

Professional Dominance or Proletarianization?: Neither

VICENTE NAVARRO

Johns Hopkins University

ONE OF THE MOST IMPORTANT THEORETICAL positions put forward to explain the nature of medical knowledge and practice and the organization of medicine in the United States has been the *professional-dominance* position, articulated primarily by Eliot Freidson. (Although the best-known representative of this position is Professor Freidson, many other authors have rooted their analysis of medicine in the United States in this theoretical position: Berland [1975], Illich [1976], and Arney [1982] among others. There are, of course, differences among these authors in the presentation and interpretation of professional dominance. In this article, I will focus on the main points of characterization of the professional-dominance position, best articulated, in my opinion, by Professor Freidson [1970a, 1970b, 1980, 1986].) In this position, the medical profession dominates the medical care system in the production of medical knowledge, in the division of labor in medicine, in the provision of health services, and in the organization of medicine. This dominance comes from the monopolistic control of the medical profession over the production of medical knowledge and the provision of medical services, and is reproduced by cultural, economic, and legal means. Culturally, the medical profession has been able to convince the dominant elites in our society of the value of its trade. As Freidson (1970b, 72–73) indicates, “It is essential that the dominant elite remain persuaded

of the positive value or at least the harmlessness of the profession's work, so that it continues to protect it from encroachment."

While the dominant elites are those that need to be persuaded, the state is the main guarantor of the monopolistic control of the physicians' trade since it gives the medical profession its exclusive right to practice. (Freidson does not touch on the relation between the dominant elite and the state. Thus, the source of state power is not analyzed in the professional-dominance position.)

The foundation of medicine's control over work is thus clearly political in character, involving the aid of the state in establishing and maintaining the profession's preeminence. . . . The most strategic and treasured characteristic of the profession—its autonomy—is therefore owed to its relationship to the sovereign state from which it is not ultimately autonomous (Freidson 1970b, 23–24).

Another requirement for the reproduction of professional dominance is that the profession convince the general public of the value of its work.

I suggested that scholarly or scientific professions may obtain and maintain a fairly secure status by virtue of winning solidly the support of a political, economic and social elite, but that such a consulting profession of medicine must, in order to win a secure status, make itself attractive to the general public which must support its members by consulting them. The contingency of the lay public was thus critical to the development of medicine as a profession (Freidson 1970b, 188).

It is important to stress that Freidson's position has remained remarkably unchanged during a time when we have witnessed enormous changes not only in the production of medical knowledge but in the individual and collective practice of medicine. In his most recent article on this topic, in which he predicts the further evolution of medicine, Freidson (1985, 32) restates that "there is no reason to believe that [in the future] medicine's position of dominance, its key position in the health care system, will change."

In this theoretical scenario, physicians and the medical profession are the dominant force that shapes the nature of medicine in the United States. This position does not deny, of course, that other forces

are competing with the medical profession for the power to determine the present and future course of medicine, but it does claim that the *medical profession has been, is, and will continue to be the dominant force in medicine.*

I believe that my summary of this position, although brief, is accurate. While I have omitted the many nuances and creative insights that the position entails, the main thrust is there: in the house of medicine, doctors are in command.

Do Doctors Control Medicine?

Let us focus on the basic assumptions that sustain the professional-dominance position and see the degree to which current and historical experience supports them. First, even in the lay press the perception that doctors are in charge in the institutions of medicine is changing very rapidly. As a *New York Times* article put it recently: "Doctors have lost some of their authority and independence to government officials, insurers, corporate managers and hospital administrators and they are alarmed at the trend" (Pear 1987). In the very same article, the head of a government regulatory agency is quoted as saying that "this loss of autonomy is extremely frustrating to doctors; doctors are pulling their hair out when bureaucrats like me tell them how to practice medicine" (Pear 1987). The article documents how government, insurance companies, and hospital administrators are increasingly dictating what is medically acceptable or appropriate in the treatment of patients. On the receiving end, the physicians increasingly feel that their autonomy is being forcefully challenged by nondoctors. The article concludes with the following statement from an orthopedic surgeon: "The judgment of physicians has been usurped by cookbook criteria created by people who are not doctors" (Pear 1987). Physicians themselves seem to feel that they are indeed losing control over their practice of medicine. According to a recent survey by the Association of American Medical Colleges of 500 students who scored well on admissions tests but did not apply to medical schools, 29 percent said that they had been discouraged from attending by physicians. In the middle 1970s there were 28 applicants for every 10 places in American medical schools; in 1987, there were only 17 applicants for every 10 places. This finding is in accord with the trend in recent

years: while the number of people graduating from college has not changed significantly in the last three years, the number applying to medical school has declined 22 percent in that period, from 35,944 to 28,123. Needless to say, this decline is a result of many different forces. But, it is important to note that doctors seem to be advising the young to look for other careers. This advice further illustrates doctors' frustrations.

I am, of course, aware of the argument that these data reflect mere popular and professional perceptions and may not correspond to reality. But, in the realm of power relations, perceptions are indeed important and part of reality. And, in this case, they are also indicators of a trend in which physicians are losing power to shape the practice of medicine. (For a detailed presentation of empirical evidence that shows the decline of professional dominance, see McKinlay and Arches 1985.)

Other trends also question some of Freidson's assumptions, such as high public trust in the medical profession and the subservience of other health care occupations to the medical profession. In support of the first position, Freidson (1985) quotes several polls indicating the high esteem that physicians enjoy among the population of the United States. But it is important to separate how people feel about their own doctors from how they feel about the collectivity of doctors as an organization, and how they feel about the medical system that doctors presumably dominate. Unpublished data from Louis Harris and Associates reveal that the public's confidence in medicine has fallen dramatically since the middle 1960s, from 73 percent to 39 percent (in 1985) (cited in Blendon and Altman 1987). And the degree of dissatisfaction with the system of American medicine is very high. A recent survey shows that the majority of the population of the United States is dissatisfied with the medical system in this country, and is calling for major changes (Schneider 1985).

Similarly, in the last 15 years we have witnessed an increasing number of health occupations that can practice without having their patients referred from physicians, as used to be the case. Physical therapists, for example, are able to receive patients directly in 16 states, and this number is growing.

Did the Doctors Once Dominate Medicine?: The Historical Roots of the Profession

My thesis, however, is not that the medical profession has lost dominance in medicine, but rather that it never had such dominance. Indeed, I believe it would be wrong to conclude from these observations, polls, and studies that once upon a time there was a medical profession that dominated medicine, but that this profession has been losing dominance with time. The lessening of power of the medical profession in the house of medicine does not necessarily mean that doctors were the most powerful force—the meaning of dominance—in that house to start with.

Indeed, a historical survey of how the professions came about does not show, as the professional-dominance position postulates, that professions were able to convince the elite of the merits of their work. Rather, it was the elite who selected, reproduced, and established the professions. Actually, the elite was a fraction of a dominant class that played a central role in defining the social, political, and economic context of the professions. Medicine as we know it—Flexnerian medicine—was established in a context of great social unrest in Germany in the nineteenth century.

Capitalism was being established, changing society from a mercantile to an industrial system. As I have shown elsewhere, these changes had an overwhelming impact on the definition of health and disease and on medicine (Navarro 1980). A conflict of ideologies took place, corresponding to different class interests. One version of medicine advanced by the working class and revolutionary elements of the nascent bourgeoisie, such as is described by Virchow, saw disease as a result of the oppressive nature of extant relationships of society, and thus saw the necessity for sociopolitical and economic interventions aimed at altering those power relationships. Epitomized by the dictum that medicine is a social science and politics is medicine on a large scale, its best representative was Engels (1968), whose work on the living and health conditions of the English working class had an enormous influence on Virchow and on the leadership of the labor movement. Engels's study was a dramatic document showing the political nature of the definition and distribution of disease. Engels's solution, reproduced by Virchow and the leadership of large sectors of the labor movement, was to call for profound change in the power

relationships of society (Taylor and Reiger 1985). This version of medicine did not prevail, however. The bourgeoisie, once it won its hegemony, felt threatened by the calls for structural change, and supported another version of medicine that did not threaten it.

From that time on, a dominant social order in which the bourgeoisie prevailed was considered the natural order, in which its class rules could be veiled and presented as rules of nature. Consequently, disease was seen not as an outcome of specific power relationships, but rather as a biological-individual phenomenon in which the cause of the disease was a microagent, the bacteria. In this redefinition, clinical medicine became the branch of medicine to study the biological-individual phenomenon, and social medicine and public health became the branch of medicine that studied the distribution of disease as the aggregate of individual phenomena. Both branches of medicine shared the same understanding of disease as a pathological alteration or change in the human body (perceived as a machine) caused by an outside agent (unicausality) or several agents (multicausality). This mechanistic view of disease and health is still the predominant interpretation of medicine. *Dorland's Medical Dictionary* (1968) defines health as "a normal condition of body and mind, i.e., with all the parts functioning normally"; and disease as "a definite morbid process having a characteristic strain of symptoms—it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown." This mechanistic understanding of health and disease explains the division of labor (specialization) in medical knowledge and practice that has evolved around specific pieces of the body machine, i.e., cardiology, neurology, etc.

This mechanistic interpretation of medicine was built upon knowledge that had been produced earlier (the discovery of blood circulation by Harvey in 1628; the invention of the microscope by Van Leeuwenhoek in 1683, etc.). But it would be wrong to assume that mechanistic medicine was the result of a linear evolution of scientific discoveries. The establishment and development of the edifice of mechanistic medicine was not the result of the piling up of scientific discoveries like bricks in that construction. Science and technology are not the motors of history. Nor is the medical profession the shaper of the history of medicine. This point must be stressed in the light of the dominant historiography of medicine that sees the history of medicine as divided into stages determined by the discovery of new medical

advances that shape the nature of medicine, advances that are led and reproduced by the medical professions. Scientists and medical professionals are seen as the leaders of change. They convince society, or the dominant elite and/or the receptive populus, of the merit of their projects.

What this interpretation ignores is the sociopolitical context in which these scientific and professional events take place. There is a continuous struggle and competition between different views and positions whose resolution does not depend primarily on the intellectual potency of the successful position. Rather, success depends on the articulation of these positions within the dominant power relationships in that society, of which class relationships are the determinants. Thus, mechanistic medicine was not the result of a linear growth of scientific discoveries that imposed themselves by the strength of its discourse or the power of its agents. To use a Kuhnian term, a shift of paradigms took place in which a new paradigm was established, supported, and directed by the bourgeoisie who established a new scientific and professional order (Kuhn 1962). Consequently, mechanistic medicine was established because it reproduced the ideology and the material interests of the newly established bourgeoisie. Alternative positions were repressed and not allowed to flourish.

For the same reason, this version of medicine—mechanistic medicine—was supported and reproduced by the American bourgeoisie at the beginning of this century by the implementation of the recommendations of the Flexner report (Flexner 1910). The establishment of the medical profession in the United States was not just the result of medical reformers convincing the elite—the Rockefeller Foundation—of the merits of its reforms. Medicine was not the only profession established at that time; most of the professions, as we know them today, were established then, and not all of them by the Rockefeller Foundation.

Those professions were to represent the cadre of experts supposed to carry out the rationalization of the social order under the hegemony of the capitalist class or bourgeoisie. As Kirschner (1986), a historian of professions in the United States, shows, there was a kinship between the calls for expertise as the leverage for change and the containment of social unrest, fear of revolt from below, and contempt for the working class with its strong immigrant component. Experts, rather than the populace, were supposed to guide the change. But that guidance took place within a context in which the capitalist called

the shots, both outside and within the professional terrain. As Kirschner (1986) indicates, there was (and continues to be) a structural tension between democracy (popular desire to rule) and the experts, supported by the dominant establishment, as to how to direct change and society and for whose purposes.

This historical detour through the origins of the medical profession is essential to an understanding of the sociopolitical context in which the power of the professions was established and continues to be reproduced. Professional power was and is submerged in other forms of power such as class, race, gender, and other forces that shape the production of the knowledge, practice, and institutions of medicine. The power of the professions is subservient to the powerful forces such as the dominant classes that have an overwhelming influence in medicine. Needless to say, dominated classes and other dominated forces such as minorities and women can also influence the development of medicine. But the dominance of a class and the hegemony of its ideology determine the parameters within which this set of influences takes place and the realization of these influences. (For a discussion of how class power appears in medicine, see Navarro 1980, 1983. Both articles are reproduced and expanded in Navarro 1986.)

How Other Social Forces Shaped What Doctors Believe, How They Practice, and How They Are Paid and Organized

In summary, whatever happens in medicine is an outcome of the resolution of internal conflicts and contradictions that occur within a matrix of class, gender, race, and other power relationships—of which professional views and interests are important but not dominant in the production of knowledge and in the practice and organization of medicine. Let me briefly outline how these sets of ideological, political, and economic influences occur in the understanding of health and disease, in the production of medical knowledge, in medical practice, and in the organization of medicine.

Health and Disease

These are collective phenomena, realized individually. As phenomena, they have a material base. Disease is also a biological process with a

relative autonomy. For example, although social conditions shape the nature and distribution of epidemics such as plague, the biological base of these epidemics gives them a certain autonomy in their development. The process we call disease is also perceived and interpreted by scientists according to a certain set of understandings and assumptions held not only by the scientific community but by the dominant ideology in that society. I have already indicated how the individual biological and mechanistic understanding of health and disease that dominates medical thought was based on a specific class ideology that was and continues to be hegemonic in our society. This understanding of disease continues to be reproduced today, even when nonphysicians form the majority of producers of medical knowledge. Most of the scientific breakthroughs of medicine are discovered by nonphysicians: the overwhelming number of Nobel Prizes in Medicine are awarded to nonphysicians, and most basic and laboratory research in medicine is done by nonphysicians. But the understanding of health and medicine and the priorities derived from it have not changed.

Medical Knowledge

This involves the collective set of beliefs, ideas, and knowledge in which the social thoughts of some classes, races, and gender are more dominant than those of others. It has a scientific element, owing in part to the relative autonomy of science, and an ideological element reproduced by the values, beliefs, and experiences of the scientists who work and operate in universities and social settings subject to a whole set of class, gender, race, and other forms of influences. Both elements—the scientific and the ideological—are not related in conditions of exteriority, i.e., scientific knowledge is not outside its ideological dimension. Rather, one is in the other. The history of medicine is crowded with examples of variations in the occurrence of scientific discoveries and their interpretations. Smith (1981), for example, has shown how black lung was “discovered” far earlier in the United Kingdom than in the United States, and how the interpretation of causality and symptomatology of that disease was different in both countries. As Smith indicates, the existence of a stronger labor movement in the United Kingdom explains these differences.

More recently, homosexuality, once defined as a disease, has been redefined as a healthy state. This occurred in spite of the resistance of the medical profession (the American Psychiatric Association), which

opposed that redefinition to its very end. The presumably dominant force in medicine became rather weak when the hegemonic ideology in society changed in response to new challenges from the feminist movement and its redefinition of sexuality and of disease.

In brief, how these two elements—the scientific and the ideological—have intermixed depends on the power relationships in society that continuously redefine the production of knowledge, i.e., what is and is not happening in medical knowledge and how it is happening.

Medical Practice

As part of social practice, medical practice has a *technical division* as well as a *social division* of labor. The former, the technical distribution of tasks in medical practice, is determined by the latter, which occurs within a well-defined set of power relationships. Thus, the different tasks carried out by the medical team (physicians, nurses, auxiliaries, and others)—the technical division of labor—are determined by the class, gender, and race relations in society—the social division of labor. None other than Florence Nightingale, the founder of nursing, spoke about the role of the nurse as one of (1) supporting the physician, equivalent to the supportive role of the wife in the family; (2) mothering the patient; and (3) mastering the auxiliaries. In essence, in medicine we witness the reproduction of the Victorian family. Today, just as the family is being redefined, the health team relationships are also being redefined. Nurses and wives are rebelling against their subordination. The increased independence of formerly dependent professions, such as physical therapists, from their past bosses is just part of that trend, which is continuing in spite of the resistance of the assumed dominant profession.

Medical Organization

Petty cottage medicine has been transformed into capitalist or corporate medicine in the same way that the dynamics of capitalism led to the change from petty commodity production to capitalist manufacture. This development has been occurring in medicine in the United States for several decades. It is important to make this observation in the light of the frequently heard remark that the corporatization of medicine and its commodification are recent phenomena due to the involvement

in medicine of the “forprofit hospitals.” This reductionist view of capitalist medicine ignores the dynamics in which medicine and medical services have been commodities and sources of profits for quite a long time. Indeed, the existence of the medical-industrial complex is not a reality discovered by Relman (1980) and Starr (1983); nor is this reality determined by the “forprofit hospitals.” Several years before, Kelman (1971), Navarro (1976), Salmon (1977), and McKinlay (1978) described the existence of this phenomenon and predicted its further expansion. The frequent practice of mainstream authors of ignoring “unorthodox” views of realities leaves them stuck in their own terrain. Starr, for example, refers to the corporatization of medicine as an unexpected phenomenon. It was not unexpected; it was very predictable, and those other authors did predict it. Indeed, the penetration of capitalism into the social services, including medical care, is a logical outcome of the overwhelming influence of corporate America in all areas of economic and social life. This class is the most powerful class in the Western world because of its centrality in the Western system of power. Moreover, its power is unhindered by a working class movement—such as a mass-based labor, social democratic, or socialist party—that could restrain some of its excesses. Consequently, we have an underdeveloped welfare state. The United States is the only industrialized country except South Africa that does not offer comprehensive and universal health coverage. To attribute this absence to the power of the medical profession is to overrate the power of that profession. Other countries with equally powerful medical associations have a national health program. To repeat: we do not have a national health program because we do not have a mass-based labor movement.

The primary focus on the medical profession in much of medical historiography leads to an overrepresentation of the role of the medical profession in the process of medical change. The limitation of this approach is frequently compounded by seeing history as being made by individuals rather than by social forces. Daniel Fox (1987), for example, denies that the labor movement was the main force behind the establishment of a National Health Service in the United Kingdom, arguing that prominent physicians and surgeons were in favor of such a service, while some socialist leaders were against it. Fox seems to be unaware that the fact that some medical leaders were in favor and some labor leaders against such a project did not mean that the medical profession was the main or even a minor force behind such a program

or that the labor movement did not play a major role in the establishment of such a program. The history of medicine is more than what the great medical men (and occasionally great women) do and say. Without denying the importance of personalities in the unraveling of events, one needs to see the forces that these individuals represent and the ideologies and interests that they reproduce. Another limitation of Fox's (1986, 212) work is that he indicates that "in both practical and philosophical sense there is no past—nor correct description of an earlier time. There is only evidence, which history must reinterpret continuously. The study of history is a source of experience." This position assumes that the historian only builds his or her vision of reality and ideology after neutrally examining the evidence. Reality, however, is different from this idealized version of historical inquiry. The historian has a personal ideology prior to selecting his or her sources of information. What evidence to look for, how to look at it, and the social construction of how the evidence appears to the historian are submerged in ideology. Fox's reading of how the National Health Service was established in Great Britain, for example, was fed by an ideology different from—and in clear conflict with—mine (Navarro 1978b; Fox 1986). This difference explains his remarks that he finds "astonishing" my statement that "the nationalization of the main components of the health sector was a victory for the British working class" (Fox 1987). A reading of history different from Fox's shows that the labor movements have been the major force behind the establishment of national health programs (Navarro 1988).

Indeed, our lack of a national health program is not due primarily to opposition from the medical profession. Without minimizing the power of organized medicine, we must see that its power is limited compared with the enormous power of corporate America, unhindered by a counterbalancing force, the power of a mass-based labor movement. The power of corporate America is such that even when government responds to popular pressure and provides health benefits coverage, the way these programs are designed and operated benefits not only the population but many corporate groups—such as the insurance companies—and professional interests. And these benefits subtract from the benefits received by the population.

Needless to say, corporate America is not uniform, nor is its power omnipotent. It needs to compromise with other forces such as the medical profession. The power relationships that underlie such ar-

rangements are changing, however, with corporate interests gaining over the professional interests. Witness, for example, the growth of private insurance companies—the main source of financial capital in the United States—taking over the dominance that Blue Cross/Blue Shield once held in the medical premium market (Navarro 1976).

Proletarianization of Physicians?

Thus, while the medical profession has never been the dominant force in medicine, it has nevertheless been a major force. Its power, however, has been declining for some time now. But this loss of power cannot be equated with the “proletarianization” of the medical profession. This understanding is rooted in Marx and Engels’s initial understanding that with capitalist development we would witness an increased polarization of classes. According to this thesis, an increasing number of strata, including the professions, would be drawn into one of the two opposing classes: the capitalist class or owners of the means of production, and the working class, which owns only its labor power and sells it to capital. As Marx and Engels (1948, 120) wrote: “Society as a whole is more and more splitting into two great hostile camps, into two great classes directly facing each other—bourgeoisie and proletariat.” The invasion of capitalist relationships in all spheres of life would mean the continuous expansion of the working class. Thus, “the bourgeoisie has stripped of its halo every occupation hitherto honored and looked up to with reverent awe. It has converted the physician, the lawyer, the priest, the poet, the man of science, into its paid wage labourers” (Marx and Engels 1948, 123). While Marx and Engels did not use the term proletarian in this sentence, it seems clear from the previous quotation that they meant proletarian when they used the term “wage laborers.”

Following this position, usually attributed to the young period of Marx, several contemporary authors have defined the process of declining control of professionals over their working conditions as a process of proletarianization (Oppenheimer 1985). In the medical field, McKinlay and Arches (1985) are the most articulate authors of this thesis when they write that “as a result of bureaucratization being forced on medical practice as a consequence of the logic of the capitalist expansion, physicians are being reduced to a proletarian function.”

The intellectual contribution of these authors to dismantling the theoretical position of professional dominance has been considerable. But we must differentiate the well-documented process of losing professional autonomy from the process of proletarianization. Indeed, one of the predictions of Marx and Engels that has been proven wrong concerned the increasing polarization of our societies into two major classes. The structural class maps of our society show a growing professional-technical stratum with material interests different from those of the polar classes. Needless to say, members of this professional-technical stratum—creatures of the need for rationalizing the system—have increasingly become wage earners and have seen their autonomy decline. The perception of that trend has been the great merit of the proletarianization school. But, it may not be accurate to say that proletarianization is

the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism (McKinlay and Arches 1985, 161).

Indeed, the process of proletarianization—of establishing the proletariat or working class—has included such a process, but it has also included many other activities, including the transformation of an intellectual activity into a manual one. Indeed, an enormous and productive debate is underway about the nature and boundaries of the working class, both within and outside the Marxist tradition. There is a certain agreement, however, at least among large numbers of Marxist scholars, that the working class or proletariat is composed of supervised, manual wage earners. These laborers do not have control over the means of production or over the organization of production; nor do they have skills that need to be credentialed. Proletarians do not have supervision over others, do not have space for some form of decision making, do not realize mental rather than manual work, and do not have skills that need to be credentialed by the state. Moreover, by their structural position, proletarians cannot exploit others, at least in class terms.

In spite of losing professional power over the material means of producing medical services (such as hospitals, medical equipment, and other resources), over the organizational forms (such as the systems

of funding and organization of medical care), and even over the credentialing of their skills, physicians still retain considerable influence over these production assets, far superior to the influence that proletarians have over theirs. Moreover, professionals will not become uncredentialed skilled workers. This impossibility is a result not only of the different nature of work and the different relationships with the production assets for professionals and workers, but of the different functions that professionals and workers have in capitalist society.

As I have indicated elsewhere, medicine has a function—curing and caring—that is needed in any society. But how that needed function occurs depends on the power relationships in that society as reproduced in the knowledge, practice, and organization of medicine. As the social movements in the 1960s and 1970s showed, medicine reproduces the dominant classism, sexism, and racism in society, not only in the uses of medicine (i.e., allocation of resources), but also in the production of medicine (i.e., knowledge and practice of medicine). In other words, medicine has a needed as well as a dominating function. And the two functions are not related in conditions of exteriority; rather, one function is realized through the other. How the needed function takes place is determined by the controlling or dominating functions. (For an expansion of this point, see Navarro 1986, 241–245).

This point is important in the light of the overabundance of authors who see medicine *primarily* as an agency of control and dominance (Illich 1976). To believe this is tantamount to believing that the popular demand for a national health program is a result of a masochistic desire for being more controlled and/or a response to an enormous false consciousness that the dominant class and the medical profession have imposed on the majority of the population. This school of thought ignores the needed function proven by the effectiveness of medical care (frequently overstated) in alleviating the damage created by disease.

On the other hand, there is the equal danger of seeing medicine as a *neutral* set of organizations, institutions, practices, and knowledge whose growth needs to be stimulated as part of “progress.” This version of medicine focuses only on the needed and useful function without understanding that this function has been structured in such a way that it reproduces patterns of class, gender, and race discrimination. This “neutral” understanding of science and medicine is responsible for the unchanged professionalization of medicine in some postcapitalist

societies (Navarro 1978a), with the reproduction of class, gender, and race power relationships in medicine. This reproduction of dominant relationships conflicts with the democratic force in those countries. The linkage of dominant sectors of the party with the “expert” profession can lead to a new dominant force that inhibits the full expression of the dominated forces.

Medicine has not only a needed but also a dominating function; the need to reproduce these dominant-dominated relationships, both in society and in medicine, by the state credentialing of skills and the associated allocation of privileges explains the impossibility of the profession becoming uncredentialed. The credentialing of skills is important not only to the recipients of the credentials but to the grantors of the credentials.

The term proletarianization of physicians, however, seems to indicate that the physicians can and will become proletarians after all. This is not likely to be the case. The process whereby professionals are losing autonomy is indeed a very real one, and the challenge made by “proletarianization” theorists to the professional dominance school remains unanswered, but the term and concept of “proletarianization” used by these authors does not accurately define and explain what happens in the house of medicine.

Even more important, the term can be politically misleading. Indeed, if physicians are becoming proletarianized, one could conclude that they are likely to take working-class positions and become not only allies of the working class but part of the working class itself. Historical experience shows otherwise. The medical profession and its instruments (professional associations, colleges, unions, and others) have rarely supported transformations in medicine called for by the labor movement and other progressive forces. To recognize this historical fact is not to deny that important sectors of the medical professions can play a critical role in stimulating change by supporting the demands from these progressive forces. The Socialist Medical Association in Great Britain, for example, played a very important role in showing that the British Medical Association’s early opposition to the establishment of a National Health Service was based not on that association’s concern for the patients’ well-being (as it claimed) but rather on the defense of its economic and material interests. In the struggle for the hearts and minds of the people, a group of professionals with white coats can be very effective in showing the assumed “medical” arguments

as covers for material interests. Moreover, the medical profession includes groups with clearly different interests, to which proponents of change must be sensitive. But in this diversity, certain interests will be held in common and will be different from and frequently in contradiction to the interests of labor and other progressive movements. It is this reality that the concept and terminology of proletarianization do not fully address.

Still, the specific conjuncture we are witnessing in the United States opens new possibilities for alliances with forces within the medical profession that see the commodification and corporatization of medicine as a threat to the well-being not only of the people but also of physicians.

References

- Arney, W.R. 1982. *Power and the Profession of Obstetrics*. Chicago: University of Chicago Press.
- Berland, J.C. 1975. *Profession and Monopoly*. Berkeley: University of California Press.
- Blendon, R.J., and D.E. Altman. 1987. Public Opinion and Health Care Costs. In *Health Care and Its Cost*, ed. C.J. Schramm, 49–63. New York: W. W. Norton.
- Dorland's Medical Dictionary*. 1968. Philadelphia: W. B. Saunders.
- Engels, F. 1968. *The Conditions of the Working Class in England*. Stanford: Stanford University Press.
- Flexner, A. 1910. *Medical Education in the United States and Canada*. New York: Carnegie Foundation for the Advancement of Teaching.
- Fox, D. 1986. *Health Policies, Health Politics: The British and American Experience 1911–1965*. Princeton: Princeton University Press.
- . 1987. Review of Navarro, V., "Crisis, Health and Medicine." *Bulletin of the History of Medicine* 61 (2):302–3.
- Freidson, E. 1970a. *Professional Dominance*. New York: Atherton Press.
- . 1970b. *Profession of Medicine*. New York: Harper and Row.
- . 1980. *Doctoring Together*. Chicago: University of Chicago Press.
- . 1985. The Reorganization of the Medical Profession. *Medical Case Review* 42 (1):32.
- . 1986. *Professional Powers: A Study of the Institutionalization of Formal Knowledge*. Chicago: University of Chicago Press.
- Illich, I. 1976. *Medical Nemesis*. New York: Pantheon Books.

- Kelman, S. 1971. Toward the Political Economy of Medical Care. *Inquiry* 8:130-38.
- Kirschner, D.S. 1986. *The Paradox of Professionalism: Reform and Public Service in Urban America 1900-1940*. Westport, Conn.: Greenwood Press.
- Kuhn, T. 1962. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.
- Marx, K., and F. Engels. 1948. The Communist Manifesto. In *Communist Manifesto: Socialist Landmark. An Appreciation Written for the Labour Party*, H. Laski, 120. London: George Allen and Unwin.
- McKinlay, J. 1978. On the Medical-Industrial Complex. *Monthly Review* 30 (5):38-42.
- McKinlay, J.B., and J. Arches. 1985. Towards the Proletarianization of Physicians. *International Journal of Health Services* 15 (2):161-95.
- Navarro, V. 1976. *Medicine under Capitalism*. New York: Neale Watson.
- . 1978a. *Social Security and Medicine in the USSR: A Marxist Critique*. Lexington, Mass.: Lexington Books.
- . 1978b. *Class Struggle, the State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain*. Oxford: Martin Robertson.
- . 1980. Work, Ideology and Science: The Case of Medicine. *Social Science and Medicine* 14C:191-205.
- . 1983. Radicalism, Marxism, and Medicine. *International Journal of Health Services* 13 (2):179-202.
- . 1986. *Crisis, Health, and Medicine*. New York: Routledge and Kegan Paul.
- . 1988. Why Some Countries Have National Health Insurance, Others Have National Health Service, and Others Have Neither. *Social Science and Medicine* (in press).
- Oppenheimer, M. 1985. *White Collar Politics*. New York: Monthly Review Press.
- Pear, R. 1987. Physicians Contend Systems of Payment Have Eroded Status. *New York Times*, December 26.
- Relman, A.S. 1980. The New Medical-Industrial Complex. *New England Journal of Medicine* 303:963-70.
- Salmon, J. 1977. Monopoly Capital and the Reorganization of the Health Sector. *Review of the Radical Political Economy* 9:125-33.
- Schneider, W. 1985. Public Ready for Real Change in Health Care. *National Journal* 3 (23):664-65.
- Smith, B.E. 1981. Black Lung: The Social Production of Disease. *International Journal of Health Services* 11 (3):343-59.

- Starr, P. 1983. *The Social Transformation of American Medicine*. New York: Basic Books.
- Taylor, R., and A. Rieger. 1985. Medicine as a Social Science: Rudolf Virchow on the Typhus Epidemic in Upper Silesia. *International Journal of Health Services* 15 (4):547-59.

Address correspondence to: Vicente Navarro, M.D., D.M.S.A., Dr.P.H., Professor of Health Policy, School of Hygiene and Public Health, The Johns Hopkins University, Hampton House, Fourth Floor, 624 North Broadway, Baltimore, MD 21205-1901.