Medical Dominance in Britain: Image and Historical Reality

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THE POWER AND POSITION OF DOCTORS AS A principal determining force in the health care system has long been a major assumption of much sociological and related policy analysis. They have been viewed collectively as the central actors in medicine's modern evolution, and are still seen by many social scientists to be responsible for the development of its principal organizational features. The medical profession has come to be understood as the clearest example of the broader sociological concept of "professionalism," as indicating an identifiably different form of work organization from that enjoyed by most employees in modern industrial societies. As influentially delineated by Freidson (1970a, 1970b), in its own sphere the profession of medicine has exemplified autonomous control of its knowledge base, of its clinical practices, and of a web of allied subordinate occupations. It has also developed a very substantial degree of control over clients of all kinds, and through all these features has escaped the managerial and bureaucratic constraints integral to most forms of work.

Sociological accounts have differed as to the precise historical origins and sustaining rationale for this rare concentration of occupational authority, from Weberian emphases on the success of market closure stratagems (Berlant 1975) to neo-Marxist accounts which link medicine's ascendancy to its facilitating role in the rise of modern capitalism (Larson 1977). Both perspectives, however, have more generally shared

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a recent and contemporary picture of medical power and authority, if not of its derivations, as being almost a "state within the modern state" with either an acquired or invested sovereignty. More recently, the bureaucratic requirements of the modern state that are linked to cost-control and profit measures are viewed as possibly challenging the accuracy of this depiction (McKinlay 1985). Freidson (1985), by contrast, has reviewed many of these developments and has judged medical dominance to be possibly a little beleaguered but far from deflated by them. Other analysts, however, detect the accumulation of a number of changes which amount to processes of deprofessionalization or proletarialization and, thus, by direct implication a qualitative change in the nature of medical power.

The character of these concepts and their empirical referents are discussed elsewhere in this volume, and, thus, will not directly be addressed in this article. It will be rather argued that both protagonists of change and those of continuity of professional dominance, in part, share a misapprehension despite their many other differences. This centers upon a common tendency to accept the "state within a state" concept or an arguably overstated version of medical dominance that was true in the past, whilst being at issue only with regard to the present. McKinlay and Stoeckle (1987), for example, review the impact of many social and economic changes upon medical dominance. They credit Freidson's account with an accuracy up to the 1960s and argue that it is now in need of substantial reevaluation. This may be a safe judgment with regard to the development of health care in the United States, but it will be argued here that such a view requires some modification with regard to the development of medical dominance in the United Kingdom. In the British context, the exercise of judging whether medical dominance is continuing or changing raises two more fundamental questions, viz., against which points in history as a basis for comparison are judgments to be made, and across what period of time is the scale and pace of change to be assessed.

Freidson's account, it will be argued through a consideration of these questions, can too readily be applied to the British context, where neither waxing nor waning theses unambiguously relate to historical evidence. The question as to whether medical dominance is stable or in decline is an issue that can only be reasonably addressed within the terms of its development across the span of this century—the principal period of the rapid evolution of the complex health care division of labor. In the United Kingdom this was also the period

of the most extensive state mediation in health care, to use Johnson's (1972) third type of occupation/client relationship. Only across such a time span is it possible to assess whether there has been a build-up or erosion of medical dominance, or whether forces and changes at particular points are indeed substantive or merely ephemeral in implication. Both advocates of variants of the deprofessionalization thesis and that of the continuity of professional dominance ultimately must test their case against medicine throughout the twentieth century, rather than through the past few, arguably very significant, decades. Both the enclosure (McKinlay 1985) of medical dominance and paradoxically its expansion, it will be argued, are inextricably intertwined.

Demonstrating this thesis is naturally a very major sociohistorical task in all aspects of the evolving position of the medical profession. Available British-based studies of professional power also chiefly focus upon medical ascendancy through the nineteenth century rather than analyze the twentieth-century nature of doctor/state relationships. The former was a period when Johnson's other categories of occupational control, of oligarchic and collegiate modes of organization, arguably have greater application. Freidson's (1985) account, however, emphasizes a major and central dimension to medical dominance that may be briefly reviewed through this century. Medical dominance, he confirms, refers primarily "to the relation of the medical profession to most other health care occupations in the division of labor." Through the twentieth century the preservation of a medical monopoly by definition implied the incorporation and subordination of potentially rival producers of many aspects of health care. In Freidson's picture these related groups were subjected in everyday practice to close medical direction, or were supervized from a distance within carefully calculated non-negotiable degrees of very limited freedom. Everyday subordination was sustained by the growth of an overarching national licensing system, which generalized and integrated medical control. The related terms of codes of conduct changed or evolved in minor detail, but only by way of reaction to changes in the expression of medical dominance, rather than by diminishing the power which remains its essence. The medical profession through time dynamically preserves its dominance by adapting to changing circumstances or, as Freidson (1985) puts it, maintains a continuing political agency:

> It is that organized character of the profession and the connection of its organization to state policy making and institutional chartering

> that pose a major barrier to actual deprofessionalization or proletarianization. Potentially critical pressures have been cushioned by adaptive changes in the organization of the interrelations among members of the profession, changes intended to satisfy the demands of consumers, politicians, and third-party payers without sacrificing overall professional control.

The medical profession in this characterization is thus able to preserve its dominance through adaptation, and associated changes are not to be confused with any fundamental erosion of renegotiated positions. As Freidson points out, however, the continuity of this adaptive capacity is not automatic nor inevitable in the present and future conditions of health care. It is predicated upon maintaining "the cohesion of the medical profession during its twentieth-century prime." The growths of specialties and other divisions within the profession may diminish its adaptive cohesion, particularly as different groups of doctors compete against each other for market shares and diminishing resources. The dangers of an internal fragmentation of interest have so far been largely contained, and have yet to diminish materially medicine's continuing ascendancy over related and potentially rival occupations. This core element of dominance thus continues, which raises a number of assumptions that can be subjected to historical evaluation in the British case. Whether medical dominance remains in force begs the further question as to the security and extent of its earlier terms of establishment. The possibility remains that the position negotiated by medicine has, in fact, been more tentative and incomplete than this perspective supposes. Medical dominance itself may have been sponsored and shaped by more powerful forces in the evolution of the twentieth-century development of health care.

One question which then arises may be put in the following form: To what extent was the development of medical power over other occupations itself subjected to processes and phases of control? Freidson's perspective would suggest that the medical profession historically negotiated consent for its control of other professions. Its own mandate from ruling elites was thus adaptively extended to this end, which still leaves the further question as to whether the terms of this contract were, in fact, those of autonomy or supervized license. In the British case, medical dominance was not achieved apart from but through and with the state. In other words its character and extent was constrained by government, rather than enlarged upon by the medical

profession in a separate zone of autonomous development. Authority in medicine has been both state-sustained and circumscribed, which points to a necessary distinction in historical analysis between medical dominance within and control of the development of the broader medical division of labor. The British state partly conceded the former type of authority, but through the twentieth century has never fully empowered doctors as a group in the latter dimension. Both functional control at a given point in time and fundamental control through time require analysis, as linked but distinct zones of change in the expression of and limits to dominance. Within this approach the very extensive historical role of the medical profession as outlined by Freidson and others may be readily acknowledged, but equally the limits of its formative influence may also be detected. These limits appear in the past—in the period of medicine's "prime" as a profession—and continue into the changed circumstances of the present, rather than recently appearing because of them.

Ministry and Medical Control

The past development of occupations in medicine must be viewed in terms not just of medical dominance but the management and containment of the medical division of labor. The medical profession assumed an agency function in this task, but on behalf of a state that carefully determined its scope. It also intervened directly over time as the medical profession deviated into a pursuit of its own interests. To sustain this thesis requires a comprehensive account of decades of development, which cannot be presented here (Larkin 1983). Some principal features of pre- and post-National Health Service occupational management may be examined and summarized, however, with regard to both orthodox and alternative health care workers. The two spheres are linked insofar as the processes of subordination within conventional medicine and the exclusion of the recalcitrant or heterodox outside of it are related facets of the same fundamental process. At the turn of the century in the United Kingdom doctors faced the tasks of meeting and capitalizing on a growing demand for health services. This challenge involved preventing any encroachment by rivals on the expanding market, together with organizing the delivery of medical care through their own controlled channels. Catering for mass medicine,

rather than solo practice, involved state support for organizing the expanding army of coworkers. The historical seniority and organized nature of the medical profession ensured that the state had no choice of partners in this enterprise.

Doctors composed the first modern health care occupation to acquire state registration through the 1858 Medical Act, which finally unified the ancient orders of apothecary, surgeon, and physician. The unitary if not unified profession was able to standardize its training and practices, as the accumulating scientific discoveries of subsequent decades began to alter the character of medicine. The discovery of the principle of an asepsis, anaesthesia, of new drugs and their dosimetry, of the microprocesses of human physiology and biochemistry, of X-rays, etc. placed the allopathic majority of the profession in an advantageous position to respond to broader changes. By the first decades of the twentieth century the state had become progressively involved in health and welfare services, given the accumulating evidence of inadequate laissez-faire industrial and social policies. Despite official British Medical Association opposition to growing state intervention in health care, in reality doctors were in oversupply for the existing private sector (Thane 1982). Thus, they joined the expanding local-authority medical schemes, municipal hospitals, and statutory insurance-backed panel practices which accumulated piecemeal up to 1939. The founding of the Ministry of Health in 1918, in particular, intensified an alliance between the medical profession and state, characterized from this point by a growing clarification of governmental control within the relationship. The expansion of hospitals, clinics, and the application of new technologies called not only for an elaborate labor force but also created a need for the creditentialing of its sections in a new and larger-scale bureaucratic order.

To carry this task forward, both doctors and the state had to resist the recognition of the remnants of nineteenth-century medical schisms and other groups with different notions of medical practice. Through the 1858 act the medical profession had not achieved the statutory powers of a substantive monopoly on health work, and thus had no strictly legal authority to proscribe nonapproved theories of healing and practice. Its statutory protection was one of title, which in itself was a weak form of market closure. This, however, was bolstered by a close alliance with the state, wherein employment for any practitioner in the growingly important public sector in whatever form was deemed

to require a registered medical qualification. The administration of state expansion in this sense added a twentieth-century monopoly in practice onto a nineteenth-century protection of the title of registered medical practitioner.

The enhanced value of state registration had thus not been diluted by its dissemination to erstwhile or new rivals. Groups such as herbalists in 1923, and osteopaths in 1933, were denied access to state registration and, in turn, to government-sponsored jobs and clients, and so were marginalized in the relatively shrinking private sector. It should be noted that the medical profession's repeated calls for a complete prohibition in law were never successful against "quack" practice. Medically trained Ministry of Health officials, in alliance with their clinical colleagues, instead protected the emergent and increasingly dominant public sector from "contamination." They were not directly able, however, to dislodge notable sections of the public or Parliament from a preference for forms of unqualified practice (Larkin 1988). The "alternative" practitioners were instead contained by exclusion from public employment, and by the use of bureaucratic criteria which deemed sicknotes signed by conventional doctors to be necessary for insurance-claim eligibility. In his respect, medical dominance over the health care market up to 1939 was established through the agency of the state.

State sponsorship of the allopathic sect against rival smaller groups was also linked to assisting it, often against medical objections, in the elaboration of control over a hierarchy of subordinate occupations. Following the limited forms of registration achieved by nurses in 1919 and dentists in 1921, many other emergent skill groups sought similar forms of recognition and legal status. Some of these still operated principally in the private market, whilst others were municipal- or voluntary-hospital-based. In the former case, ophthalmic opticians and chiropodists repeatedly tried through the 1920s to press bills for state registration through Parliament. Both the medical profession and Ministry of Health at first invariably obstructed these efforts. Ministry policy in this respect for a short while was closely aligned with that of the major medical bodies—such as the British Medical Association and General Medical Council—in opposition.

Following settlements with nurses and dentists after World War I, it was thought politic by all three bodies to resist any further claims for state registration by other groups. Health care, it was

argued, would be fragmented by the further recognition of a myriad of partly autonomous professions. The retention of authority through market control in this way was an end to the medical profession, which for a time coincided with ministry support for medical dominance as a means of bureaucratic control. The medical profession's claim to a monopoly, e.g., over all sighttesting, however, increasingly became untenable in the interwar years and indeed became an obstacle to other state policies linked to spreading the provision of optical benefit under the accumulation of insurance acts. Quite simply, there were not enough competent doctors to maintain the monopoly claimed, which led to state recognition of a Council of Opthalmic Opticians in 1936, and an open breach in unqualified ministry support for medical monopoly.

The conditional nature of state support for medical dominance over other health care occupations also became increasingly apparent in the hospital sector, although at a slightly slower pace. By the late 1920s a policy of immediate opposition to all but the most minimal of medical auxiliary ambitions became subject to internal debate within the British Medical Association (BMA). After all, as the chairman of its council argued (*British Medical Journal* 1928), doctors required subordinates, and thus had an interest in recognizing and stabilizing their modes of practice and training. Technicians and therapists, he argued, were increasingly important to the success of medical practice, and if properly controlled were highly useful. This position, thought at the time by many doctors to be dangerous, stimulated a succession of debates over eight years, before the BMA founded its own Board of Registration for Medical Auxiliaries in 1936. Whilst ministry officials supported this development, the profession remained divided between those who feared that any form of recognition, however minor and subjugating, would advance the erosion of medical authority and those who feared that reactionary and defensive attitudes would ill-secure its future.

Those tensions resulted in the board, decreasingly supported by the Ministry of Health, essentially failing in its central imperialist policy in the years up to the inception of the National Health Service. To allay medical fears, its constitution had incorporated two central features, of a permanent BMA-nominated voting majority on all policy matters and a duty on all affiliates to work exclusively under the

direction of registered medical practitioners. In effect, affiliates were offered medical legitimacy as a lure into accepting or acknowledging medical subordination, through the accredited control of their training and practice. Over the following years, however, the board was unable to cut through a number of dilemmas and tensions in its development. First, the entry terms so thoroughly subordinated applicants that many auxiliary groups would not join, or their associations split on the issue of affiliation. Second, any expansion of membership was opposed by the first few affiliates as diluting the scarcity value and status of medical legitimacy. Third, the system was voluntary, and many self-employed opticians, chiropodists, physiotherapists, and others in the extrahospital sector would not pay fees for BMA recognition. After the foundation of the Emergency War Health Service in 1939 and during the planning stages for a National Health Service, the BMA began to press the Ministry to upgrade its Board of Registration. In effect, it lobbied through the 1940s for the board to be granted powerful statutory powers of management over the remaining majority of, as yet, nonregistered and recalcitrant medical auxiliary occupations. This was also judged to be unrealistic, as the Ministry was forced to recognize increasing hostility to the BMA's plans. Its recognition of divergent interests intensified along with the approach of its direct management role in the new service, which required cooperation from many health professional groups in addition to doctors (Larkin 1983).

Through the interwar years the Ministry had been content to block an extension of state registration acts, and to support the BMA's attempt to establish an essentially voluntary system of control. It was not prepared to fully empower the medical profession in any statutory way to control others and thereby diminish its own authority, least of all in the post-1945 period as the state itself became the direct employer of all health care workers. Through this period the medical corporations decisively and enduringly influenced many aspects of the National Health Service at its formative planning stages, but they also faced defeats. Representatives of medical interests failed to push forward their already fragmenting policy of complete dominance over the many emergent professions. From the early 1940s, official medical policies were increasingly judged to be prejudicial to effective and stable administration, and in their full forms too reactionary to implement. The recommendations of the *Cope Report* (1951)—the BMA's

inter-war policy in its last but transparent disguise—were quietly dropped by the government, anxious to secure the cooperation of all groups in the new service.

Through the 1950s the premier profession went on with decreasing success and credibility to continue to lobby, against the state registration of opticians in 1958 and of a further eight professions supplementary to medicine two years later. Instead, in recognition of the importance of medical authority, doctors were allowed a substantial but far from determining statutory presence on the registration boards of other groups. Medical dominance was thus not allowed to extend to the blocking of other occupations from achieving the validation and regulation of their own standards of training and practice. Medically opposed further registration laws on the one hand certainly limited any encroachment by new groups on doctors' carefully guarded responsibilities, principally the tasks of diagnosis and prescription. On the other, they also carefully limited the extent of doctor interference in paramedical affairs. The state in an umpire role was intent on developing and stabilizing an occupational structure. It preserved medicine's premier position within it rather than promoted its full power to determine the structure's present and future.

In the British case, state opposition to complete doctor control of the emergent division of labour paradoxically sustained the preservation of medical authority within it. This feature of state intervention was, for example, also seen by sections of the medical profession as advantageous, at least at this juncture. The *Lancet* (Fox 1956) supported the aims of state policy to create an ordered commonwealth of health occupations, rather than an arguably self-destructive rigid system of control in line with majority medical opinion. Looking back over the half century up to 1960 as a period of progressive state involvement in the health care system, it is possible to view medical hegemony in this way as preserved through amendment by the state. The medical profession faced numerous instabilities in the interwar period, which took the form of continuous occupational boundary disputes. It was not in this sense a period when medical power was at its zenith, but rather one in which it failed finally to secure its own ends of extensive occupational domination.

Armstrong's (1976) argument of a post-1948 decline in medical hegemony is thus misleading, particularly through its principal theme that state recognition of the skills of other groups came into force in

the subsequent decade. The state had been involved in both the rise and constraint of modern medical dominance for a half century up to that point. Its interest through this whole period was in the medical profession as a proxy manager within a medical division of labor, subject in outline to its own control. The medical division of labor was progressively codified in law, and paramedical specialization compatible with a growing hierarchy of roles and a modified medical authority was encouraged. As these groups multiplied, direct medical supervision over time diminished, which led occupations such as physiotherapy into greater organizational autonomy within, but not with, in this analysis, final control over its skill boundaries (Ovretveit 1985). Hierarchical and bureaucratic control have thus been systematically advanced by an accumulation of increasingly internally autonomous but carefully circumscribed occupations.

Post-1960 Developments

The inherently substantial yet limited nature of occupational advance up to the 1960s in Britain led to a growing awareness across all paramedical areas that state registration and professionalization were only loosely related. In particular, through the 1970s many health professional associations came to feel that their qualifications, by separation from higher education, lacked academic and broader status credibility (Council for Professions Supplementary to Medicine 1979). Forms of training in National Health Service schools, albeit monitored and validated by statutory boards of inspection staffed by their fellow professionals, decreasingly satisfied their preferred self-images and ambitions (United Kingdom Central Council for Nursing, Midwifery, and Health Visiting 1986). Increasingly, professional organizations, with statutory board support, have set their sights on higher education and graduate, rather than simply licensed, status for their membership. These ambitions and the increasingly specialized nature of paramedical tasks, in turn, could now suggest the emergence of new challenges to medical authority and more fundamental changes in the rigidity of medical division of labor.

Although much discussion over training reforms has been generated and has recently intensified, it should be noted that only 1.7 percent of nonmedical and dental health professionals are the products so far

of compulsory higher education degree-standard training in England (Department of Health 1985). Other groups such as nurses now have noncompulsory degree schemes, but for only a very small fraction of their better-qualified neophytes. The vast majority of nondoctor health professionals are still trained in National Health Service schools with their associated traditional patterns of occupational socialization. Ironically, these widespread aspirations for change have gathered force through the years of a state-perceived crisis in the financial management of public health, welfare, and educational institutions. It is difficult at this stage to predict the future outcome of these countervailing pressures, given also an overall requirement to replenish the health-professional work force from a decreasing pool of eligible applicants, given demographic changes. It is arguable that far from a general and radical upgrading of training occurring, which might bring major changes to the social organization of medicine, further segmentation within professions will occur. In each case a minority stratum of graduates may take managerial roles, so that health professions are also placed under pressure to drop entry standards for the majority. Thus, "re-skilling" and "de-skilling" may occur simultaneously, as fewer of the fully qualified control an increasing number of lesser paid and trained "aides." Such an outcome is not likely to diminish but rather to extend and reinforce the principle of professional division and bureaucratic elaboration that have always characterized the organization of the health work force. Professional aspirations may thus extend the hierarchy of control rather than directly, if realized, impinge on the authority of doctors within it.

In addition to rekindled paramedical ambitions, there is also evidence that medical authority is undergoing direct and indirect local managerial erosion. As Harrison (1988) points out, for approximately forty years both doctors and hospital managers shared a broad consensus over spending priorities, which may be ending in an era of fast-developing performance indicators, capped budgets, and unit-cost measurements. These developments may have longer-term implications for the stability of the medical division of labor, which in the past has been underpinned by a supposed fundamental stability in central funding. In Britain over the past forty years, there have been no local financial inducements of retained benefit from any challenge to professional boundaries by the use of lower-cost alternatives, such as nurses, for aspects of medical work. Very radical changes in the funding of the National Health

Service, under discussion at present, involving internal markets and public/private local joint services if realized (Davies 1987), could strain commitments to role boundaries, skill mixes, and professional monopolies previously underpinned by a nationally administered expanding budget.

Doctors together with many occupations instead may face changing relations with former administrators, now managers jointly charged with creating profitability and an advance toward governmentally decided priorities in spending. It is very difficult to interpret the fixed-term ministry-approved appointments of health authority general managers, following the Griffiths Report (Department of Health and Social Security 1983) in any other way. Caution, however, is again required in linking, as yet, unfinished policy developments to fundamental erosions of medical authority. First, managers cannot deliver treatment, which in practically all major forms still requires a doctor-coordinated division of responsibilities. Even superficially less hierarchic forms of teamwork usually leave medical authority still in a vital place at its center. More fundamentally, however, apart from practical limits to possible reductions in medical authority, it should be noted that the earlier partly mythical period of expanding or open-ended budgets was not the product of medical authority. It may have enhanced clinical autonomy by giving doctors a wider range of treatment options, and thus extended their sense of the extent of their choice. Medical authority did not produce earlier, more favorable, budgetary phases, however, but rather has been their beneficiary in the history of the National Health Service. It was and remains in this sense secondary to, rather directly constitutive of, state policy which evolves under the force of many other factors.

The state management of doctors through bureaucratic encroachment may also endorse rather than dislodge the premier or senior position held by doctors in the medical division of labor. The consequences of further bureaucratic supervision for the relative position of occupations in part depend on the range of control, and whether it specifically affects the medical profession or all health care professions. Whilst particular instances of increasing supervision can be cited which disadvantage doctors, it is difficult to see that the longer-term burden of bureaucratic constraint will only affect doctors. In Britain so far, they have not been comparatively disadvantaged to any point of serious erosion of their authority, status, and income differentials over other

health care workers. The same forces which may reduce medical control over the planning and delivery of health care are also likely to have a notably greater impact upon less-powerful professions. Productivity measures for medical work, however novel, follow, it should be noted, decades of "time-and-motion" studies in the National Health Service of other workers to establish "cost-effective" staffing levels. Both dominance and disestablishment theses must be tested not only against the single profession of medicine but also the broader context of the many related dimensions of power between occupations. As in other spheres of sociological analysis, zero-sum assumptions may simplify rather than fully delineate the complex, linked relativities in the distribution of occupational power.

Governmental management and supervision of doctors, along with all other health professions, may be intensifying through the National Health Service, but the position of the medical profession at earlier points was established through centralized state supervision of health care. The expansion and limits of its authority have both grown with state intervention, which may distinguish Britain from other countries with regard to the sequential rise and diminution of medical dominance. Coburn's (1986) view that, inter alia, a process of decline in medicine's power in health care is brought about by state involvement in the health field may well apply to countries where the medical profession was entrenched in a modern elaborate health system only latterly subject to governmental regulation. On the other hand, a state-sponsored conversion of a cottage industry into a more rationalized and bureaucratic health care system may also initially promote a partial expansion of medical hegemony. In the British case, state intervention largely facilitated an expansion of medical power in a symbiotic but also unequally growing relationship between the two processes. Within it, in Freidson's full sense, the medical profession has held not so much full control but instead a managerial role subject to review and amendment. It has arisen with state intervention in a complex but subordinate relationship subject, to date, in at least one major feature of controlling allied occupations, to neither sustained domination nor yet to disestablishment. It may be that phases in medical dominance are not inversely related to state intervention, but grow and diminish in the longer term according to the type and expression of this intervention. A full articulation of these links may, at present, be inhibited in the British case by our experience to date of only one

phase in our recent history, that is across half a century of the relative reduction up to the last decade of the private market.

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