The Professional Dominance Perspective, Revisited

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LET US BEGIN WITH TWO QUESTIONS. WHO NOW reads Talcott Parsons (1951)? Who now reads Eliot Freidson (1970a)? The answer to both questions, as evidenced in part by this special issue of the *Milbank Quarterly*, is anyone and everyone who desires to understand either the role of health and health care in American society, or the American health care delivery system itself. The field of medical sociology was originally planted in chapter 10 of Parsons's *The Social System*, and Freidson's *Profession of Medicine* is the river that has nourished it. Although the winds of time have altered the topography of the field and the course of the water has some new bends, those original maps are still quite serviceable. Indeed, it can be (and has been) argued that most of the medical sociological work done over the past several decades fundamentally amounts to debating, modifying, and filling in (with finer brushstrokes) the details of those original maps (see Fox 1979; Wolinsky 1988).

The purpose of this essay, then, is to revisit the professional dominance perspective yet again. To do this, I have somewhat arbitrarily organized the essay into three major sections. The first part provides a brief review of the professional dominance perspective as originally presented by Freidson (1970a). (Although it was the *Profession of Medicine* for which Freidson received the American Sociological Association's most prestigious Sorokin Award, elements of the theory are also contained in *Professional Dominance* [1970b].) The second section begins with a

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very brief review of the two major schools of thought—deprofessionalization and proletarianization—that have criticized the professional dominance perspective. (For greater detail on these matters see the articles by Haug and Navarro elsewhere in this issue of the *Milbank Quarterly*.) This is followed by a somewhat more detailed exegesis of Freidson's response to these critics, emphasizing how he has clarified, but not modified, the theory in light of the changes that have taken place over the past two decades. In the final section, I introduce my own thoughts about how the professional dominance perspective will likely need further modification as society, in general, and the health care delivery system, in particular, continue to change.

The Professional Dominance Perspective

In a series of provocative works, Eliot Freidson has developed what has come to be known as the professional dominance perspective (see especially 1970a, 1970b, 1980, 1983, 1984, 1985, 1986a, and 1986b). It begins with the argument that the word *profession* has two very important meanings. On the one hand, it represents a special kind of occupation. On the other hand, it represents an avowal or promise. For Freidson, the study of the profession of medicine, and hence the professional dominance perspective, requires emphasis on both meanings. As he writes (1970a):

> It [is] useful to think of a profession as an occupation which has assumed a dominant position in a division of labor, so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous or self-directing. The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members. The trustworthiness it professes naturally includes ethicality and also knowledgeable skill. In fact, the profession claims to be the most reliable authority on the nature of the reality it deals with.

Thus, a profession is defined as an occupation that has achieved autonomy or self-direction.

There must, however, also be formal institutions that exist for the sole purpose of serving to protect the profession from external "competition, intervention, evaluation, and direction by others" (Freidson

1970b). These formal institutions are what separates and stabilizes the organized autonomy of medicine from that of those occupations which by default are left to their own devices because the nature of their work is sufficiently uninteresting to warrant attempts at intervention (such as cab drivers or lighthouse workers). Furthermore, the scope of the profession's autonomy extends beyond itself, including all other occupations within its segment of (i.e., industrial cluster within) the division of labor.

Within any labor segment, one and only one occupation may achieve such organized autonomy. Freidson (1970b) writes that within the health care industry:

> We find that . . . the only occupation that is truly autonomous is medicine itself. It has the authority to direct and evaluate the work of others without in turn being subject for formal direction and evaluation by them. Paradoxically, its autonomy is sustained by the *dominance* of its expertise in the division of labor.

Although other occupations within the health care industry may claim to be professions, they uniformly lack either organized autonomy or dominance. For Freidson (1970b), that is a critical distinction:

> While the members of all [health care occupations] may be committed to their work, may be dedicated to service, and may be specially educated, the dominant profession stands in an entirely different structural relationship to the division of labor than does the subordinate profession. To ignore that difference is to ignore something major. One might call many occupations "professions" if one so chooses, but there is a difference between the dominant profession and the others.

The difference, of course, is that the profession has achieved autonomy.

And how, then, is that autonomy achieved? According to Freidson (1970a), it involves a two-stage process. The first stage consists primarily of demonstrating that the occupation does reliable and valuable work. This is often facilitated and demonstrated by the establishment of educational requirements, licensing procedures, a code of ethics, the formation of a professional association, and some element of peer control. These things an occupation can pretty much achieve on its own. Frequently, the possession of such traits is used to distinguish

the paraprofessions (e.g., nursing and physician extenders) from the less prestigious occupations (e.g., nursing aides and transporters).

The second stage of the process involves the conferral of autonomy. It results from the critical interaction of political and economic power, and occupational representation. Although it may be facilitated by educational institutions and the other forces (described above) that help to differentiate the paraprofessions from the less prestigious occupations, autonomy is always a granted, legal process. It is not something that the occupation may obtain on its own. Indeed, the conferral of autonomy occurs if and only if the public recognizes that the occupation (now a profession) has an extensive collectivity and service orientation (i.e., that it professes to adhere to its ethical code, as exemplified in the Hippocratic Oath or the Prayer of Maimonides). Whether the profession actually has such an orientation, however, is irrelevant. All that really matters is whether the public has imputed that such a service orientation exists. If society has been persuaded to make that imputation, then autonomy is granted and supported.

If society grants the profession its autonomy, then the profession must be self-regulating (i.e., providing its own quality control or self-management). This represents a significant departure from the formal, hierarchical control by lay individuals to which mere occupations are subject (Freidson 1984). The reason for this departure, of course, is that after it has been granted autonomy, no one else has the power to regulate the profession. And that is especially important inasmuch as the profession of medicine dominates the rest of the health care industry. Although this may seem rather straightforward, the conferral of professional autonomy has potentially staggering implications. If the autonomous profession so chooses, it may go lax on the issue of self-regulation, leaving its members to practice as they please. Because there is no other social control over the profession but the profession itself, the possibility arises for the profession to misuse its autonomy and abuse its clientele (which includes both the public and the other workers in the health care industry). Therefore, the profession must have and employ both formal and informal ways of collegially regulating the performance of its members.

This potential for failure to self-regulate represents the flaw of professional autonomy (and ultimately of professional dominance). Freidson (1970a) notes that the flaw allows and encourages:

> . . . the development of self-sufficient institutions, it develops and maintains a self-deceiving vision of the objectivity and reliability of its knowledge and the virtues of its members. . . . [Medicine's] very autonomy has led to insularity and a mistaken arrogance about its mission in the world.

In essence, Freidson argues that over the years, medicine has deceived itself to the point where it believes that it really is self-regulating, deserving of professional autonomy, and acting in the public interest. Freidson is quick to point out, however, that the flaws described above stem not from the men and women recruited to the profession of medicine, but from the structural characteristic (i.e., autonomy) inherent in professions themselves.

Although there are somewhat different interpretations of how it actually occurred (see Anderson 1985; Starr 1982; Stevens 1971; Wolinsky 1988), there is a general consensus that professional autonomy was conferred on American medicine around 1910. It was then that the Flexner (1910) report was published, documenting the existence of a gap between the level of medical knowledge and its practical application. In essence, organized medicine (primarily represented by the American Medical Association [AMA]) was granted broad, monopolist-like powers over the health care industry (such as it was at the time), in exchange for its promise to provide quality medical care and eliminate the sad state of affairs described by Flexner. And from that point on, medicine and the health care industry have never been the same.

The Deprofessionalization and Proletarianization Arguments, and Freidson's Response

In the two decades since Freidson (1970a, 1970b) first presented the professional dominance perspective, much has changed in the United States, in general, and in the American health care delivery system, in particular. Indeed, a number of scholars have argued that the traditional autonomy of the profession of medicine has eroded, and that medicine has become subject to the same kind of formalized and hierarchical controls from outside the profession that other occupations

routinely face. The two most well-known schools of criticism focus on the notions of deprofessionalization and proletarianization.

Marie Haug (1973, 1975, 1977, 1988; see also Haug and Lavin, 1978, 1981, 1983) has been the primary force behind the deprofessionalization argument. Her view is that the profession of medicine has been losing its prestigious societal position and the trust that goes with it. She cites five principal reasons for this loss. The first two are quite related. One is that medicine's monopoly over access to its defined body of knowledge has been eroded by the increased use of automated retrieval systems, such as computerized algorithms for symptom assessment. The other is that marked increases in educational attainment have made the public less likely to view medical knowledge as mysterious. As a result, people are more likely to challenge physicians' authority today than ever before.

The third reason cited by Haug involves the increasing specialization within medicine. This has made doctors more dependent on each other and also on nonphysician experts, especially engineers. Dependence on the former diffuses the power of any single physician, inasmuch as he or she must rely on the advice and expertise of colleagues. Dependence on the latter diffuses the power of all physicians, inasmuch as they must rely on advice and expertise from outside the profession. Thus, both individual and professional dominance (i.e., autonomy) have been reduced.

As her fourth reason, Haug cites the growth of consumer self-help groups coupled with the emergence of a variety of allied health care workers. This has increased the reliance on the lay, or at least the nonprofessional, referral system. For many people the experiential information exchanged in these lay (or nonprofessional) encounters poses a rather attractive alternative to the physicians' academic knowledge. Thus, the profession's magnetic field is no longer as unopposed as it once was. The final reason cited by Haug is that the physicians' altruistic image has not weathered well the recent storms over the rising cost of health care. Indeed, she notes that physicians are now being held far more accountable for their role in cost containment. Thus, the continued and excessive increases in medical care costs serve only to deflate the confidence of the public about medicine's commitment toward the common good.

John McKinlay (1973, 1986; see also McKinlay and Arches 1985; McKinlay and Stoeckle 1988; Navarro 1988) has been the most el-

oquent spokesperson for the proletarianization argument. He builds on Marx's theory of history, emphasizing the inevitability of all workers in capitalistic societies like the United States to be stripped eventually of their control over their work. This occurs when individuals are reduced to selling their services rather than producing finished goods. McKinlay argues that the growing corporatization, or bureaucratization, of medicine has resulted in eliminating the self-employment and autonomy of physicians. As the number and extent of intermediaries between patients and their doctors increases, physicians become more like other laborers. Moreover, as the medical workplace becomes more bureaucratized, physicians are increasingly subject to rules and other hierarchical structures that are not of their own making. As a result, the ability of doctors to govern themselves, especially by using their preferred informal methods of self-regulation, declines.

Thus, the fundamental tenet of the proletarianization argument is that as the process occurs, the profession of medicine is systematically divested of its control over certain key occupational prerogatives. McKinlay and Stoeckle (1988) demonstrate support for this thesis by contrasting physicians in small-scale fee-for-service practices at the turn of the century with physicians currently practicing in bureaucratic settings on seven issues, including entrance criteria, training content, autonomy, and the object, tools, means, and remuneration of labor. They conclude that important changes have occurred with respect to each and every issue, especially within the past decade. Specifically, medical schools have been forced to recruit women and minorities; the federal government and other outside interests now affect the content of medical school curricula; medical work has become segmented; patients have become clients of the organizational entity rather than the individual doctor; technological tools and the physical plant are now owned by the corporation rather than the individual doctor; and physicians have become employees of the corporation. The end result is that the members of the medical profession have been reduced to a common service level within the broader interests of capital accumulation. As such, they can no longer be considered professionally dominant.

As one might expect, Freidson does not find much support for either of the critical appraisals of his analysis of medicine's privileged professional status. His dismissal of the deprofessionalization thesis

asserts that although some specifics may have changed over the last two decades in the absolute, the overall situation remains relatively the same. But let us allow Freidson (1984) to speak for himself:

> The professions . . . continue to possess a monopoly over at least some important segment of formal knowledge that does not shrink over time, even though both competitors and rising levels of lay knowledge may nibble away at its edges. New knowledge is constantly acquired that takes the place of what has been lost and thereby maintains the knowledge gap. Similarly, while the power of computer technology in storing codified knowledge cannot be ignored, it is the members of each profession who determine what is to be stored and how it is to be done, and who are equipped to interpret and employ what is retrieved effectively. With a continual knowledge gap, potentially universal access to stored data is meaningless.

Thus, although Freidson readily acknowledges the changing events identified by Haug as important, he nonetheless refuses to accept them as evidence for the deprofessionalization argument. Indeed, he dismisses outright the notions that the profession of medicine has lost its *relative* (a) position of prestige and respect, or (b) expertise, or (c) monopoly over that expertise.

With regard to the proletarianization thesis, Freidson (1984) takes a different tack. He emphasizes that although the autonomy of individual physicians may have been reduced, the autonomy of the profession remains intact. Indeed, Freidson readily admits that individual physicians may now have to take orders from other physicians, much like blue collar or clerical workers must take orders from others. The difference, however, is that the orders taken by physicians come from other physicians, and only from other physicians. In essence, although he recognizes many of the same changes identified by McKinlay, Freidson views them as occurring within medicine, rather than outside of it. But again, let us allow Freidson (1985) to speak:

> [These changes] might be interpreted as bureaucratization in Weber's ideal-typical sense, for they are accompanied by an increase in hierarchical positions as health care organizations grow in size, records become more elaborate, specific standards govern the formal evaluation of more and more work, supervision in the form of evaluation of work becomes more widespread, and hierarchical positions of responsibility increase in number and variety. . . . [They]

> do not affect the position of the profession as a corporate body in the social as well as institutional division of labor so much as they affect the *internal* organization of the profession, in the relations among physicians. . . . [T]hey are creating more distinct and formal patterns of stratification within the profession than have existed in the past, with the position of the rank and file practitioner changing most markedly.

Thus, Freidson believes that the stage is not set for the profession of medicine to have its advantaged position wrested away from the outside. Rather, he believes that a variety of modifications will occur within the profession.

There are, then, two key points to note in Freidson's response to his critics. Both relate to a clarification (but not a modification) of the scope conditions for the theory of professional dominance. The first point is that the theory of professional dominance is (and always has been) cast in relative, and not in absolute, terms. That is to say, that relative to any other occupation in the health care (or related) industries, medicine will always be in a position of professional dominance. No other health-related occupation will ever come to dominate medicine.

The second point is that the theory of professional dominance is (and always has been) cast in terms of the profession, and not in terms of the individual physician. That is to say, that the professional dominance of medicine is a collective (or, to use Freidson's [albeit connotatively troubling] term, a corporate) property. Thus, the emergence of a vertical stratification system (as opposed to the horizontal divisions that exist in a company of equals) within the profession itself does not alter the profession's relations (i.e., dominance) with (i.e., over) its external environment (i.e., the health care industry).

Essentially then, Freidson's response to his critics has been threefold. He has: (1) agreed that the events that they have identified are important, but disallowed that they circumvent his theory; (2) clarified, but not changed, two important aspects concerning the scope of his theory; and (3) described the emergence of (or to use his words, "the magnification and formalization of these [previously informal] relationships [between doctors] into") a vertical stratification system within the profession itself. Thus, he has effectively refused to yield any ground, either empirically or conceptually.

What the Future May Hold

At this point, it would seem appropriate to present four additional points, prior to identifying what I consider to be the major problem facing the professional dominance perspective today. The first two involve trends in the relative supply of physicians, which were recently interpreted by McKinlay and Stoeckle (1988) as evidence for the proletarianization thesis. The latter two points involve questions that have yet to be raised in the debate, but nonetheless have important implications for it.

McKinlay and Stoeckle (1988) argue that the increase in the relative supply of physicians (i.e., the physician to population ratio) has resulted (or will result in) increased competition within the profession. In particular, they believe that the net result will be to pressure new physicians away from more traditional practice settings (i.e., solo, fee-for-service) and toward more bureaucratic settings (i.e., health maintenance organizations [HMOs] or other salaried reimbursement arrangements). In addition, they expect these new physicians to be willing to settle for reduced incomes. Using data from a variety of sources, they provide what appears at first glance to be a convincing argument.

A more careful review of their and other data (see Glandon and Werner 1980; American Medical Association 1987), however, suggests that the evidence is at least somewhat more equivocal. Consider the issue of physicians' salaries. Average annual physician income increased from $41,800 in 1970 (when Freidson first presented the theory of professional dominance), to $119,500 in 1986 (the most recent year for which complete data are available). It would seem difficult to consider such a highly paid occupational group as having been proletarianized. Moreover, when the 1986 data are expressed in constant 1970 dollars (i.e., adjusted by the Consumer Price Index), it becomes clear that physicians' real annual incomes actually rose during the period in which this proletarianization is said to have taken place. And although younger physicians do report lower annual incomes than their older counterparts (about $90,000 in 1986 for those under the age of 36), this is entirely consistent with traditional curvilinear career-earning trajectories in both medicine and other occupations (see Mincer 1974).

Consider also the issue of the type of practice settings and reim-

bursement arrangements into which new (or relocating) physicians go. McKinlay and Stoeckle (1988) point out that the proportion selecting solo practices has decreased, and that the proportion practicing under some form of salaried arrangements has increased. This is true enough. It must, however, be tempered by the confounding effects of increasing specialization, which is less conducive to solo practice, and by the proliferation of relatively innocuous portions of salaried income generated through part-time affiliations with HMOs and other more bureaucratic health care delivery systems (see Wolinsky and Marder 1985). It must also be tempered by an understanding of the developmental aspect of individual physician's careers (see Hall 1948), and how this may be changing over time.

The two questions that have yet to be raised in the debate are these. First, when does a physician-administrator cease being a colleague to physicians? Second, is organized medicine (i.e., the AMA) all powerful, or was it just at the right place at the right time? The salience of the first question arises from Freidson's (1985) identification and acceptance of the emergence of a vertical stratification dimension within medicine. If the hierarchical gap between physician-administrators and physicians (or between any two hierarchical layers within the profession) becomes too great, then will there not emerge a new, dominant profession of physician-administrators? Only, I think, if the physician-administrators as a class fully and permanently divest themselves of all actual medical practice. And that is unlikely, inasmuch as the traditional (and current) career path for physician-administrators is that of rising through the practice ranks within the organization (much like the career path of academic department heads and deans, who generally retain their professorial heritage). Therefore, the changing relations between and among physicians are not likely to seriously threaten medicine's professional dominance.

The salience of the second question lies in picking the latter answer. If the AMA was simply in the right place at the right time, then its (i.e., organized medicine's) monolithic influence likely has some half-life to it. In particular, the extension (or spread) of that influence into extra-medical domains (i.e., the medicalization of life, q.v. Conrad and Schneider 1980; Illich 1976; Zola 1972) may have begun to deteriorate with the emergence of a post-industrial and service-oriented societal order. As a result, what we are witnessing today may actually be the reduction to, and restriction of, medicine's professional dominance

to legitimately medical matters. And that represents something quite different than its deprofessionalization or proletarianization.

Although all of the issues identified above are important in discussions of the American health care delivery system, I believe that they fail to focus proper attention on the major problem facing the professional dominance perspective. In the end, that perspective comes down to just one thing—autonomy. All other characteristics of a profession flow from it. Thus, autonomy is the acid test of professional status. It is granted (never taken), based on the avowed promise of the profession to self-regulate, i.e., to live up to its ethical code. It should follow, then, that the only way in which a profession may lose its autonomy is to have it taken away because it failed to keep its promissory house in order. Therefore, the issue is not which forces external to medicine will wrest away its professional dominance, but whether medicine will lose that professional dominance by the benign neglect of its avowed promise.

According to Freidson's (1970a, 1970b) theory on the emergence of the profession (and its dominance), the conferral of autonomy was based on the public imputation of medicine's extraordinary trustworthiness. Therefore, it should follow that the potential revocation of that autonomy may occur at any point at which the public imputes that the profession has not lived up to its side of the bargain. It is especially important here to remember that such an imputation may be based entirely on perceptions. That makes moot the issue of who (or what) is in reality to blame for the current crisis in the health care delivery system. Thus, the future of medicine's professional dominance may actually ride on the outcome of the manipulation of public opinion (i.e., the maintenance [or support, to use Freidson's term] of the public imputation that it warrants professional autonomy).

If that is the case, then in order for medicine to retain its professional dominance, it must exchange its traditionally combative style for one far more cooperative. In particular, it must return itself again to a fiduciary agency (see Parsons 1975), from which it has wandered over the past two decades. That includes significantly greater stewardship of the limited resources available for the provision of health care. And as the profession becomes more conscientious about the way in which it allocates and consumes health care resources, it must also become more cognizant of how it has been so disproportionately rewarded for its services in the past.

What will the future hold for the professional dominance of medicine? For the most part, I believe that the answer is up to medicine. If the profession maintains its current posture, then it just might lose its dominant position. But that loss will not be due to deprofessionalization (as described by Haug 1988), or to proletarianization (as described by McKinlay and Stoeckle 1988). Instead, the loss of professional dominance will accrue from the benign neglect of maintaining the public's imputation of medicine's original avowed promise. Indeed, it can be argued that what we are witnessing today as the monopsonistic intervention of (or regulation by) the federal government (and in similar ways by other third-party insurers) is actually an attempt to stimulate self-regulation among physicians and their return to stewardship and their role as a fiduciary agency. If medicine fails to heed the call, then its privileged status and professional dominance may well go the way of the dinosaur.

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