to be accomplished);

(4) The objects of labor (e.g., commodities produced or the clients served);

(5) The tools of labor (e.g., machinery, biotechnology, chemical apparatus);

(6) The means of labor (e.g., hospital buildings, clinic facilities, lab services); and

(7) The amount and rate of remuneration for labor (e.g., wage and salary levels, fee schedules).

The extent to which there are gains and/or losses in these prerogatives (i.e., changes in the power of any occupational category) is a function of the degree of unity and cohesiveness within an occupational grouping, the stage of production associated with the sectors in which the occupation is located, and the extent to which the tasks of the occupation can be technologized. Table 1 lists these 7 theoretically derived prerogatives and contrasts the situation in the United States of small-scale fee-for-service doctoring around the turn of the century with the typical situation of bureaucratically employed doctors today. Every single occupational prerogative listed has changed, many only over the last decade or so.

Levels of Analysis

In approaching the changing social position of doctors it is useful to distinguish among four levels of analysis, each of which affords a different view of doctoring in the United States, and perhaps elsewhere. What sometimes appear to be diametrically opposed viewpoints become simply perspectives from different levels. The same game looks different for the spectators in the stands (the public) than it does for the players on the field (health workers) or the teams' owners in the board room, or elected league representatives who mandate changes in the rules. The four levels are:

- The level of financial and industrial capital. Here I refer to the activity of vast multinational institutions—both financial and industrial corporations and the individuals and interests controlling them—and how their presence in and around the medical business is profoundly changing all spheres of medical care and especially the organization and content of medical work.
- The activities of the government (the state). At this level we are

TABLE 1
Some Differences between the Working Conditions of Doctors around 1900 and Today

Key prerogatives of an occupational group	Physicians in small-scale, fee-for-service practice (1900)	Physicians in bureaucratic practice today (1989)
1. Criteria for entrance	Almost exclusively upper- and middle-class white students.	Medical schools forced to recruit proportion of minorities and women.
2. Content of training	Largely dictated by American Medical Association through local medical societies.	Federal government and other "outside" interests affect content and scope of curriculum through training programs, student loans, etc.
3. Autonomy over the terms and content of work	Work typically more generalized and controlled by individual practitioner himself.	Work typically segmentalized and directed by administrators in accordance with organizational constraints (profit).
4. The object of labor	Patients usually regarded as physician's "own patients."	Patients technically clients, or members of organization, who physicians share with other specialists.
5. The tools of labor	Equipment typically owned or leased by practitioner and employees hired by the practitioner.	Technology typically owned by employing organization and operated by other bureaucratic employees.
6. The means of labor	Physical plant typically owned or rented and operated by physicians themselves.	Physical plant typically owned by and operated in interests of organization (profit).
7. Remuneration for labor	Hours worked, level of utilization, and fees charged pretty much determined by individual practitioner.	Work schedule and salary level determined by organization. Sometimes limitations on "outside practice."

concerned with how the vast resources of the state, subordinated as they now clearly are to the institutions and interests identified with the first level, are employed to: (a) protect and brokerage the prerogatives of these institutions; (b) ensure that medical care, as an area of investment, remains conducive to the realization of profit; and (c) shape, through partisan legislative action, the scope and content of medical work and the consumption behavior of the public with respect to medical care.

- The level of medicine itself. At this third level we are interested in how—within the constraining context of the partisan activities of the state on behalf of the prerogatives of financial and industrial interests—medical activity is actually conducted. This level of analysis includes, for example, research on the training and content of medical labor, managerial studies of medical organizations, positivistic accounts of the efficiency of medical practice, and epidemiological rationalizations for the existence of medicine. And, it is at this and the following fourth level that most medical care and health services research continues to be conducted.
- The level of the public. Here we are concerned with the vast number of people who are the potential users of, and increasingly the subjects for medicine—a category loosely termed "the public"—which may actually be incidental to medical activity itself (it could conceivably proceed without their involvement) and is presently the most vulnerable of all to the activities of those at the three other levels already distinguished.

By way of analogy, one can conceive of medical-care-related activities as *the game* among a group of highly trained players, carefully selected for the affinity of their interests with the requirements of prevailing medical institutions, that is, watched by a vast number of *spectators* (involving all of the people some of the time and, increasingly, some of the people all of the time). And surrounding this game itself, with its interested public, is *the state* (setting the rules by which the game ought to be played before the public), the presence of which ensures the legitimacy of the game and guarantees, through resources derived from spectators, that the prerogatives and interests of the owners of the park (*financial and industrial capital*) are always protected and advanced.

In the context of this analogy, it becomes clear where most of the

research on the occupational division of health work is now being focused. When supposedly independent medical care researchers are not caught up observing the game of medicine itself (and I admit that it is sometimes very difficult not to), they are usually to be found observing the observers of the game (the public).

Once one becomes aware of the magnitude of the structural changes now being forced upon the business of medicine, then the very issues selected for investigation and the levels of analysis and concepts adopted to explain them are profoundly influenced. As it is generally practiced, health services research overlooks the political and economic setting within which the medical game is currently played and, consequently, remains preoccupied with issues of relative unimportance. I am of the opinion that there is very little in the existing common fund of knowledge of traditional medical care and health services research that will enable us to get a handle on what is now going on in and around the business of medicine today. Indeed, the current preoccupation with, for example, managerial changes and the measurement of efficiency, while interesting, is likely to yield little that will enable us to understand the changing nature of the medical game and the position of participants within it (both medical care workers and a consuming public) that could result in political action, effective social policy, and change aimed at fulfilling collective needs.

Outline

Given this general background, a few words on the overall organization of this special issue are in order. It is divided into two general sections: the first focuses on the situation of doctoring in the United States. The opening article by Donald Light and Sol Levine is intended to provide a general introduction to theoretical perspectives which follow. Some pervasive conceptual issues are outlined. Three articles, more or less representative of presently dominant viewpoints, follow this and discuss theories of professional dominance (Fredric Wolinsky), deprofessionalization (Marie Haug), and proletarianization (Vicente Navarro). While these authors assess these general theories, there is no suggestion that they represent or advocate them. Moving from the abstractly theoretical to the everyday world of doctoring, John Stoeckle (a practicing primary care doctor) reflects on modern medical work.

His insights from everyday practice and many years of experience are a counterbalance to the sociological and theoretical contributions which precede his essay. Many observers of modern doctoring have little intimate knowledge of changes in the house of medicine and how they affect everyday doctoring.

The second general section is devoted to discussion of recent changes in doctoring in other national settings. Frequently, the adequacy of different theoretical explanations is assessed by reference to experience in other countries. How come explanation *x* doesn't account for what is occurring in country *y*? Recognizing the importance of cross-national comparative experience, internationally recognized authorities discuss the current social position of doctors in their own national setting or country of interest. The wisdom of examining cross-national experiences is clearly demonstrated in the insightful discussions of Canada (David Coburn), Great Britain (Gerald Larkin), the Nordic Countries (Elianne Riska), Australia (Evan Willis), Italy (Elliott Krause) and the Soviet Union (Mark Field). These articles, assembling data and experiences not always readily available, provide a gauge by which we can assess the magnitude of changes in the United States and the adequacy of the different theoretical explanations outlined in the first section. A final contribution by Frederic Hafferty serves as a carefully balanced concluding discussion of some of the major strengths and limitations of the preceding articles.

The fine contributions in this supplement to the *Milbank Quarterly* reveal a welcome maturity in the analysis of modern doctoring. The ideological basis of work in the 1960s and 1970s required a villain to whom responsibility could be ascribed. For many conservatives, liberals, and progressives—for reasons that cannot be discussed here—physicians became an easy target. Here we move beyond the superficial level of "doctor bashing" to consider the situation of doctors and their activities in relation to more basic structural and systemic processes that impinge upon them. None of the contributors to this supplement find the earlier conspiratorial theories in any way adequate.

It has been my privilege to work with the contributors in putting together this special issue. The effort in compiling this work has been more than worthwhile because I have learned so much from valued colleagues. I hope that this new contribution to the common fund of knowledge will stimulate further research and understanding of the

changing social position of doctors, not only in the United States, but in other national settings as well.

References

McKinlay, J.B. 1977. The Business of Good Doctoring or Doctoring as Good Business: Reflections on Freidson's View of the Medical Game. *International Journal of Health Services* 7 (30):459–87.

McKinlay, J.B., and J. Arches, 1985. Toward the Proletarianization of Physicians. *International Journal of Health Services* 15 (2):161–95.

———. 1986. Historical Changes in Doctoring: A Reply to Milton Roemer. *International Journal of Health Services* 16 (3):473–77.

McKinlay, J.B., and J.D. Stoeckle. 1988. Corporatization and the Social Transformation of Doctoring. *International Journal of Health Services* 18 (2):191–205.

Starr, P. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

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