

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

FREDERIC W. HAFFERTY

University of Minnesota-Duluth

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.

References

- Adamcik, B.A., H.E. Ransford, P.R. Oppenheimer, J.F. Brown, P.A. Eagan, and F.G. Weissman. 1986. New Clinical Roles for Pharmacists: A Study of Role Expansion. *Social Science and Medicine* 23:1187-1200.
- Arluke, A. 1977. Social Control Rituals in Medicine: The Case of Death Rounds. In *Health Care and Health Knowledge*, ed. Robert Dingwall, 108-25. New York: Prodist.
- Asch, D.A., and R.M. Parker. 1988. The Libby Zion Case: One Step Forward or Two Steps Backward? *New England Journal of Medicine* 318 (12):771-75.
- Becker, H.S. 1962. The Nature of a Profession. In *Sixty-First Yearbook of the National Society for the Study of Education*. Part 2: 24-46. Chicago: University of Chicago Press.
- Bosk, C. 1979. *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press.
- . 1986. Professional Responsibility and Medical Error. In *Applications of Social Science to Clinical Medicine and Health Policy*,

- ed. L.H. Aiken and D. Mechanic, 460-77. New Brunswick: Rutgers University Press.
- Brown, J.V. 1987. The Deprofessionalization of Soviet Physicians: A Reconsideration. *International Journal of Health Services* 17:65-76.
- Elder, S. 1987. Rx: Nostra Culpa. *Yale Alumni Magazine* 50:42-46.
- Field, M.G. 1957. *Doctor and Patient in Soviet Russia*. Cambridge: Harvard University Press.
- . 1975. American and Soviet Medical Manpower: Growth and Evolution, 1910-1970. *International Journal of Health Services* 5:455-73.
- Folli, H.L., R.L. Poole, W.E. Benitz, and J.C. Russo. 1987. Medication Error Prevention by Clinical Pharmacists in Two Children's Hospitals. *Pediatrics* 79:718-22.
- Freidson, E. 1970. *Profession of Medicine: A Study in the Sociology of Applied Knowledge*. New York: Dodd, Mead.
- . (ed.). 1971. *The Professions and Their Prospects*. Beverly Hills, CA: Sage Publications Inc.
- . 1977. The Future of Professionalization. In *Health and the Division of Labour*, ed. M. Stacey, M. Reid, C. Heath, and R. Dingwall, 14-23. London: Croom Helm.
- . 1984. The Changing Nature of Professional Control. *Annual Review of Sociology* 10:1-20.
- . 1985. The Reorganization of the Medical Profession. *Medical Care Review* 42:11-35.
- . 1986a. The Medical Profession in Transition. *Applications of Social Science to Clinical Medicine and Health Policy*, ed. L.H. Aiken and D. Mechanic, 63-79. New Brunswick: Rutgers University Press.
- . 1986b. *Professional Powers: A Study of the Institutionalization of Formal Knowledge*. Chicago: University of Chicago Press.
- . 1987. The Future of the Professions. *Journal of Dental Education* 53:140-44.
- Getzendanner, S. 1988. Special Communication. *Journal of the American Medical Association* 259:81-82.
- Glickman, R.M. 1988. House-staff Training: The Need for Careful Reform. *New England Journal of Medicine* 318 (12):780-82.
- Goben, R. 1988. The Emerging Role of Clinical Pharmacists. *Stanford Medicine* 5 (Winter): 18-21.
- Goode, W.J. 1957. Community within a Community: The Professions: Psychology, Sociology and Medicine. *American Sociological Review* 25:902-14.

- Haug, M. 1973. Deprofessionalization: An Alternative Hypothesis for the Future. *Sociological Review Monographs* 20:195–211.
- . 1975. The Deprofessionalization of Everyone? *Sociological Focus* 3:197–213.
- Haug, M., and B. Lavin. 1981. Practitioner or Patient: Who's in Charge? *Journal of Health and Social Behavior* 22:212–29.
- . 1983. *Consumerism in Medicine: Challenging Physicians' Authority*. Beverly Hills: Sage.
- Illich, I. 1976. *Medical Nemesis*. New York: Pantheon Books.
- James, F.E. 1988. Approved Drugs Find Unapproved Uses. *Wall Street Journal* (July 12):31.
- Johnson, K.B. 1988. Statement from A.M.A.'s General Counsel. *Journal of the American Medical Association* 259 (1):83.
- Kohn, M.L. 1987. Cross-national Research as an Analytic Strategy. *American Sociological Review* 52:713–31.
- Levine, S., and D. Light. 1987. The Professional Status of the Physician. Paper presented at the annual meetings of the American Sociological Association, Chicago, August.
- Levinsky, N.G. 1988. Compounding the Error. *New England Journal of Medicine* 318 (12):778–80.
- Lorber, J. 1984. *Women Physicians: Careers, Status, and Power*. London: Tavistock.
- . 1985. More Women Physicians: Will It Mean More Humane Health Care? *Social Policy* 16 (1):50–54.
- . 1987. A Welcome to a Crowded Field: Where Will the New Women Physicians Fit In? *Journal of American Women's Association* 42:149–52.
- McCall, T.B. 1988. The Impact of Long Working Hours on Resident Physicians. *New England Journal of Medicine* 318 (12):775–78.
- McKinlay, J.B. 1982. Toward the Proletarianization of Physicians. *Professionals as Workers: Mental Labor in Advanced Capitalism*, ed. C. Derber, 37–62, Boston, G. K. Hall Publishers.
- McKinlay, J.B., and J. Arches. 1985. Towards the Proletarianization of Physicians. *International Journal of Health Services* 15:161–95.
- . 1986. Historical Changes in Doctoring: A Reply to Milton Roemer. *International Journal of Health Services* 16:473–77.
- McKinlay, J.B., and J.D. Stoeckle. 1988. Corporatization and the Social Transformation of Doctoring. *International Journal of Health Services* 18:191–205.
- Millman, M. 1976. *The Unkindest Cut*. New York: William Morrow.
- Reed, R.R., and D. Evans. 1987. The Deprofessionalization of Medicine: Causes, Effects, and Responses. *Journal of the American Medical Association* 258:3279–82.

- Roth, J.A. 1974. Professionalism: The Sociologist's Decoy. *Sociology of Work and Occupations* 1:6-23.
- Ruffenach, G. 1988. When Druggists Second-guess Doctors. *Wall Street Journal*, May 19.
- Walsh, D.C. 1987. *Corporate Physicians: Between Medicine and Management*. New Haven: Yale University Press.
- Wallis, C. 1987. Re-examining the 36-hour Day. *Time* (August 31):54-55.
- Wardwell, W. 1952. A Marginal Professional Role: The Chiropractor. *Social Forces* 30:339-48.
- . 1972. Limited, Marginal and Quasi-practitioners. In *Handbook of Medical Sociology*, ed. H. Freeman, S. Levine, and L. Reeder, 250-73. 2d ed. Englewood Cliffs, N.J.: Prentice-Hall.

Address correspondence to: Frederic W. Hafferty, Ph.D., Associate Professor, Department of Behavioral Sciences, School of Medicine, University of Minnesota-Duluth, Duluth, MN 55812.