

The Position of the Soviet Physician: The Bureaucratic Professional

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FACILE GENERALIZATIONS ARE FASHIONABLE WHEN examining the status and position of the Soviet physician; they range from an over-idealized view of a doctor able to practice medicine without worrying about office expenses, repaying educational loans, and other entrepreneurial problems that often plague the private practitioner under capitalism to the image of the doctor as a kind of poorly paid, indentured medical functionary employed by a powerful state-run bureaucratic machine and without clinical autonomy or professional prerogatives. The reality, as one might expect, falls between these two hyperbolic clichés. The purpose of this article is to throw some light on the position of the doctor in contemporary Soviet society and to examine some of the paradoxes inherent in that role.

Although the focus here will be the Soviet physician, occasional references will be made to Eastern Europe, particularly Hungary, Poland, and Czechoslovakia. The position of the physician there is quite similar to that in the Soviet Union, but additional insights can be gathered because these societies are more accessible to Western observers.

A Bit of History

At the time of the Communist revolution of October 1917, there was little that distinguished the Russian doctor's position from that

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of his colleagues in the West. Physicians saw themselves as professionals and experts, charged with important responsibilities, and enjoying a high regard and status among the population. Physicians were members of the *intelligentsia*, a Russian term that denoted those who had had a higher education. Most of them would rank themselves among those who were hoping, or working, either for major structural reforms in the Tsarist system, if not a revolution. Many Russian physicians, particularly those in community medicine and public health, inspired by their social-hygienist German colleagues, were convinced that the health and well-being of the population depended not so much on personal or clinical medical care but resulted from the social and economic conditions under which the majority of the population lived. Changes in these conditions implied political reforms of the type that the Tsarist autocracy was unwilling, for the most part, to contemplate. Indeed, medical reform had become an important political issue in the years before the 1905 revolution (Frieden 1981, 231–311). Although a high proportion of Russian doctors were private practitioners, others served in salaried positions, particularly those who worked for the Zemstvo or local rural boards and who provided a modicum of health care to the largely impoverished peasant population. Forsaking the cultural and economic advantages of city life, Zemstvo physicians were seen as dedicated individuals, who sacrificed their personal comforts for the sake of those more unfortunate in the countryside (where the majority of the population resided). To some degree, the Zemstvo physicians symbolized what was the best in the “populist” tradition, i.e., unselfish service to others. The revolution was to bring major changes in the role and the position of the physician in the new society, and a loss of the personal dedication of the Zemstvo doctor.

The Revolution and the Profession

Most physicians, who were liberals in their ideology, viewed with distaste, distrust, if not hostility, the coming to power of the Communist regime (Krug 1979). They were concerned that, in the rush of revolutionary and egalitarian enthusiasm, their roles as experts and specialists would be looked upon as “bourgeois,” and that they would be placed under the control of ignorant or unqualified, but politically acceptable, subordinates. There is, indeed, in any left-wing or proletarian revolution,

a deep anti-intellectual and antispecialist distrust. The specialists and those who have had anything above an elementary education are associated with the formerly exploiting class, and often are subject to discrimination. An extreme case is, of course, that of the Khmer Rouge regime in Cambodia, where even people who wore glasses were automatically assimilated to the educated-specialist classes and often exterminated. Nothing that extreme happened in the Soviet Union, but the specialists, trained under the old regime, remained under suspicion at least for the first years of Soviet power. As Hutchinson (1987, 27) has pointed out, "Physicians were usually perceived as the enemies of Soviet rule, and the majority of them had refused to recognize that the Provisional Government was dead, and that the Soviets were in power." There were, indeed, cases when nurses or feldshers were appointed directors of hospitals and began giving orders to physicians. Physicians also rejected the ideologically determined "class" approach that members of the proletariat and the peasantry should receive medical care ahead of other members of the population as a simple case of retributive justice. It went against their ethical universalism that held that a sick or wounded individual deserved care regardless of his present or past class membership. This the Bolsheviks rejected as pure hypocritical cant, arguing that under the Tsarist state (i.e., capitalism) most physicians catered first and foremost to the upper classes, and paid but scant attention to the lower orders. It was also reported that, in some instances, physicians refused to treat Bolshevik wounded, or had to be coerced to do so (Barsukov 1951, 74). There is evidence (Krug 1979), however, that the new regime and Lenin, in particular, did not, at first, want to mount a frontal assault on the medical profession and associations and sought a *modus vivendi* with these "bourgeois" physicians, in particular with the Pirogov Society, the most visible and powerful medical association and the most outspoken opponent of the new regime in the medical arena. The Pirogovists had also taken a strong adversarial stance against the Tsarist regime. What the Bolsheviks wanted was to secure, as far as one can determine it, either the benevolent neutrality, if not the collaboration, of physicians' associations or to seize control of these associations in order to utilize them to achieve their aims. But the Pirogovists and others would have none of that and eventually they and other "old regime" medical associations were dissolved on the familiar ground that they were "counter-revolutionary." This was

consistent with Inkeles' (1954, 90) observation that "totalitarianism does not merely subordinate the *individual* to the state, but it also preeminently subordinates human *associations*, the organizations and institutions that man creates to meet his social needs."

This was the death knell of the medical "profession," if, by that term, we mean an association of practitioners who constitute a corporate group (or corporate groups), with a fair degree of political autonomy. As such, a profession represents power; its practitioners, collectively, are capable of influencing decisions concerning practically all aspects of the practitioners' occupational life. They can propose, shape, and sponsor legislation, often control the number of students admitted to the medical schools and thus the size of the profession. They can, and do, claim that because their work is so complex, only they are capable of passing judgment on the qualifications of new entrants into the profession, as well as on the misdeeds of their members. Moreover, as Freidson has pointed out, doctors constitute a "dominant profession" because they are able to give orders and determine the working conditions of a whole series of subordinate health personnel. They proclaim and enforce a code of ethical behavior which they say ensures the highest standards of care and protection for the public. They can threaten to go on strike and indeed strike, if they so please, in an effort to wring concessions from the government. It was precisely that kind of power that the Soviet regime could and would not countenance. It should be noted that the Soviet regime initially abolished the oath that physicians took upon completion of their studies because of its "bourgeois" character, and it was only in 1971 that a new oath was reinstated. It emphasizes not only the duties of the physician toward patients, but also toward the Soviet government and Communist society.

Although the ground is now starting to shift under the feet of physicians in the West, and is beginning to erode their autonomy and political power (McKinlay and Stoeckle 1988), this position of power and dominance has existed during the first three quarters of the twentieth century in democratic-pluralistic societies. One thinks of the American Medical Association, or the British Medical Association as prototypical. They thus serve as a good contrasting medium when looking at the position of the Soviet doctor; there is no Soviet counterpart to any of these associations. There is no free-standing "association of Soviet physicians" capable of taking an independent stance vis-à-vis the government and its policies (either in health or in other matters).

The nearest and quite inappropriate equivalent would be the Union of Medical Workers. This grouping includes all those who work in one way or another in health—not only physicians—and is a union in the Soviet sense of the world, i.e., a company union, the company being the state: It exists primarily as an instrument of control over health personnel; its major function is to protect the interests of the state first, its members second; it does, however, have certain house-keeping and bureaucratic functions. For example, it will help union members determine what their pension eligibility is. But it does not represent the associational power of a professional group or corporate body.

Neither does the Union of Medical Workers have intellectual functions in promoting knowledge of the field or subfields of medicine or health care. This is a function of various scientific-medical societies which are strictly substantive and thus do not concern themselves with political issues. The profession as a corporate group or social force is powerless.

The Doctor as a State Employee

The point of departure for an examination of the position of the Soviet doctor is his/her status as a paid state functionary. The overwhelming majority of practicing Soviet doctors, if not all, are essentially hired by the Soviet state to perform their functions. They were educated in Soviet schools and medical institutes and did not pay tuition. Most even received stipends. At graduation, then, the Soviet doctor does not owe a sum of money to anyone, nor does he have to worry about borrowing more money to establish a practice. On the other hand, he is beholden to the state which paid for the education. This often takes the form of assignments to medical posts in areas that are underdoctored because of their isolation or unattractiveness. This has not worked well.

It has been indeed one of the problems of the medical care system that newly graduated and trained physicians who have been assigned by the health ministries to work in designated areas do not, in many instances, either report to their assigned posts, or remain there for their tour of duty (Field 1967, 108ff.). This is due to a variety of reasons, the most important being their reluctance to spend time in

the primitive conditions of the Soviet countryside and outlying districts. Not only are living conditions often abysmal, but so are the medical facilities. According to the health minister himself, only 35 percent of rural district hospitals have hot running water, 27 percent have no sewerage system, and 17 percent have no running water at all. And the minister asked rhetorically: "What good are such hospitals for modern medical care?" (*Sovetskaia Rossia* 1987). In addition, the lack of cultural life (theaters, movies, restaurants, and so on) make such assignments undesirable. One way to escape them (available mostly to women) is a regulation that forbids sending a spouse away on assignment, so that they can easily escape through marriage. The health bureaucracy is a large and complex one, and there are also many opportunities to manipulate and bribe health bureaucrats to avoid such postings. Finally, young physicians are often terrified at the idea of assuming responsibility for patients when they have had little previous clinical experience. The health minister has been complaining of the fact that an unacceptably high proportion of medical students receive their diplomas when they are unqualified to perform the simplest clinical tasks—for example, deliver a child, or read an electrocardiogram (*Pravda* 1987c). There is also an economic factor that accounts for the fact that physicians may be driving taxicabs, rather than report to the countryside; there is not much forgone income, given the very low salaries earned by physicians. Thus, whereas in the prerevolutionary era, *Zemstvo* physicians, out of a sense of duty and dedication, voluntarily went to the villages to minister to peasants, this dedication and voluntariness seems to have largely evaporated from the Soviet scene.

Any further discussion of the position of the Soviet doctor must take into consideration the degree of internal differentiation in the medical contingent. Physicians are stratified and ranked. At the bottom, one finds those who serve as interns or residents; above them, are physicians in general clinical work in polyclinics and hospitals; above the practitioners are those who have gone into academic medicine and into research and teaching. They usually hold (or work toward) the higher degrees of Candidate of Medical Sciences, and the Doctor of Medical Sciences, the latter usually awarded in mid-career and backed by a significant scientific contribution. (It is thus a higher degree than the Ph.D. in American terms.) And still, above them are the members and corresponding members of the prestigious Academy of

Medical Sciences (not to be confused with the older, and still more famous Academy of Sciences). These members of the medical establishment constitute but a very small minority of the total number of physicians, and, therefore, outside of calling attention to their existence, we shall concentrate on the other regular doctors. At the same time, we must remember that *all* Soviet physicians, regardless of their rank, are employees of the state, trained and remunerated by the state, and subject to its discipline and directives.

The Economic Status of Doctors

Most Soviet doctors (except the medical élites) are poorly paid, not only by comparison with their colleagues in other non-Communist countries (where the differences appear to be huge), but even within Soviet society. Of all occupational groups in the Soviet Union, those in health occupy the lowest level in terms of official salaries. This determination, however, is not quite fair, because these calculations are based on *all* health personnel, including the more numerous allied health professionals whose salaries are notoriously poor. Physician salaries are not that much higher, however, than those of nurses and ward attendants. But even with a pay increase decreed in 1986, which we will discuss later, the average Soviet medical doctor's pay is only that of any qualified worker. As Jones and Grupp (1987) have pointed out: "Although the occupation [of medicine] enjoys relatively high prestige, salary levels are not particularly high compared to other professionals jobs or to skilled blue-collar work." The fact that the majority of Soviet doctors are women (close to 70 percent) may be the result or the cause of the relatively poor income of physicians, at least officially. As we shall see, some physicians (and most of them seem to be males) have other ways of supplementing their income.

Bureaucratization

An examination of the "bureaucratic" nature of the medical occupation in the Soviet Union cannot be adequate without some consideration of the type of society that has evolved there over the last seventy years or so. It is a society dominated by bureaucracies, from top to bottom.

This applies equally well to the medical bureaucratic professionals who make up the majority of Soviet doctors. As the conventional wisdom suggests, they are at the mercy of the powerful state and its agencies. Thus, when the KGB or other services want to remove, silence, or isolate a dissident or an "inconvenient" citizen, they may resort to ordering a psychiatrist to have the person declared mentally incompetent under some kind of contrived diagnosis, and to have that person hospitalized or placed under the supervision of an outpatient psychiatric facility (Bloch and Reddaway 1972, 1984; Grigoryants 1988). And so far, physicians cannot be sued for malpractice or misdiagnosis, although there is some evidence that the question has recently come up in the wake of glasnost-inspired revelations about the abuse of psychiatry and the corruption of some psychiatrists. But altogether, it would not occur to most Soviet physicians or psychiatrists to disobey orders. It is in this respect that the absence of a profession, in the sense outlined earlier, and the submission of the individual to the state conforms most closely to the stereotype of the captive practitioner.

But, and this is the paradoxical aspect of the role of the practitioner (and the Soviet bureaucrat in general), the Soviet physician exercises over his patient and subordinates the kind of absolute power that would hardly be possible nowadays in other more pluralistic settings. There are thus at least three elements that enter into the equation of the power of the Soviet practitioner: (1.) There exists the usual jurisdictional authority entrusted to the bureaucratic professional. In essence, this is the same type of power exercised by bureaucrats generally, and by Soviet bureaucrats in particular, over those with whom they officially deal. Anyone who has wrestled with Soviet and Intourist officials, sales personnel, hotel clerks, post-office employees, or any person who has a smidgeon of authority and power, can attest to the pervasiveness of the phenomenon. In one sense, the bureaucratic power of the official over the client, customer, applicant, or patient may be seen as *compensation* for the lack of power and the subordination the bureaucrat experiences from his or her superiors. This situation apparently exists from top to bottom in Soviet society, including the medical sector. The same situation obtains, for example, in Czechoslovakia where the "doctor-patient relationship was defined as a 'totalitarian' one, reflecting a 'totalitarian' society" (Hertlinger 1987, 105). (2.) The power just mentioned is reinforced, in the case of the

medical specialist, by the very nature of “professional” authority; the physician is held to know more by virtue of his education and experience than the patient. Indeed, were it not for this asymmetry of knowledge, there would be no need to consult a medical specialist. (3.) The final element is the subjective and often devastating emotional significance of the experience of illness and trauma, and the overwhelming dependency of the patient on medical and allied personnel. Thus, the doctor/patient encounter is endowed with more affective meaning than that of most others.

Soviet society, in spite of its original socialistic inspiration, is a deeply hierarchical society, aware of the importance of rank and its associated power. The patient is thus very much at the mercy of the physician, aware of that person’s bureaucratic *and* specialized power, and is, therefore, usually in the position of a supplicant. In the Soviet scheme, the customer or patient is rarely right.

An examination of the doctor/patient relationship is thus akin to a time warp. It goes back to a situation present perhaps in the West forty to fifty years ago, when the physician was lord and king and knew it all, and his word was undisputed. The situation has changed; increasingly, in the West physicians are being pulled off their pedestals. There is a growing rebellion against the dictatorial style, sparked at first by the feminist revolt against the insensitivity of the physician, and particularly the obstetrician-gynecologist. A more egalitarian and informal relationship has emerged, one in which there is some degree of parity between a physician brought down to earth and an inquisitive, challenging, and increasingly better-informed patient. And in the background there lurks the threat of a malpractice suit. In addition, specialization and subspecialization and the proliferation of allied health professions have decreased both the charisma of the physician and the unity of the profession, as well as its near monopoly in the practice of medicine; nowadays, many of his functions have been taken over by other health professionals. Practically none of these trends are (as yet) visible in the Soviet Union. Here, for instance, is a vignette from the Moscow City Hospital No. 68 as observed by an American physician,

The patients usually walked close to the wall, slowly and keeping their hands in the pockets of their robes. The center was kept clear for physicians, nurses and visitors who walked quickly, arms swinging freely, talking loudly (Knaus 1981, 144).

The situation is similar in Poland, for instance, where according to Millard (1981), there is virtually no concept of the doctor/patient relationship.

Patients are cases to be dealt with; they are the passive recipients of the treatment and organization manipulated by experts. . . . When a patient does ask about a drug or method of treatment she/he may have . . . heard about, the request is regarded as inappropriate or even mischievous. . . . Doctors do not always explain, but they sometimes tell deliberate lies to patients and their families in cases they regard as incurable or doubtful.

Natalia Gorbanevskaia, a former dissident, remarked about the "attitude so common among our doctors that the patient is completely in their power and that he must be treated like a silly baby with neither mind nor will of his own" (United States Congress 1972, 130). The Soviet physician also enjoys a virtual monopoly. There is little competition except from quacks, and to some degree homeopaths. And thus, while the Western physician is slowly losing ground to a host of forces that he cannot control, including the corporatization of medical practice that is slowly turning him also into a bureaucrat, the Soviet doctor remains strong and firmly in charge of patients. And investigative journalists are often angrily told to stay away by health authorities, that it is not their business to stick their noses into these complicated matters, and that looking into the "dark sides" of health care undermines the prestige of an important profession. (*Pravda* 1987b). Moreover, given the demand for medical services in the Soviet Union, the doctor does not have to "market his services," compete for, or cater either to the wishes or the emotional needs of patients. There are, in the Soviet context, so far, no equivalents to the Boston Women's Health Collective that published *Our Bodies, Ourselves*, or the Canadian feminist health quarterly *Health Sharing*, the decentralized Caesarean support groups in the United States or the La Lèche League. As in other countries of the Soviet bloc, childbirth and breastfeeding, for example, are under undisputed medical monopoly (Hertlinger 1987, 100). In most instances, patients cannot choose their primary care doctor; doctor and patient are automatically assigned to each other either on the basis of residence or occupation. The question of the free choice of physician is obviously difficult in a system as rigid and bureaucratic as the Soviet one. And it is not

surprising that a survey of medical professionals, whose average age was 38.5 years, and who had been practicing over twelve years, showed that the majority of doctors (70 percent) opposed the idea of a free choice of a general practitioner by the population, 28.1 percent had no objection, and 2.4 percent, no opinion. One of the main reasons was the belief that patients, because of their lack of medical knowledge, were unable to evaluate correctly physicians' qualifications. The conclusion was that free choice would "not serve society's interests." But this view of patients sharply contrasted with that of the population itself. In other surveys, 25 to 49 percent of individuals questioned wanted to change their assigned doctors, and 55 percent favored a free choice of medical specialists. The patients' main complaints were that insufficient attention was paid to them during the examination, the general hastiness (the hurly burly of a railroad station) in the provision of treatment (Trehub 1986, 5), as well as the insufficiency of the information given them by doctors regarding their illness, problems in getting sick leaves, and other issues (Antipenko and Nesynova 1983). To some degree the training of doctors is at fault. As Beilin (1977) complained some time ago, the future physician is taught little medical psychology or how to deal with patients and their emotional problems. At the present time, he added, a total of 19 hours were allocated to medical psychology out of the 7,800 hours and commented: "For knowledge of the body, 7,781 hours, for the psyche (*dusha*) . . . 19." If the Soviet physician is under no pressure to satisfy patients, he or she must, on the other hand, please the managers of the health care system. One of the perennial complaints of Soviet physicians, usually expressed in letters to the editors of newspapers, is that their work is assessed in quantitative terms (which are easier to judge). In this respect, the Soviet health system, just like Soviet industry, operates on the gross-output principle with its emphasis on quantity. For instance, physicians are expected to see a norm of about eight patients per hour at the outpatient clinic or about one patient every 7.5 minutes (Trehub 1986, 2-3). Most of that time, however, more than one-half usually, is consumed by paper work; indeed, some Soviet studies show that five of these seven minutes are spent filling in forms. According to Dr. Tomashevskii (1986) writing in *Izvestiia*, "the doctor's work is evaluated primarily according to statistical indicators. . . . Numbers determine our way of working."

In response to Dr. Tomashevskii's letter, a flood of letters confirmed

that observation. Dr. G. Ivanov (1986), from Moscow, confirmed that one-half of his time "was spent on paper work and that he has to make diagnoses and prescribe treatment as quickly as jet pilots in aerial combat." Given the powerful position of the physician vis-à-vis the patient and the press of work, it is not surprising that physicians are often criticized in the Soviet media for their rudeness and callousness. Thus, a recent party and governmental decision aimed at restructuring the Soviet health system states in its preamble:

Among health personnel, such phenomena have become widespread as bureaucratism, corruption [taking of bribes], callousness, cruelty, rudeness, and an irresponsible attitude toward the fulfillment of professional duty. Moral and ethical distortions (i.e., corruption) have spread to the admission of students into the medical schools, and in assessing the results of student performance, and in promoting people at work. There exists a system of payment that does not stimulate the striving to acquire knowledge and practice, the improvement of qualifications, the improvement of the quality of work (Proekt 1987).

And in another context, three Soviet authors wrote that although there were more than one million physicians in the Soviet Union "almost one-third of them do not conform to contemporary professional, socio-psychological and moral demands" (Shchepin, Tsaregorodtsev, and Erokhin 1983, 357). In the last few years, one also hears more and more about the need for physicians (and others) to display more compassion, more charity, more kindness toward patients, to give up the "segmental" and impersonal responsibility of the physician who is on duty from a specific hour to another, to be replaced by the more universal medical ethic of providing assistance whenever needed to anyone. "What Soviet doctors lack most," recently declared the health minister, "is humanity" (D'Anastasio 1987). Moreover, the power of the physician (and the temptation to abuse that power) is inherent in his "certification" role; for example, workers and employees cannot be away from work and still receive benefits on the basis of being sick without an official sickness certificate (called *bulletin*). The delivery of bulletins not only takes valuable time, but each *bulletin* has to be renewed every three days, reinforcing the role of the physician as an agent of control. Moreover, it is the power inherent in that capacity that provides many temptations to corrupt or bribe the physician.

These factors not only tend to alienate the patient from the doctor, but to emphasize the general trend toward depersonalization evident in medical care the world over, often exacerbated by a constant division between medical labor and the increased use of technology. The term "veterinarism" has crept into Soviet discussions of the matter and underscores the growing tendency to look upon patients as physiological and passive entities to whom something should be done, rather than sentient human beings with their shares of emotions and anxieties (Bilioni 1968). This leads then to a closer examination of what might be called the "commercialization" of Soviet medicine.

The "Commercialization" of Soviet Medicine

A few years ago, the newspaper *Musbtum* (1985), of Tashkent, the capital of Uzbekistan, published a cartoon showing a patient on an operating table, with organs coming out of his stomach. A surgeon was leaning over him saying, "The success of the operation depends on what you will pay," and a balloon around the surgeon's head showed stacks of 10 and 25 ruble notes. This epitomizes the fact that the principle of "free medical care" has been compromised by the increased corruption of medical and allied personnel in the last two decades or so. Patients feel impelled to make payments to physicians and other health personnel. These have become routine both at the outpatient level and particularly in hospitals. Apparently, the staffing situation in hospitals is so poor, and the salaries of nursing and other personnel so low, that the patient must come to the hospital armed with a sheaf of ruble notes for the smallest services, be it medication, a bed pan, or clean sheets. Physicians openly solicit payments, particularly for surgical operations. Since most surgeons tend to be males, most stories that appear in the press suggest that male physicians are the primary perpetrators of what is, in essence, illegal acts. An illustration of this is the story told by Daniil Granin (1987), a well-known Soviet writer, in an article entitled "On Compassion":

The mother of a friend of his became ill, and needed an operation. He had heard somewhere that one must "give" to the physician. He was a shy person, but his worry about his mother conquered his timidity and he went to see the doctor. He offered him twenty-five rubles ostensibly because she would need certain types of medications

(and pharmaceuticals are perennially in short supply), but, in fact, it was a "gift" or a "bribe." The physician threw up his hands, saying, "I do not take such money." "And what kind is needed?" asked his friend. "Ten times as much." Granin goes on to say that his friend is an ordinary engineer; he is not rich, but it was a question of the health of his mother. So he managed to gather the money (250 rubles is more than the average monthly wage) and he brought the money to the doctor. But he was so ashamed at such a transaction, that he put the money in an envelope. The physician had no such compunctions. He took the money from the envelope and quietly counted the bills.

The mother died after the operation. The physician explained to his friend: "I checked; your mother died not as a result of the operation. Her heart could not take it, and, therefore, I am keeping the money." And Granin adds that the physician was convinced of his own decency; if the mother had died as a result of the operation, he would have returned the money. Granin further says that he told the story not because it was so uncommon, but precisely because it was so usual. According to data gathered by sociologists, 74 percent of patients have resorted to such payment for medical attention (*Izvestiia* 1987).

The purpose of that vignette is to indicate how far the doctor/patient relationship has deviated from ethical "professional" norms. It is the essence of that ethic that the professional must put the interests of the patient or client before his own, and that the quality of the professional service (by contrast to the commercial service) is held to be independent of the remuneration. It is indeed that capacity and obligation not to exploit the client's powerlessness that permits professionals to claim they are special, a "breed apart." The "decoupling" between payment and professional service implies that the professional will perform to the best of his ability regardless of who the patient is and what the pay (if any) will be. Thus, if the patient dies, the physician will still send his bill. What we have seen in this Soviet case is the sliding of the professional relationship into the commercial mode where there is a relation between service and remuneration. In the Soviet context, physicians assume that patients are unable to judge the quality of services, and that they are the ones who determine it, and then decide *on their own* whether the payment was justified or not. And thus, according to that code, they will, if indicated, return the money like any decent plumber. One might also wonder whether the relatively miserable salaries of health care personnel are rationalized

by the government, because physicians have other possible sources of income. At the same time, as a commentator described it in the case of Hungary, gratuities to doctors and nurses (and other purveyors of services) are socially condoned and regarded as a built-in part of the average salary. That "shadow market" serves to adjust the low salaries imposed by central authorities (Kemeny 1982). The same seems to hold for the Soviet Union.

The fine point, and one that cannot be determined, is whether these payments, whether solicited, requested, or hinted at should be regarded as bribes for preferential treatment or tokens of gratitude, or both. But perhaps, more than anything else, they constitute a countervailing power at the disposal of the patient to exert some kind of control *over* the physician. It meets "the drive to have a choice, to gain some sense of control over the care received, to manipulate the bureaucracy, instead of the other way around" (Shipler 1983, 219). Such payments may also express a belief that whatever is available free of charge is of no great value. There is, indeed, a Russian saying that "Lechitsa darom, darom lechitsa", which can be roughly translated as, "Treatment for free is treatment in vain" (Shipler 1983, 217).

It has become clear that, with the exception of a small group of élite physicians, most Soviet doctors' official salaries are very modest, even in Soviet terms. Apparently, the regime has decided to correct the situation by decreeing, in October 1986, increases in doctors' and other health workers' pay. These increases, to be phased in gradually, do not seem to alter significantly the financial position of the Soviet doctor. Thus, if the average physician salary in the Soviet Union is about 200 rubles per month, a 35.6 percent average increase as announced would mean around 270 rubles (*Meditsinskaya Gazeta* 1986). This then must be contrasted to the 250 rubles demanded for *one* surgical intervention in the story by Granin mentioned earlier. Thus, outside of illegal or illegitimate incomes garnered by some physicians, particularly surgeons, the financial position of the Soviet doctor hardly resembles that of his colleagues in the West. On the other hand, the position of the medical occupation in the Soviet Union does not necessarily reflect, in the same way it would in the West, the financial position of the occupation. The Soviets seem to regard income as relatively secondary in judging the prestige or attractiveness of an occupation. But there is well-recognized dissatisfaction with what the Soviets call the material conditions of life for health workers. As a

representative of the ministry of health declared, in conjunction with the pay increase for medical workers, additional other measures of a material nature were being considered (presumably in housing, leisure, and so on) that would "facilitate the raising of the prestige of medical work and improve the quality of work of the personnel" (*Meditsinskaya Gazeta* 1986). Gorbachev's attack against egalitarianism in incomes has as its purpose motivating people to work better and to reward those who do. In interviews the health minister has declared that he was hoping that "good" physicians would attract more patients and that they would be better paid than poor ones. Income differentiation would then undermine the usual bureaucratic style of work and hopefully improve the work of physicians.

The Prestige of the Medical Profession

It is difficult to assess with any degree of accuracy what the general prestige or relative desirability of the medical occupation is in the Soviet Union. Physicians are well thought of, but they certainly do not have the visibility of the more technical and military or space occupations. In a study of the attractiveness and prestige of medical doctors carried out by Cherednichenko and Shubkin (1985), it is reported that the prestige of medical doctors for urban male youths fell by 10 percent over the past two decades (study published in 1985) and by 5 percent for rural youths, though it increased slightly among girls (3 percent and 6 percent, respectively). And in a paper on "the prestige of the profession of doctor," Kosarev and Sakhno (1985) state that a declining proportion of Soviet youths want to become doctors. Since 1978, for example, the number of applicants for each vacancy at the 1st Moscow Medical Institute has dropped from 3.45 in 1978 to 2.35 in 1983, though that last figure applies only to candidates from Moscow. The number of applicants for that same institute in that same year who were from outside of Moscow was reported at 4.65 per available place.

Conclusions

In this short article, we have been able to touch only on the major aspects of the position and role of the Soviet physician, and to examine

that interesting combination of certain professional characteristics (derived from expertise and monopoly of that expertise), corporate powerlessness, and bureaucratic power. In trying to explain the general position of the average Soviet doctor to a Westerner, and particularly to an American, the nearest analogue (and a flawed one, at that) is that of the elementary or secondary American school teacher. Both the Soviet physician and the American school teacher fulfill extremely important social functions, one in "shaping capacity," the other, in "maintaining that capacity." Although the amount of training is greater for the doctors, and the life/death responsibilities certainly more stressful than in teaching, the conditions of work (salaried), the relatively poor compensation in both cases, the "cleanliness" of the work as against factory work, the preponderance of women, the shortage of capital equipment, and so on, make the resemblance interesting. At the same time, the increased bureaucratization of medical care in the West, the "corporatization" or the "proletarianization" noted by McKinlay and others, does suggest a degree of approaching convergence in the position of Soviet and Western doctors. While the percentage of women in Soviet medicine is slowly decreasing, it is increasing in the West, so that we can contemplate in the not too distant future a medical contingent in both cases made up equally of men and women. At the same time, women in Soviet medicine become increasingly invisible as one scans the higher level of scientific, academic, and administrative medicine, where most of the jobs are held by men, as is also the case in American education. In the whole history of the Soviet health care system, only once did a woman occupy the top position of minister of health protection USSR (under Khrushchev). One begins to wonder whether the Soviet situation is, to some qualified extent, a portent of things to come in the West as medical care becomes increasingly bureaucratized and corporatized. And will the loss of the power of the medical profession then be compensated by an increase in the authority enjoyed by the corporate physician in the clinical sphere, or will his discretion in that sphere, as many think, also be increasingly constricted by the need, for example, to control costs. At the same time, parallels and convergence hypotheses are to be taken with great caution. In essence, the practice of medicine and the position of the doctor reflect at least two important and differentiated sets of factors: (1) the universal aspects of medicine as a type of applied knowledge valid in all settings and situations and, (2) the particular

characteristics of the culture and the structure of the society in which this knowledge is applied. A physician is not simply any trained person who applies the universal knowledge of medical science uniformly. He or she is also the product of the culture, the tradition, the history, and the personal life course in the social setting in which he and she applies that knowledge. This was well expressed by Shipler (1983, 216):

The system of medical care expresses the full range of strengths and weaknesses of Soviet society; it is a model of the country's hierarchy, reflecting the instincts of authoritarianism, conservatism and elitism that pervades all areas of life. . . . Soviet medicine can be excellent and incompetent simultaneously, available in mediocrity to all and accessible in high quality only to the chosen or the canny or to those blessed by chance.

The position of the Soviet physician thus reflects the corporate weakness of the profession and the power of the clinician as a bureaucratic employee. Soviet society and Soviet socialized medicine have thus produced an intriguing form of status inconsistency that deserves greater attention as medicine, the world over, becomes increasingly bureaucratized.

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Theories at the Crossroads: A Discussion of Evolving Views on Medicine as a Profession

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THE WIDESPREAD PERCEPTION THAT MEDICINE IS undergoing significant (some say revolutionary) changes in its social position and professional status is of sociological importance for several reasons. Obviously, the threat of change in the status and stature of the medical profession is of great concern within the profession itself. In the United States, for example, issues such as an increasing supply of physicians, a rise in consumer activism and litigation, and changes in the organization, delivery, and financing of medical care have generated a growing amount of apprehension both within organized medicine and among its individual practitioners about medicine's continued ability to maintain its professional prerogatives and its status as an autonomous and dominant provider of health care services (Elder 1987; Reed and Evans 1987). At stake are such important issues as money, power, and prestige, and, as some would contend, this country's continued leadership role in the areas of medical education, services, and technology.

In addition to understanding medicine's own construction of reality, the dynamic nature of professions is of considerable theoretical relevance to sociology. Within sociological circles, medicine has long been

considered the archetypal profession. The possibility that current social, economic, and political forces will meaningfully alter the status and professional stature of medicine provides interested observers with an exciting opportunity to explore what these changes might tell us about the current adequacy and future directions of a sociological theory of the professions.

Finally, as pointed out by Riska (Nordic countries), Navarro (de-professionalization), and others in this issue, transformations in medicine reflect changes and structural features within the broader social fabric. Thus, the study of the changing social status of medicine also provides additional insights into issues such as class, race, gender, and other power relationships in society at large.

The co-mingling of these issues raises a distinct challenge for sociology. As social scientists attempt to untangle the myriad considerations embedded in this topic, there is the distinct possibility that efforts to explicate will instead become an apologia for the ideology of professionalism and a defense of the medical prerogative. The concern that the sociological study of the professions has become contaminated with the ideology, hopes, and self-interests of professional groups is not new. Roth (1974) argued that many of the characteristics often listed as attributes of professions are, in fact, mixtures of unproven and often unexamined claims for professional control and autonomy. More important, Roth pointed out how a scholarly fascination with characteristics and attributes can mistakenly transform the analysis of professions into a study of the product and not the process. At a time when the current health care climate is increasingly dominated by governmental concerns (and thus definitions) about "runaway inflation," and physicians' own laments about their perceived loss of power, prestige, and autonomy, Roth's warnings are of particular salience. My central thesis here is that the study of medicine as a profession needs to emphasize process over product. It must strive not only to understand how a particular group (medicine) comes to establish or perpetuate its prerogatives, but also how a dominant sociological paradigm (professional dominance) seeks to do likewise. In short, attention must focus on delineating the conditions under which dominant concerns (be they groups or paradigms) are threatened, the nature of those threats, and the actions taken to counter them. Roth's (1974) warning that sociologists should not become too convinced that "what is good for the professions is good for society" uncannily anticipates

the recent Reed and Evans (1987) article in the *Journal of the American Medical Association*, in which the authors seek to attach a broad number of undesirable social costs to "deprofessionalization." From this vantage point, these authors fervently argue that any movement toward deprofessionalization should be zealously countered because it is ultimately "undesirable for the society" (Reed and Evans 1987, 3279).

In the following pages I examine the responses by professional dominance theory (as illustrated by Freidson 1984, 1985, 1986a, 1986b, 1987) to the challenges raised by the deprofessionalization (Haug 1973, 1975; Haug and Lavin 1981, 1983) and proletarianization (McKinlay 1982; McKinlay and Arches 1985; McKinlay and Stoeckle 1988) schools of thought. Based on Freidson's rejoinders, I suggest possible avenues of research that will add some clarification to a debate often marred by a lack of empirical clarity (see also Light and Levine in this issue). Finally, I wish to devote attention to a particular strength of this special issue, the variety of cross-national data and perspectives contained herein. It is clear from the articles by Coburn (Canada), Field (Soviet Union), Krause (Italy), Larkin (Great Britain), Riska (Nordic countries), and Willis (Australia) that both the attainment and maintenance of professional dominance is a decidedly problematic process. Not only has medicine failed to achieve professional dominance in a number of industrialized countries, but the interplay among bureaucratic, state, and group interests has formed anything but a singular or stable pattern of interrelationships and power mosaics. As such, these cross-national contributions have much to tell us about past, present, and future dynamics of professions.

The Dominance of Professional Dominance Theory

Taken as a whole, these articles tend to reaffirm the dominant status of Freidson's model. Beginning with the critiques by Light and Levine (theoretical overview), and Wolinsky (professional dominance), we find that even the deprofessionalization (Haug) and particularly the proletarianization (Navarro) points of view have somewhat retreated from their earlier attacks on the validity and adequacy of the professional dominance model. The preeminent status of the professional dominance model is also evident in the cross-national articles. Coburn (Canada),

for example, clearly sides with the professional dominance perspective, although he does close with a futuristic wink toward proletarianization. Willis (Australia) argues for a modified professional dominance explanation, and concludes that changes have not yet been substantial enough to support either a deprofessionalization or proletarianization position. Riska (Nordic countries) presents more of a mixed picture. In the case of Finland, for example, she identifies a dual labor structure divided along function and gender lines. Riska associates a proletarianized work setting with the high profile of women in municipal health and primary care. In turn, she finds a professional dominance model reflected in the more specialized, autonomous, and norm-generating positions occupied by male physicians. Although Krause (Italy) labels the professional dominance perspective as incomplete, ethnocentric, and irrelevant, he does note a rather late (1980s) movement toward professionalization in Italy. He also sees the growth of state power as possibly resulting in a trend toward either deprofessionalization or proletarianization.

A more clear-cut presentation of the proletarianization perspective is thus left to Field (Soviet Union) and Larkin (Great Britain). Field notes that medicine, as a corporate group and social force, is essentially powerless in the Soviet Union. The diminutive status of organized medicine, however, stands in decided contrast to the power of individual practitioners vis-à-vis their patients, a state of affairs he labels "paradoxical" and "an intriguing form of status inconsistency." Field does conclude that a process of proletarianization is currently at work in the United States, but provides only meager evidence for this assertion. He also identifies a period of time when medicine occupied a position of professional dominance in the Soviet Union, a dating that corresponds to the initial evolution of professional dominance in the United States, at least as plotted by Wolinsky (professional dominance) and others.

Finally, Larkin (Great Britain) argues that all three theoretical positions are mistaken in their common belief that the issue of professional dominance has become problematic only in more recent times. On this score, Larkin is joined by Navarro (proletarianization), Light and Levine (theoretical overview), and Stoeckle (physician's perspective) who argue, in varying ways, that not only are professional dominance claims often historically overstated, but also that inroads by corporate powers are of more longstanding than recent vintage. Larkin's basic position is that medical dominance is not necessarily inversely related to state intervention, and that under certain circumstances a more

rationalized and bureaucratic health care system may actually promote an expansion of medical hegemony. Krause (Italy), I believe, would certainly agree.

Similarities and Differences among the Theories

To date the professional dominance/proletarianization/deprofessionalization debate has been complicated by the different analytical frames of reference employed by the principal players. Freidson has chosen to direct his arguments more toward medicine on a macro-organizational level. Many of the counter arguments raised by proponents of the deprofessionalization and proletarianization schools, however, have focused primarily on changes at the practitioner level (either as individuals or collectivities). The result has been that Freidson (1984, 1985, 1986a, 1986b, 1987) has been able to acknowledge many of the data cited in support of these alternative models, while at the same time denying that such changes demonstrate any weakening of medicine's dominant status as a corporate entity. Freidson's ability to challenge successfully his critics has also tended to obscure the similarities shared by all three of these perspectives.

Haug, McKinlay, and Freidson all agree that health care delivery is undergoing substantial changes, including increased rationalization and formalization. All acknowledge an increase in the supply of physicians and an intensification of competition among practitioners. All recognize a promulgation of regulations governing medical practice, and a decrease in the autonomy and work satisfaction among individual practitioners. All cite a declining (or at least leveling off) of physicians' income, and all acknowledge a rise in consumerism among patients. Thus, despite their differences (see particularly Light and Levine, Wolinsky, and Willis in this regard) there is substantial agreement among these three schools of thought regarding the nature and direction of changes occurring both within medicine and in society at large. What is also clear, however, is that evidence at the practitioner level does not adequately challenge Freidson's thesis of professional dominance. For Freidson, the "core of professional autonomy" lies with those who control the credentialing process, the administrative process, and the technical criteria by which work is organized and evaluated. All of

this, Freidson argues, continues to remain within the domain of the medical profession *as a corporate entity*. For Freidson, individual physicians may well have lost individual autonomy and authority vis-à-vis their patients or other types of health providers, but the profession, as a corporate entity, has retained its legally enforced and enforceable monopoly, and its basic cultural authority. Control over work is the key variable for Freidson, and since he perceives physicians as remaining in charge of establishing the criteria for review, then the profession, as a corporate entity, still retains its professional status. In summary, Freidson acknowledges many of the pieces of evidence cited by the proletarianization and deprofessionalization camps, but concludes that much of their evidence is either incorrectly interpreted, or essentially irrelevant to his basic argument.

Freidson's Views on the Undermining of Professional Status

Freidson's dismissal of his critics notwithstanding, the challenges raised by the proletarianization and deprofessionalization camps have substantially contributed to the development of a theory of professions, in general, and, not incidentally, to the refinement of professional dominance theory itself. In the former case, they have broadened the discussion of professions to include a fuller treatment of the sociopolitical context in which scientific and professional events take place (see Navarro, and Light and Levine). They have also, and particularly in the case of proletarianization, moved the focus of professions toward more of a cross-national perspective. Finally, they have challenged Freidson to become more explicit about the conditions under which he would consider the dominant status of medicine to be weakened. Freidson's (1984, 1985, 1986a, 1986b, 1987) explications in this regard have served to identify several points at which the professional dominance model might be fruitfully tested. I would like to comment on some of these points below.

Although Freidson (1987, 144; 1984, 16–18) continues to maintain that medicine is not currently losing its professional status in the United States, he does foresee the potential for “a deep split within the ranks of professions.” The split, for Freidson, reflects an increasing rift between the managers and the managed, the rule setters and the

rule followers. This increase in the internal division of medicine has been precipitated by the increasing external regulation of medicine which carries with it "dire consequences for the profession" (Freidson 1987, 144). As a part of this process, Freidson notes that rank-and-file practitioners may become increasingly unlikely to see their colleagues-turned-professional administrators as "real" doctors and therefore as "fellow" professionals. As pointed out by Wolinsky, such a shift would undermine medicine's professional status since decisions concerning the organization and content of work would no longer be under the control of peers and "colleague insiders." Freidson professes not to know whether this split will actually occur, or what shape it will take. Stoeckle (physician's perspective), however, contends that physicians already see themselves as being externally regulated. The fact that they might be "wrong," (in that Freidson argues that decisions are, in fact, still being made by physician insiders) is actually irrelevant to Freidson's overall theory on this point. Freidson, however, does appear to consider the state of affairs as defined by the rank-and-file physician to be the definitive frame of reference. What is the most critical in this regard, however, is that Freidson does specify conditions under which professional dominance may crumble; this is a significant development for the theory of professional dominance.

Wolinsky suggests that the critical operational distinction be whether or not physician-administrators, as a class, "fully and permanently divest themselves of actual medical practice." To the best of my knowledge, Wolinsky's criterion (although quite stringent) represents the first attempt to define this critical issue in professional dominance theory. Wolinsky's relatively "objective" criterion for assessing physician status stands in contrast to the "other-defined," collegially based definitional criteria hinted at by Freidson. Unfortunately, Freidson does not offer explicit suggestions as to how we might come to know when physicians cease to be physicians, and thus cease to function as representatives of and defenders of medicine's professional prerogatives. Furthermore, when viewed within the context of Freidson's (1970) well-known contention that it is not prior training but current practice setting that determines professional orientations and performance, the issue of who functions as, is thought of, or thinks of oneself as a physician may very well constitute a divergent point within Freidson's overall writings on medicine. Whatever the case, the issue of what happens to physicians who perform administrative tasks in bureaucratic

settings is very much at the heart of Freidson's argument of professional dominance. More important, it is an issue that can be empirically explored. Admirable beginnings can be found in the work of Walsh (1987), but the surface has only been scratched.

Additional avenues for exploring medicine's changing social status may be drawn from other critiques by Freidson himself. As one example, Freidson identifies two changes in the norms and practices of professional control that he considers may have dire consequences for the communal foundations of medicine's professional status (see Goode 1957). The first involves an increase in competition among practitioners. The second is the "collapse" of norms governing peer review and the formalization of review procedures being mandated by federal legislation or private health insurers (Freidson 1984, 1985). Both movements, according to Freidson, can lead to internal dissension, and an increasingly strained collegial core, the consequences of which have been outlined above. Both movements are amenable to empirical investigation; the latter has already generated a rich sociological heritage (Arluke 1977; Millman 1976; Bosk 1979, 1986).

On a different level, Freidson notes that if medicine, as a corporate entity, were to lose its legally enforced monopoly and basic cultural authority over the credentialing process, the administrative arena, and the technical criteria by which work is organized and evaluated, then medicine's professional status would be undercut. As only one example, we might turn to Haug's focus on the computerization of medical knowledge, and the potential of that technology to exert a deprofessionalizing influence. Freidson (1984, 1985) has specifically challenged Haug's thesis and counters that the control of this technology still lies with the medical profession, that it is still physicians that define the categories, operationalize the variables, and interpret the data. Once again, the beauty of this particular disagreement is that it, like other areas of contention, can be operationalized and tested. We can, for example, empirically assess the presence and role of physicians who work to construct, organize, and interpret relevant data bases (see also Light and Levine). Similarly, we can investigate the role played by computer technology in the vertical stratification of medicine, and the conditions under which individuals with an M.D. degree, residency training, or prior practice experience maintain their status or self identity as physicians once they have become immersed in the development or management of information technologies.

On another score, Haug has long maintained that an important impetus toward deprofessionalization lies in the narrowing of the knowledge gap between physicians and their patients. Freidson (1985, 1987), while acknowledging a rise in consumerism, argues that the knowledge gap remains as broad as ever, given the corresponding growth of medical scientific knowledge. Freidson (1986a, 74), however, has recently come to identify a class of patient that he believes can challenge the knowledge-based authority of physicians in a contract practice. Whether or not this identification represents a modification of his earlier objections to Haug's thesis is not an important issue. What is more important is the fact that the emergence of such a class of patient is yet another event which can be empirically verified, and that such an examination has implications for both a theory of professions and the changing social status of physicians.

An additional focus for research lies in the nature of the relation between organized medicine and those bodies representing alternative providers of health care. Although autonomy may well be the acid test of professional dominance (Wolinsky), there is little professional dominance without other groups to dominate. An analytical watch over the boundaries between medicine and other types of health care providers is thus critical to understanding the dynamic nature of professional relations. Even if one were to agree with Wolinsky, Navarro, and Light and Levine that individual physicians are not currently becoming proletarian (in terms of control over their own work), this does not mean that medicine's dominance over the work of other provider types is not being challenged successfully, or even fatally weakened. Freidson (1986a, 76–78), for example, cites the declining influence of the American Medical Association (AMA) on issues of economic and social policy, and notes recent splits between the AMA and the American Hospital Association (AHA) and the Association of American Medical Colleges (AAMC), as well as the emerging influence of other health-related organizations representing interests other than those of traditionally organized medical practices. Chiropractic's recent successful antitrust suit (*Wilk et al. vs. the American Medical Association*) against the AMA is only one of numerous recent challenges to medicine's dominant status in the health care sector. In this case, the AMA and its members were found by a U.S. District Court to have conspired, both overtly and covertly, to "contain and eliminate chiropractic as a profession" (Getzendanner 1988, 81). Of

additional sociological interest is that medicine was unable, during the period in question (the 1960s and 1970s), ultimately to control the growth of chiropractic, in spite of its deliberate and concerted efforts to this end.

Does a failure by medicine to flex its professional muscle successfully allow for a conclusion that medicine's professional dominance is being eroded? If one is to believe the AMA and its general counsel (Johnson 1988), the answer would be no. Not only did the AMA consider the decision to be fundamentally "unjustified" (thus rationalizing their decision to appeal), but the general counsel was also quick to point out to its members, other physicians, and lurking pretenders, just what the decision did not say. These "absent facts" concluded that nothing in the court's decision required an endorsement by the medical profession of chiropractic, that the scientific validity of chiropractic was not endorsed by this decision, and, in what sounds like a vindication of Freidson's analysis, the court decision did reaffirm that patient care in acute care hospitals and the medical staff of acute care hospitals should remain under the control of physicians. In addition, and once again echoing facets of the professional dominance argument, Johnson pointed out that the court did not find that the Joint Commission on Accreditation of Health Care Organizations' requirement that a majority of its executive committee be physicians was a restriction of competition. Finally, Johnson noted, the request by chiropractic for a membership position on the joint commission was not granted.

Although the relevance of this case to the professional status of medicine must await a more detailed examination, it appears that the current decision will appeal to both the proponents and critics of professional dominance theory. On the one hand, the court did reaffirm the right of medicine to establish exclusionary standard in the institutionalization of professional dominance. On the other hand, the court's decision did fundamentally weaken medicine's traditional control over chiropractic (see Wardwell 1952, 1972). Interestingly, Freidson's (1986b, 113-19) own analysis of the impact of antitrust law on professional autonomy appears to support this conclusion. In his review, Freidson (1986b, 118) concludes that relevant court decisions have tended to reorganize professions internally, but "without seriously influencing their relations with competing occupations." Although the operative word here is "serious," it does seem clear that the Getzendanner decision speaks more to the topic of competition among

occupations than it does to that of internal reorganization. Two other facts also seem clear, the AMA counters notwithstanding. First, the AMA did attempt to eliminate a competing group, and failed. Regardless of its motivations, it was not successful in achieving its desired goal of eliminating a rival provider. Second, medicine's legally sanctioned dominance was reaffirmed by the court, but only for acute care settings and not for the delivery of nonhospital-based outpatient or ambulatory care. As the delivery of health care continues to move toward a greater utilization of outpatient and ambulatory care services, this distinction may loom increasingly more troublesome with respect to medicine's continued claims to a dominant status. In this context it is worth noting that Freidson (1986a, 73) himself identifies ambulatory care settings as harboring the greatest potential for an increasing level of tension between practitioners and administrators, and thus potential for either internal dissension and/or the rise of a new administrative elite.

The cross-national studies also speak to this issue of control over alternative providers, but from a somewhat different perspective. Rather than focusing on the relevance of control for the *maintenance* of professional dominance, Coburn (Canada), Field (Soviet Union), Larkin (Britain), and Willis (Australia) offer insights into how medicine's lack of control over other health occupations plays an influential role in the *development* (or lack thereof) of a professional status for medicine. Larkin, for example, devotes considerable attention to a discussion of organized medicine's inability to establish an organization monopoly over alternative providers. He documents how state opposition to medicine's effort to establish complete control over the emergent division of labor in medicine was directly tied to medicine's longstanding lack of hegemony in Britain. Willis, and Coburn in somewhat less detail, specifically refer to chiropractic in discussing medicine's diminishing control over competitors in Australia and Canada.

Returning to the United States, no single court decision, technological innovation, or even piece of legislation will necessarily sound a death knell for the professional status of organized medicine. *Wilk et al. vs. the American Medical Association*, however, is not an isolated challenge to medicine's control over the organization and delivery of health care. The Libby Zion case (Willis 1987) involving the unexpected death of an eighteen-year-old woman in a New York hospital in March of 1984, has generated another challenge to medicine's control over work,

this time with respect to the extended hours worked by hospital residents, and the adequacy of supervision for interns and junior residents (Wallis 1987; Asch and Parker 1988; McCall 1988; Levinsky 1988; Glickman 1988). Although organized medicine has attempted to maintain control over future training recommendations and regulations by generating its own series of physician-dominated blue-ribbon panels and studies on residency stress, the threat of externally imposed controls over how physicians are trained remains very real.

Another area of contention is the movement toward new clinical roles for pharmacists (Adamcik et al. 1986) (see also Light and Levine). This includes growing interest in the practice of "therapeutic substitution," in which pharmacists are legally sanctioned to provide patients with pharmaceuticals other than that called for by physicians' prescriptions (Ruffenach 1988). Over ten years ago, Freidson (1977) compared the work domains of medicine and pharmacy. He concluded that although both were nominal members of the professional class, both were the products of higher education, and both held exclusive licenses allowing for a monopoly over certain tasks, the pharmacist could work "only at the order of the physician." (Freidson 1977, 23). Although medical prerogatives continue to exert their dominant influence over the work of pharmacists, this is decidedly less true today than when Freidson made this comparison. Looking toward the future, one could well envision a series of changes that would culminate in pharmacy's legally sanctioned review of medical work. The scenario begins with an increasing inability by physicians to cope with the proliferation of new pharmaceuticals and changes in drug regimens. Concern deepens as both the general public and organized purchasers of health care mount opposition to the resulting and costly escalation of clinical iatrogenesis due to unforeseen drug interactions and general prescribing errors (see Illich 1976). Compounding this picture, physicians continue to prescribe drugs for purposes other than which they were originally approved by the Federal Drug Administration (James 1988). The result is a mandated review of physicians' work by pharmacists. Just as therapeutic substitution may be viewed as a logical and practical extension of the more widely accepted practice of "generic substitution" (where pharmacists are legally empowered to substitute the generic equivalent for the prescribed drug), the practice of therapeutic substitution may someday be extended to cover the legally sanctioned

review of medical work (particularly prescription writing activities) by a group not dominated by physician "insiders."

Critical to Freidson's theory of professional dominance is the fact that all of the conflicts and controversies regarding medicine's proper role in the delivery of health care ultimately will be contested within the public arena. As such, any politicization of medical issues will ultimately come to be adjudicated on the issue of medicine's service orientation. As noted by Wolinsky, the autonomy of the medical profession is legislatively and culturally predicated on the premise that medicine will live up to its service orientation and ethical code. Although Freidson, Wolinsky, Haug, and others have all pointed out that there is nothing in a theory of professions to require that a professional group actually practice the altruism that it professes, the fact that medicine has been perceived to have wandered from its fiduciary responsibilities opens up another window of potential vulnerability. Indeed, the previously cited Reed and Evans (1987) apology for the medical profession concludes just that, and urges members of the medical profession to counter movements toward deprofessionalization with a revitalized service ethic. How medicine might come to manipulate further public opinion in the face of increasing challenges to its traditional message of "medicine in the public interest" is then yet another area for sociological inquiry.

In summary, there are a number of points of inquiry at which we might examine Freidson's theory of professional dominance. Although it may be true, as argued by Larkin, that conclusive answers will be derived only over an extended period of time, one need not wait for history to reveal its decision. There is a wealth of data that can be gathered today, much of which has been suggested by the ongoing debate between the deprofessionalization, proletarianization, and professional dominance schools of thought.

Cross-national Perspectives

Taken as a whole, the contributions by Coburn (Canada), Field (Soviet Union), Krause (Italy), Larkin (Great Britain), Riska (Nordic Countries), and Willis (Australia) provide us with multiple examples of the benefits to be derived from a cross-national perspective (Kohn 1987). These

articles also furnish us with a welcome balance to Freidson's focusing his analytic acumen almost exclusively on the United States. Indeed, Freidson has recently argued that the concept of professions is not widely generalizable to a variety of historical and national settings (1986b, 35). I believe these articles suggest otherwise.

The Disappearance of Deprofessionalization

As noted earlier, most of these authors find themselves in at least partial accord with the professional dominance model. When points of disagreement are raised, the proletarianization model is the one most often invoked as an alternative explanation. Conversely, references to deprofessionalization are relatively absent. Although each author devotes some introductory attention to a comparison of these three schools of thought, subsequent discussions of data largely ignore the deprofessionalization perspective (Willis on Australia being a partial exception). In some cases (see Larkin on Great Britain), the terms deprofessionalization and proletarianization appear to be used synonymously. Whether this absence of reference and/or differentiation can be tied to the particular authors included here (and their own theoretical persuasions), a belief that deprofessionalization offers the least attractive alternative to the professional dominance model (a point none of the authors explicitly makes), or some general confusion about what exactly constitutes the differences between these two schools of thought, will not be answered here. The relative absence of the deprofessionalization model in these pages, however, is something that should be noted.

The Theoretical Importance of "Internal Cohesion"

One theme common to the arguments of most of non-United States authors is how an absence of internal cohesion, and the corresponding presence of dissension, serves as either a barrier to professional status (e.g., Willis), or as a condition for a fall from professional dominance. Coburn, for example, criticizes Freidson for maintaining too homogeneous a view of physicians and the assumption that all physicians have similar interests and motivations. In the case of Canada, Coburn notes splits along specialist/generalist lines during the recent strikes by specialists to preserve their opting-out and extra-billing practices. Krause, in

his analysis of government by political party (*partiocrazia*), notes a split between elite specialists and generalists, in this case along political party lines. He argues that such an historical split has weakened the solidarity of the "profession," and consequentially hindered the movement of medicine toward a professional status in Italy. Field notes a great deal of internal differentiation and stratification within the Soviet medical system, and directly links this differentiation to medicine's long standing lack of a professional status in that country. Larkin warns against the internal fragmentation of the medical profession and concludes that increasing divisions within the medical profession in Great Britain may further weaken its adaptive cohesion. Finally, although Riska does not raise the topic directly, it is implicit in her analysis of a dual labor market along gender lines.

In summary, the issue of internal cohesion is notable not only for the important, but largely hypothesized, role it plays in a possible loss of professional dominance, but more significantly, the role it has been accorded in explaining why medicine in certain industrialized and highly bureaucratized countries (Italy, for example) has yet to develop anything resembling the professional dominance attained by medicine in the United States.

The Routinization of the Term "Professional Dominance"

One potential, if unintended, victim of the preeminent status accorded the theory of professional dominance is the frequent inability of social scientists to use the term "medicine" without the seemingly obligatory prefix "profession of." What was once intended as a descriptive qualifier and analytic tool has become so routinely fused with its base term as to lose a significant measure of its analytic power. As a consequence, references to medicine as an "occupation" appear somewhat anachronistic, and a phrase like "occupational dominance" a veritable malapropism. This lack of willingness to refer to medicine as something other than a profession has resulted in, among other things, a certain degree of confusion regarding what arguments are actually being made. In this issue, for example, Field variously refers to medicine as a "profession" (without quotation marks), a "profession" (bracketed by quotation marks and thus indicating an ironic distance), and as an "occupation" (without quotation marks). He also refers to the Soviet physician as a "bureaucratic professional." Even Soviet analysts are cited using the

term "profession" to describe medicine in their country (see Field's reference to Kosarev and Sakhmo 1985). In a second example, Krause consistently refers to medicine as a "profession" even as he structures a compelling argument that the evolution of Italian medicine's autonomy and power vis-à-vis the state is a most recent and not yet complete process. As a third example, Riska takes great (and quite illuminating) pains to detail the many differences in health care organization and delivery among the countries of Denmark, Sweden, Norway, and Finland, with respect to professional status. The term "profession," however, is ubiquitously used when referring to medicine in all four countries.

The problem of what exactly is meant by the term "profession" also exists outside of this special issue. Brown (1987), for example, has developed an interesting challenge to Field's writings (see the article in this issue; see also 1957, 1975) on the proletarianization of the medical profession in the Soviet Union. Brown (1987, 65) argues that the Bolshevik revolution did not usher in a "deprofessionalization" (her term) of medicine because "the Russian medical profession was never autonomous and powerful [to begin with]." If it is true that Soviet medicine was never autonomous and powerful, then we may question whether organized medicine in the Soviet Union was ever a profession. Consequentially, we may also question whether references to processes such as "deprofessionalization" or "proletarianization" are thus rendered contextually nonsensical. The key issue, of course, is whether one considers autonomy to be either a necessary or sufficient condition for professional status. Although Brown basically wishes only to attach Field's conclusion that physicians were necessarily opposed to any attempt by the Bolsheviks to "level" the profession, what we are left with is a certain degree of conceptual confusion in which a group routinely referred to as a "profession" does not undergo "deprofessionalization," but is also alleged to lack the autonomy and power necessary to have achieved professional status to begin with. Field's analysis may or may not be "ethnocentric and ahistorical" as charged by Brown (1987, 67), but Freidson's identification of autonomy as a central ingredient of professional status certainly deserves better. We need not insist that other social scientists agree with Freidson's construction of this concept (see Levine and Light 1987 for a brief mention of an alternative Prussian-based model), but readers do have a right to be warned in advance that the concept of profession is being

used in some alternative fashion. Over twenty-five years ago Becker (1962) noted the indiscriminate use of the term "profession" and how it had come to function as a collective symbol and folk concept. We are in danger today of having the term "profession" function, at least within social science circles, as a routinized and potentially meaningless appendage.

Issues of Gender and Professional Dominance

One important topic which has been all too briefly mentioned in this issue is the relation of professional status to the presence and role of women in medicine. Coburn, for example, does note that medicine in Canada is rapidly becoming "feminized," but he does not comment further. More substantively, Field links the low income and status of physicians in the Soviet Union to the plurality of women physicians in that country. Field also observes the relative absence of women in the areas of scientific, academic, and administrative medicine. Similarly, Riska identifies a dual labor market in Nordic countries based on gender, with men again occupying positions of administrative power and control. Both of these findings parallel those of Lorber (1984, 1985, 1987), who finds that positions in American medicine are also stratified on the basis of gender. Although not specific to the issue of women in medicine, Light and Levine credit the women's health movement with playing an influential role in changing cultural definitions of health and illness.

The issue of whether an increase in the number of women in medicine will result in a corresponding increase in the status and power of women physicians is a most important question. It is, however, somewhat different from asking what impact such an increase will have on the professional status of medicine as a social force or corporate entity. In the former case, attention is often directed toward investigating, for example, the relation of gender to the delivery of quality health care. In the latter case, the focus is more structural in nature. How, for example, will the commodity of internal cohesion, deemed so important by Freidson, be affected by an increasing influx of women physicians? In a most provocative hypothesis, Lorber (1985) suggests that female physicians will soon find themselves split into two camps: those who will identify with the dominant medical system and thus work to preserve traditional professional prerogatives, and

those who align themselves with nursing, other female-based health care occupations, and consumers, who desire a less stratified health care system. This hypothesis, however, represents only one of many which need to be generated with respect to this long-neglected issue. Riska is certainly correct to criticize the study of professions for its sex-neutral posture.

Closing Comments

The Convergence of Professional Dominance and Proletarianization Perspectives

Freidson's use of the term "professional dominance" refers to both a state of affairs and the process of maintaining that state. As proposed earlier in this article, the theories of deprofessionalization and proletarianization have pushed Freidson to articulate the conditions under which an erosion of professional dominance might occur. Unfortunately, Freidson does not provide us with a particular concept or label by which we might more readily refer to such a process. Consequently, there has been a tendency by others to resort to the use of the terms "proletarianization," "deprofessionalization," and "corporatization," even as these concepts are concurrently being criticized as inadequate or incomplete. Even Freidson (1986, 70) can be found to invoke the concept of proletarianization when commenting on the possibility of future changes in the professional status of medicine. These alternative concepts, however, do not adequately represent the process as outlined by Freidson. Consequently, my own preference in this regard is for the term "professional subordination."

Freidson's willingness to entertain aspects of the proletarianization argument should not be altogether surprising. Irrespective of their differences, both the concepts of proletarianization and professional dominance share a common analytic concern with the nature and organization of medical work. Although Freidson does level criticisms at both deprofessionalization and proletarianization, he does appear to favor the later theory over the former. Proletarianization, for Freidson (1987), has more complex ramifications than deprofessionalization. In addition, proletarianization, much like professional dominance theory, centers its analytical gaze more on economic and organizational phe-

nomena, directed more toward the internal dynamics of professions and highlighting more the themes of power and control than does deprofessionalization (Freidson 1984, 6).

The similarities between professional dominance and proletarianization, however, do not rest entirely on modifications by Freidson to his earlier arguments (see also Light and Levine, in this issue, on such changes). McKinlay (McKinlay and Arches 1985, 1986; McKinlay and Stoeckle 1988) has also continued to clarify his earlier writings (1982) particularly with respect to the criticisms raised by Freidson (1984, 1985, 1986a, 1986b, 1987). In a move more cosmetic than conceptual, the authors have even substituted the term "corporatization" for "proletarianization." This decision to deemphasize proletarianization's Marxist roots has, in turn, generated a much more positive response by physicians and other medical "insiders" to an argument which most likely would have been rejected out of hand had it been cloaked in its traditional Marxist garb (J.B. McKinlay, *Personal Communication*, 1988).

Although there continue to be obvious differences between professional dominance and proletarianization, many of these differences are eminently reconcilable. For example, professional dominance advocates often criticize the proletarianization perspective by arguing that the employment status of physicians (self versus other) is irrelevant to professional status. Somewhat ironically, McKinlay makes a similar argument when he contends that it is inappropriate to apply rigidly traditional Marxist concepts to the analysis of modern complex organizations (McKinlay and Arches 1985, 1986). On another point, critics of proletarianization have long pointed out that bureaucratic organizations can and do make accommodations to the presence of professionals. An acceptance of this point by those advocating a proletarianization perspective will not fatally weaken their theoretical position, whatever their fears to the contrary. Professional dominance advocates, on the other hand, need to stop invoking images of physicians' elevated incomes when issuing their rejoinders to proletarianization. The issue has become moot given McKinlay and Arches (1986) recasting of the issue in terms of surplus value rather than absolute salary. Similarly, objections to proletarianization based on "common sense" appeals that physicians could never become "just like" blue collar workers unnecessarily position proletarianization advocates within arguments they no longer wish to make.

For Freidson, the major barrier to any erosion of professional dominance lies in medicine's continuing ability to maintain its necessary ties to state policy making and institutional chartering. In turn, a lack of internal cohesion would mark a diminished capacity for effective political organization on the part of medicine. It is at this juncture that Freidson identifies an important dialectic in his writings on the subordination of professional dominance. For Freidson, the very processes that insured the transfer of standard setting, the review of performance, and the exercise of supervision and control from individual physicians to the profession as an organized entity, also foster the potentially disabling processes of rationalization and formalization. In a similar fashion, Light and Levine argue that in the United States the medical profession, driven by its own self-interests, created the very protected market conditions necessary for capitalism to flourish, and thus establish the conditions necessary for capitalism to exert control over the profession itself. In summary, we find arguments emanating from three ostensibly different vantage points (Freidson, Light and Levine, and McKinlay) in which medicine's successful struggle for professional dominance is conceptually and consequentially linked to the emergence of conditions under which that very dominance might be subordinated.

There remains, however, at least one critical distinction between the theories of proletarianization and professional dominance. This difference centers around the issue of autonomy and the degree of control attributed to medicine with respect to its future as a dominant profession. Freidson (1987, 144) believes that medicine still has the choice to become either "servants of capital or of the state" or, conversely, to "identify with the ideals of their professions and concern themselves with sustaining the integrity of the work for which they have taken responsibility." It is at this point that Freidson and McKinlay part ways. For Freidson, medicine still has the time, and more importantly the ability, to exercise deliberate and purposeful control over its future. Reflecting this optimistic stance, Freidson's analysis of change and his detailing of the process of professional subordination is centered entirely within the profession itself. The proletarianization perspective, with its broader sociopolitical, historical, and cross-national roots does not accord medicine—or any other organization or institution for that matter—such a degree of independence or insulation from larger social forces. What then remains missing in Freidson's writings is a sense of what broader social forces, if any, might underlie the processes of

rationalization and formalization so central to his arguments. If medicine's professional status can be or is being eroded, then to what is it being subordinated? Is capitalism the driving force? Advocates of proletarianization would say yes. Freidson rejects such a conclusion. Alternatively, Light and Levine suggest that the encroachment of large-scale profit centers within medicine reflects not capitalism per se but rather the still more basic force of "corporatization." Their formulation of a theory of corporatization is, however, more suggestive than definitive. What does remain promising is that this effort by Light and Levine, as well as the efforts of the other authors in this issue, represent a continued and committed search for concepts and insights which will illuminate what is happening in health care systems, both nationally and internationally. As noted by Light and Levine, "Finding concepts that characterize what is happening matters because good concepts capture essences, identify dominant forces, determine our focus, and suggest future direction." In the end, it is not so important who "wins" the deprofessionalization/proletarianization/professional dominance debate, as it is the fact that this debate has immeasurably enriched our understanding of the world we live in.

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