



**SUPERVISED AUTONOMY:
MEDICAL SPECIALTIES AND STRUCTURED CONFLICT IN AN
AUSTRALIAN GENERAL HOSPITAL**

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ABSTRACT OF THE THESIS

This thesis describes and analyses changing relationships between the medical profession and the state, and within the medical profession itself, as acted out in the arena of an Australian public hospital. The methodology and the arena have been chosen deliberately. Based upon ethnography, both participant and observational, and upon historical material, I argue that a critical feature of hospital culture is the diminishing autonomy of medical staff in the face of increasing state intervention. Furthermore, developments within the medical profession have facilitated an increasing subordination to and a consequent progressive penetration by bureaucratic ideals and practices. The result has been a process of fragmentation whilst, at the same time, continual attempts have been made to achieve unity by reinforcing or restating professional ideals. This contemporary situation is analysed by a careful ethnographic investigation which attends to the hospital's present and makes accessible and useful its historical process.

The thesis proceeds from the work of Freidson and Willis but extends their work by addressing the problems of professional autonomy and medical dominance within an Australian hospital. At a practical level, it became apparent that the medical world described by both authors was not totally congruent with the experience of some categories of hospital staff. At a theoretical level the question arose of the generalisation of the arguments of Willis and Freidson, and of the relevance of the medical dominance perspective to the position of the medical staff at a general hospital.

The analysis here is based upon a series of extended case studies which have been chosen for their ability to test or to clarify some of the elements of my position. Other critiques of medical dominance theories have emphasised proletarianisation or deprofessionalisation of the medical profession. Whilst I address both of these theories in the corpus of my thesis, my argument adopts neither stance in totality. Rather, the case-study material leads me to a concept of supervised autonomy.

The analysis of conflict, both within the medical staff and between the staff and the state, points not only to the need to re-examine the medical dominance perspective but also to the inadequacy of a static approach to the analysis of a profession. In particular, the process of increasing employment by the state of professionals in its institutions has allowed state heteronomy to erode professional autonomy and the hospital formed an important stage for this struggle. I argue further, however, that orthodox models of bureaucracy and professionalism are insufficient to analyse fully the structural position of the hospital medical staff. The perspective adopted in this thesis is that the hospital functions as an arena for control of the medical staff. I argue that medical supervision is a consequence of the development of the discourse of managerialism and economic rationalism.

Finally, the increasing centrality of the hospital to the medical profession derived from the opportunities it presented for specialist practice. The fragmentation resulting from specialisation increased the need for and the power of hospital coordination. Therefore, whilst the hospital provided a source of medical prestige, simultaneously the need to rationalise patient care laid the foundations for a decline in medical power. This paradox constitutes a central feature of the thesis, even within the doctor-patient relationship. At this level the

application of medical technology has been modified by attempts to reconstruct a fragmented patient.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university, and to the best of my knowledge, it contains no material previously published or written by another person except where due reference is made in the text. I agree to this thesis being made available for photocopying and loan if accepted for the award of the degree.

J. Gary Williams

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ABBREVIATIONS

A.M.A.	Australian Medical Association (after 1962)
A.S.A.	Australian Society of Anaesthetists
A.T.S.	Admissions, Transfers and Separations
B.M.A.	British Medical Association (local branches in Australia until 1962)
P.A.C.	Public Accounts Committee
P.C.S.	Patient Care System
P.S.A.	Public Service Association
P.S.B.	Public Service Board
S.A.S.M.O.A.	South Australian Salaried Medical Officers Association



CHAPTER 1

INTRODUCTION

The central problem of this thesis is the changing relationship between the medical profession and the state in the arena of the public hospital in Australia. A basic premise is that this problem can be elucidated by a study of the relationship and conflicts within the medical profession itself. The public hospital studied here, the major medical institution of South Australia, has been chosen specifically for its value in identifying some of the elements of these relationships. The hospital, which has played an increasingly central role in the overall system of medical organisation and practice, and, hence, in medical culture, is the context for the ethnography of this thesis.

The window, through which I view much of the conflict to be discussed later is medical specialisation and the specialty of particular focus is anaesthesia, which provides a connecting thread between several chapters. From a foundation of the experiences of hospital medical specialists, I argue that a critical feature of the structural position of the medical staff has been a decrease in its authority in the face of increasing state intervention. A major factor in the changing authority of the medical profession has been its fragmentation, developing as a result of competitive medical strategies. At the same time, continual attempts have been made to achieve unity by reinforcing or restating professional values. These values I present as ideal 'charters' which legitimated activity and, at some points, opposed the processes of a rationalising bureaucracy. The notion of conflict between competing 'rationalities', between competing charters, is a major theme of this thesis.

This is not to say that such changes were imposed on the medical profession by external forces. On the contrary, I will argue that developments within the profession - in particular, specialisation - facilitated an increasing subordination to, and a consequent penetration by, bureaucratic ideals and practices. With qualification, I shall adopt some of the perspectives of Max Weber and his supporters who argue that the crucial trend of the modern state is the development of 'rationalising' processes and their imposition upon subordinate institutions in society. My analysis, however, should not be described as 'Weberian' as my theoretical debt is owed to a diversity of authors which I discuss later. At present, I draw attention to the diverse nature of the empirical material which emphasizes the complexity of the process underlying the events analysed.

From this analysis, I propose an alternative view of the medical profession to that expressed originally in the work by Eliot Freidson (1970a; 1970b). This perspective was characterised as 'professional dominance' and Freidson focussed on the medical profession, in particular. In his view,

Health services are organised around professional authority, and their basic structure is constituted by the dominance of a single profession over a variety of other, subordinate occupations.

Freidson analysed the medical profession as a formal organisation and emphasised its difference from other health occupations. He concluded that the crucial feature of the medical profession, and one which resulted in its dominance over the health arena, was its legitimate and highly organised autonomy. This had a dual foundation in esoteric knowledge and in state patronage which resulted in a legal monopoly derived from the profession's association with strategic elites. These are defined as strategic precisely by their proximity to state power. Medical

dominance, therefore, is seen as a consequence of a professional/state relationship. Freidson's more recent publications, some of which are discussed more appropriately in later chapters, have continued to sustain this position, which has achieved a certain level of orthodox ascendancy. This perspective, for example, informed a major study of the division of labour in Australian health care undertaken by Evan Willis (1989).

Willis analyses the Australian medical profession under the rubric of 'medical dominance'. He argues that:

Medicine dominates the health division of labour economically, politically, socially and intellectually. This phenomenon of medical dominance is the key feature of the production of health care in Australian society and the central analytical focus in exploring the social structure and organisation of health care (1989:2).

The study by Willis is particularly important not only because it is Australian but also because it offers insights into the processes of medical tactics which, hitherto, have had limited documentation. He approaches his analysis from a position of structural Marxism and argues specifically against technological determinism as an explanation for the dominance of the medical profession in health care. The orthodox argument (see Pensabene 1980) is that medicine could lay claim to status and a dominant position in the division of labour in health care by virtue of its accumulating scientific knowledge. Willis argues, to the contrary, that it was the ideological component of scientific medicine rather than its technological efficacy which promoted medical dominance.

Scientific medicine as an amalgam of science and ideology promotes a view of illness and appropriate treatment that is compatible with dominant class interests. Doctors thus contribute to the promotion of bourgeois ideological hegemony in Australian capitalist society (1989:202).

Willis locates the profession in the wider politico-economic context and he concludes that its dominance is a result of the development of the capitalist state.

Medical dominance then rests upon state patronage, achieved through medicine's role in reproducing the relations of production and seeking to maintain bourgeois ideological hegemony. Medicine however is not only a mechanism for the reproduction of the class structure but has also been a beneficiary, as control over the health field has been achieved to a considerable extent. Such control is legitimated by the ideology of professionalism; a specific form of the ideology of expertise (1989:204).

The use of legitimating ideologies is also an important feature of my approach as discussed later.

Willis identifies three levels of medical dominance - autonomy, authority and sovereignty. He defines autonomy as medical dominance at the level of control over its own work; authority denotes control over other health occupations; and medical sovereignty relates to authority in wider society. To propose a decline in medical dominance, it would be necessary, argues Willis, to demonstrate significant diminution in one or more of these levels. Willis concludes that what evidence there is does not really indicate much of a decline. The evidence I present here points to an erosion of the bases of medical dominance and provides an ethnographic view of the medical profession which will emphasize its increasing subordination rather than its dominance.

I have outlined the medical dominance perspectives of Freidson and Willis because, to a large extent, this thesis proceeds from their work. Apart from building upon their analyses, their approaches directed me towards a study of the medical staff in an Australian public hospital. In particular, on reviewing the literature it became evident that what was lacking in most analyses of the medical profession was a detailed ethnography of hospital medical staff; an observation of

the medical staff from 'the inside' and its subsequent analysis. I emphasize the inside view because it became apparent that the medical worlds described by both Freidson and Willis did not transfer easily to the life-world of the hospital medical staff in Australia.

At this practical level, therefore, it appeared that both authors were describing and analysing medical worlds not inhabited by a significant proportion of doctors. In the case of Freidson, his material was drawn from American sources and so from a health service where the organisation and administration of hospitals differed significantly from the Australian experience. Willis, on the other hand, drawing from Australian sources analysed medical dominance within the health care system as a whole and defined the strategies used to reproduce this dominance over other health workers. The medical world of the hospital, in my view a unique showcase of medical values, remained mainly unaddressed. The question arose, therefore, at the theoretical level, of the generalisation of the arguments of Willis and Freidson, of the correspondence of the medical dominance perspective with the position of the medical staff at an Australian general hospital. This question directed the focus of my research.

The hospital at the centre of my study is the largest and originally the only, public teaching hospital in South Australia - the Royal Adelaide Hospital. The hospital is large enough, and sufficiently typical of a general teaching hospital, not only to illustrate the particular points at issue locally but also to allow a cautious generalisation beyond this institution. The story of the Adelaide Hospital has been documented by a previous member of the senior medical staff (Hughes 1982) and his book serves as a source of dates in the objective sense but also the book is data for an analysis of the ideology of the medical profession in a

public hospital in Australia. Other studies of Australian hospitals have been largely historical works. The histories of Prince Henry's Hospital (Templeton 1969) and the Alfred Hospital (Mitchell 1977), both in Melbourne, offer some sociological clues but, in the main, are directed to a catalogue of people and events. The earlier study of the Royal Melbourne Hospital by Inglis (1958) offers more fertile ground for sociological interpretation but, in his historical enterprise, the sociological analysis is inevitably secondary. The same criticism can be applied to other hospital histories. This thesis, therefore, will offer a unique sociological analysis of an Australian public hospital and its attendant medical staff; an analysis which, based upon the everyday activities of the medical staff, an ethnographic methodology, is also distinctively anthropological.

Furthermore, my work is intended to add to the corpus of knowledge of the Australian medical profession in general. Examination of the contributions to date reveals another gap in the social analysis of the medical profession in Australia. Most authors have been content to extend American or English analyses of the medical profession to the Australian context without due attention to the distinctiveness of Australian society and culture. The work which has drawn from its Australian context, has mainly attended to health policy and economics, addressing such issues as organisation, distribution and use of health services (see for example Scotton 1974, Tatchell 1984, Buchanan and Prior, 1985, Butler and Doessel 1989). Other works have focused on medical politics, analysing organisational responses to perceived threats to medical authority and so detailing the history of the Australian Medical Association (see McGrath 1975, Glasner 1979, Hunter 1984).

In addition to the work of Willis, a few attempts have been made to expand beyond merely narrative histories. Claudia Thame (1974), for example, examines the provision of health services in terms of a 'collective responsibility'. By this she means, in the strict sense,

acceptance by the state of financial responsibility for the provision of services to all persons in the community irrespective of their means (1974:341).

Her contention is that the state in Australia was only minimally involved in health matters at the beginning of the twentieth century. Whilst she documents the increasing concern of the state with health standards, she argues that the medical profession defeated the government's attempts at collective responsibility. From her sources of parliamentary papers, departmental reports, Commonwealth enquiries, Royal Commissions and so forth, she concludes that individual responsibility won the day because of,

the refusal of the medical profession to co-operate in any scheme which threatened its freedom to practise medicine within the traditional financially based doctor-patient relationship (1974:342).

Self-interest triumphed over social justice and collective responsibility for Australian health care 'failed to become a reality'. Nonetheless, self-interest was not the only value guiding the behaviour of the medical profession. Many supplied hospital care without financial recompense. In South Australia, however, there was a dearth of public benefactors to found the hospital and, thus, this aspect of charity was undertaken, reluctantly, by the government. The result was a continuing review of this obligation by the government.

Tony Pensabene's (1980) study of the development of the medical practitioners in Victoria from 1870, proceeding from his brief of economic history, provides an explanation of status in terms of technological determinism:

It was from the late 1870s that advances in medical science began to alter colonial medical practices and raise professional competence (1980:5).

This technical success led to the ability to construct a body of formal knowledge and to act as a major pressure group in medical and social affairs. The political strength of the profession, however, depended upon its financial resources and its personal links with leading politicians. Pensabene concludes that any study of the medical profession must come to grips with its political economy.

The important contributions of Thame and Pensabene are based on an 'archival approach' to the analysis of the medical profession. Neither author provides an ethnographic dimension to the material. Papers are quoted, reports summarised and journals cited but the actors remain absent from the ongoing situation except in the report of a speech or the relating of an anecdote to reinforce the argument. The analyses are not grounded in the activity of the participants. In contrast, one of my aims is to analyse key aspects of the routine everyday world of the medical professional in order to provide a social context to the rhetoric of public statements and to ground its analysis in situated practices and meanings. My ethnographic methodology will complement and enlarge upon certain features of the historical background of the medical staff of an Australian public hospital. The approach employs the ethnographic present, the observation of activities during the event, as well as the archival past, to analyse the internal and external conflict of the medical profession at the everyday level of the participants.

The analysis of the Australian medical profession was extended considerably by the work of Evan Willis, particularly in his book Medical Dominance (1989) originally published in 1983. This work follows a pattern of

analyses of the medical profession which was established in the 1970s notably by Eliot Freidson and which rejected previous analytical frameworks.

Early analyses of the professions, such as the classic work by Carr-Saunders and Wilson (1933), assumed a structural-functionalist perspective. Social stability was maintained by the free association of professional men exerting "a stabilising as well as a progressive influence upon society" (1933:495). An ever-present danger to social order was the potential fragmentation of society. Professional organisations, therefore, were stable ordering elements in society.

This theme was repeated by Parsons (1954) who emphasized the professional values of universalism, specificity of function and disinterestedness to solve what he called the Hobbesian problem of social order.

"It seems evident that many of the most important features of our society are to a considerable extent dependent on the smooth functioning of the professions" (1954:34).

Parsons located "the dynamics of health and disease at the centre of the social fabric of modern societies" (Holton and Turner 1986:109). Parsons' medical sociology had far-reaching implications, particularly his analysis of the doctor-patient relationship. He treated the relationship as a social system which was, in some ways, a microcosm of his large-scale theoretical analysis. Whilst the contribution of Parsons to medical sociology has been reassessed, notably by Bryan Turner (in Holton and Turner 1986), his analysis remains distant from my approach.

The analysis here builds upon the work of theorists, who departed radically from what became known as the 'trait' theory of professionalism. That perspective was expressed in a body of literature which sought to analyse the professions in terms of the definitional elements of professionalism. Authors took for granted

and documented a list of attributes or traits generated by professions in order to define a profession. In the 1970s, as a reaction to this model, some critical literature began to appear. Pre-eminently, Eliot Freidson (1970a, 1970b) advanced beyond this functional viewpoint of the medical profession, and despite criticisms (see McKinlay 1977), his work still remains an important basis for succeeding analysis of the professions.

Larson (1977), for example, takes up his notion of autonomy as a critical ideological component of the professional project. However, she does not establish the basis of professional power beyond rather vague sources of relationship with the dominant ideology (see 1977:219) - the ideology of the ruling class. The advantage of her analysis of the professions is its inclusion of their changing significance historically. In her conclusion, she draws attention to their place as 'agents of power' achieved by their sharing in the dominant ideology which, in fact, disguises their own subordination:

The individual freedom and control which professionals enjoy in and out of work is in part a mask: for themselves as well as for less privileged others, it helps to conceal collective powerlessness, subordination, and complicity (1977:243).

She explicitly relates power to knowledge and mentions the contradiction between ideological expectations and work conditions. These points are not developed by Larson but form part of the corpus of this thesis. The particular paradox I explore is that increasing attempts to maintain a professional superiority facilitated an increasing control by state agencies.

For Larson, professionalisation involved pursuit of both market control and collective social mobility. Parry and Parry (1976) proposed a similar argument. Employing an explicit Weberian concept of social closure, they argue that professionalism is an occupational strategy of the middle class aimed at a

collective social mobility. The eventual goal of this mobility was a legally enforceable monopoly designed to control the market. They emphasize, however, that the strategy of professionalism is employed within a broad context and collective social mobility should be understood as, "part of a wider movement of class structuration and indeed of social structuration" (1976:256). They used the historical case study of the English medical profession not only to demonstrate collective social mobility via professionalism but also to explore,

the growth and extent of its dominance of the institutions and organisations of medical care, as well as its changing relationship with the state (1976:265).

It is to this specific and changing relationship with the state that this thesis is partly directed in its assessment of the notion of medical dominance.

Professional power and professionalisation have been analysed by Terence Johnson (1972) through the producer-consumer relationship 'the core of uncertainty', and its tension. He identified three broad resolutions of this tension which were producer-defined, consumer-defined or mediated by a third party. Producer-defined is referred to as collegiate control and professionalism is a sub-type of this. Professionalism is, thus redefined as a type of occupational control. "A profession is not, then, an occupation, but a means of controlling an occupation" (1972:45). He argues that,

The conditions which gave rise to the institutions of professionalism are no longer dominant in industrialised societies - a fact which should direct attention to alternative forms of control such as those suggested in the discussion of patronage and mediative systems (1972:89).

The area of mediation of interest to Johnson is that of state control, where the state attempts to determine the content and context of practice. I intend to argue that such intervention in the medical profession is characteristic of the state in South Australia.

To a degree, many of these authors limit the treatment of conflict to the boundary problems of medicine as a collective enterprise. The medical profession is theorised as an unproblematic homogeneity and scant attention is paid to divisions within the profession. Intra-professional conflict with its implications for disunity and, therefore, the variable success of professional ideals is not addressed. Freidson argues that analyses should attend to the medical profession as an organised social entity rather than an aggregate and be sensitive to "critical forms of functional and hierarchical differentiation within the profession" (1985:23). My ethnography focuses upon this neglected aspect but emphasizes the structural tension resulting from these divisions within the medical profession and the consequent fragmentation rather than cohesion.

I have drawn attention to a number of authors and commented briefly on their approach. There have been a few insights into alternative areas which otherwise are poorly analysed. Berlant (1975), for example, in applying a Weberian theory of monopolisation, raises the issue of medical ethics not only,

as an instrument of internal domination within the profession, but also as an instrument for dealing with changing external political exigencies of the profession (1975:2).

He interprets the emergence of a code of ethics as an organisational strategy designed to support the interests of collective behaviour. Berlant argues that internal competition may be controlled by assuming moral structures which are unproblematic. At the level of rhetoric, I agree with Berlant but he fails to theorise adequately the practical effect of continuing divisions within the medical profession. As Waddington (1975) argues,

the development of medical ethics may be much more closely related to the need to regulate relationships between practitioners than has commonly been held (1975:48).

The need to regulate relationships arises because of fundamental divisions within the profession which are unresolved by appeals to moral strictures. I discuss medical ethics further in chapter seven.

The analysis of Bucher and Strauss (1961) provides a way forward which is not suggested directly by the other writers. They point to the disadvantages of assuming that a professional group is a homogeneous unity in advance of the evidence from research. They propose the alternative assumption of,

the idea of professions as loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history (1961:326).

Strauss and his colleagues pursued this idea within the context of a psychiatric institution and their resultant analysis was one of negotiation and settlement amongst the representatives of competing paradigms within the institution. Unresolved conflict, however, as a continuing process, received inadequate attention and, whilst their ethnographic methodology was commendable, the context of a specialised (psychiatric) hospital limits a generalisation of their analysis. More importantly, Strauss et al. did not sufficiently relate the internal incidents to the wider politico-economic sphere and, particularly, they did not analyse state penetration into the local context.

Subsequent analyses, however, have rarely developed the idea of 'segments' as a major feature of the medical profession. This thesis emphasizes that fragmentation is a structural property of the medical profession which undermines professionalism and threatens medical dominance. There is a contradiction between the conflicting aspects of professional ideals and values: between the attempt to achieve a unified occupational group, a collectivity and an opposing thrust towards individual specialisation. Professionalism as unity contradicted

professionalism as expertise. Both movements may be accommodated and transcended by re-stating professional ideals but the structural tension remains. The perspective of this thesis, rather than emphasizing growing unity, will consider the deepening contradictions in the medical profession.

My approach, therefore, is related less to the positions discussed above and more to a framework of analysis which has gained increasing respectability over the past two decades. This alternative framework has been described variously as a proletarianisation or a deprofessionalisation thesis and proposes, in general, that medical dominance is on the decline. Martin Oppenheimer (1973) argued that

a white collar proletarian type of worker is now replacing the autonomous professional type of worker in the upper strata of professional-technical employment (1973:213).

He used the concept of an 'ideal-type' towards which examples tend, with proletarianised work at one end of a continuum and professional work at the other. By proletarianised he meant the form of work where there is an extensive division of labour, the conditions of work are not determined by the worker, the primary source of income is a wage and in order to defend deteriorating standards the worker moves toward collective bargaining.

Without adopting the "proletarian" terminology, the de-skilling and power-stripping aspects of the approach are useful for my purpose. They are described by John McKinlay (1976) who also supported the proletarianisation thesis and has repeated this, with a number of co-authors, over the succeeding years (see McKinlay and Arches 1985, McKinlay and Stoeckle 1988). He defines proletarianisation as,

the process by which an occupational category is divested of control over certain prerogatives relating to the location, context, and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism (1988:200).

The specific prerogatives at issue include autonomy regarding the terms and content of work, the amount and rate of remuneration for labour, the objects, tools and means of labour and so forth (see 1988:201). Erosion of these prerogatives means the reduction of a professional group to some common level. McKinlay has repeated these arguments in his many publications but, and here I agree with the criticisms by Freidson (1985) and Willis (1989), he has not continually amassed supporting evidence.

The same charge is laid by Freidson against Marie Haug (1973) who proposed 'deprofessionalisation' as an alternative hypothesis to proletarianisation; a hypothesis in which, in the struggle for control of work, the professional loses.

Deprofessionalisation is defined as a loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over their client (1973:197).

Haug admits that her first essay was a 'revulsion' against the 'syrupy ideas about the future of our industrial social system' (1988:49). Deprofessionalisation was proposed as an alternative process and she argues that at present there is no evidence favouring its rejection. On balance, however, she presents very little direct information to support her stance. The main 'imponderable', in her analysis, is the future effect of technology. Those effects form the basis for a number of chapters in this thesis.

Finally, in my review of the contributions to the discussion of the theory of medical dominance, I note, at the other end of the spectrum, a viewpoint which doubts whether medical professionals were ever dominant. Vicente Navarro in an early article asserts that,

the most predominant force in determining the nature of medicine and resulting iatrogeneses and dependencies has been not the medical profession but the capitalist system and the capitalist classes (1976:440).

His argument is that, to understand the medical care system, an analysis is needed of the distribution of power and "the nature, role and instrumentality of the state" (1976:453). Navarro proposes quite forcibly in his later writings that,

My thesis, however, is not that the medical profession has lost dominance in medicine, but rather that it never had such dominance (1988:61).

He argues that a decrease in medical power does not mean that doctors were the most powerful to begin with.

This radical stance receives limited support from Larkin (1988) who points out that the question of the rise or fall of medicine must be tested over the span of the twentieth century rather than the past few decades. Larkin argues that in the British case, state intervention and medical dominance may not be inversely related in a simplistic way. State intervention both promoted and controlled the cause of medicine so that,

the medical profession has held not so much full control but instead a managerial role subject to review and amendment. It has arisen with state intervention in a complex but subordinate relationship subject, to date, in at least one major feature of controlling allied occupations, to neither sustained domination nor yet to disestablishment (1988:130).

The limits to the influence of the medical profession were laid years ago and state intervention facilitated medical power in a symbiotic but unequally growing relationship.

This argument approaches my position, which takes the view that in the arena of the hospital the medical profession is initially dependent upon the state. As the hospital comes to occupy a more central role in medical practice and with continuing medical specialisation, this dependency is increasingly revealed. Most obviously the state supplies facilities but, in addition, the divisions within the medical profession as a result of the pursuit of professional aims allow, even compel, increasing organisation and supervision by the state. I argue further that

a characteristic of the imposition of state control is its legitimacy, and legitimation, of both state and medical activities, is an important part of the processes discussed later. The result is the erosion of medical autonomy by an increasingly interventionist state. Legitimacy and state intervention are discussed in the next section.

The Role of the State

At a number of points in this chapter, I have noted the importance given by most writers to the role of the state vis-a-vis the medical profession. The activities of the state and its agencies are a prominent feature of many of the succeeding chapters, and at this stage it is appropriate to address the notion of 'the state'. A common thread running through many of the arguments of the previous authors is the necessity of state support - state patronage. Whilst there is no guaranteed historical path to professional autonomy, all writers apart from medical triumphalists agree that it is a political process involving state legitimation and cultural values. State patronage is seen as essential to autonomy and, hence, medical dominance, which is described in terms of independence from a state which provided the very means of that autonomy. In a sometimes over-eager adoption of the profession's definition of the situation, analysts have under-emphasised the dependence on the state created by its underwriting of the legitimacy of the structural position of medical professionals. The granting of a legitimate autonomy to the medical profession paradoxically created a dependence upon the state for this independent position which the medical profession would

prefer to ignore. Furthermore, the state retained the power to modify the level of 'freedom' so valued by the profession.

On the one hand, therefore, relative autonomy has been highlighted by analysts, whilst on the other hand relative dependence has been neglected. This contradiction has been under-theorised in a literature which has instead emphasised the concepts of negotiation, transaction and patronage at the expense of addressing unresolved conflict. In most of the works quoted, conflict with the state receives a one-dimensional attention. Indeed, the state appears to assume a peculiarly passive and perhaps benevolent role. This thesis will document a chronicle of disputes and conflicts which will lead to the conclusion that legitimisation by the state of a number of developments within the medical profession laid the foundation for a growing state intervention, and to a consequent modification of the very autonomy at issue.

The state, therefore, is the other major player in the hospital game. As Freidson writes,

The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society - the state (1970a:83).

He argues that much of the strength of the medical profession arises from a monopoly of practice guaranteed by a system of licensing granted by the state. This view is repeated by Willis;

Licensing provides the legal foundation for the division of labour and thereby medical dominance (1989:29).

This is state patronage and typifies the support given by the state in the health arena. He sees an alliance between new middle class doctors and the state to be at the root of the phenomenon of medical dominance (see 1989:27).

Willis (see 1989: 26 et seq.) takes a neo-Marxist position on the state, drawing particularly from the analysis by Poulantzas. He views the state as serving the interests of the dominant class whilst avoiding direct representation of these interests which are best served by maintaining the economy, the political order and legitimacy of state action. The state is seen, not as a thing, but as a set of relations between institutions which constitute a material framework and organisation. The material structure is expressed as a state bureaucracy whereby the state gains part of its autonomy by promoting the idea of a neutral, independent organisation of impartial officials. As Willis writes,

The state must protect the economic interests of the dominant class without appearing to do so (1989:28).

This, for Willis, is the crucial feature of the state - its maintenance of the capitalist relations of production to support the interests of the dominant class.

Whilst sharing some common ground, my position departs from that of Willis in emphasizing facets of state activities which are more appropriate to a Weberian framework of analysis. I view the state as perhaps more regulatory than does Willis, similarly to the discussion by Poggi;

The modern state is perhaps best seen as a complex set of institutional arrangements for rule operating through the continuous and regulated activities of individuals acting as occupants of office (1978:1).

The state, therefore, determines relationships between individuals or groups of individuals and by 'institutional arrangements for rule' forms those relationships into a social order. The implication is that such a regulated order is expressed in ranking, in a hierarchy. In the same way as Willis, I am concerned with relationships and state activity and, in particular, the justifiable limits of that activity. As Poggi points out, the state inevitably confronts the problem of its own legitimacy (see 1978:101). The exercise of power other than force of arms

requires a unity of shared understanding by society such that the rightness of the state's activities is acknowledged. The legitimate use of power, the authority of the state, depends both upon its moral character and also upon the consent of its population.

Max Weber stressed the importance of the beliefs of a population in consenting to a form of rule. He distinguished "three inner justifications" (Gerth and Mills 1970:78) and, hence, three familiar ideological bases for the legitimacy of authority - traditional, charismatic and legal-rational authority. Traditional authority means a system of rule founded upon the mores and customs of ancient practice - 'the eternal yesterday'. Charismatic authority depends upon a personal 'gift of grace' which transcends accepted practice. Within a system of legal-rational authority, practice is based upon rationally created rules and carried out by the modern 'servant of the state'. Indeed, legal-rational authority is characteristic of the modern state whose organisational needs are satisfied most completely in the system of administration known as a bureaucracy.

The well-known description of bureaucracy by Weber has served as the starting point for most subsequent analyses and I follow the tradition here. Weber noted the increasing importance of career administrators in pursuing the goals of the state. He defined bureaucracy as a system of administration characterised by a formal body of rules, a hierarchy of authority, management based upon records, specialised tasks and training, selection on merit and the continuity of a full-time career (see Gerth and Mills 1970: 196). For Weber, bureaucracy possessed the important feature of predictability. By extension, this meant that institutional organisation and development could be planned. In addition, the rules and records of bureaucratic structures made bureaucratic activity impersonal. As

Poggi suggests, depersonalization of power is part of the Weberian notion of legal-rational legitimacy (see 1978:107). The legitimacy of the modern state, therefore, is grounded in "the taming of power through the depersonalization of its exercise" (1978: 101). The rules controlling its expression minimize any arbitrary exercise of power by subjecting it to the test of reason. Rationality, therefore, is the benchmark of legitimate state activity and the formative impulse of its bureaucracy.

Thus, for Weber, rationality and the historical processes of rationalisation constitute the central theme of analysis. The most famous expression of his topic is The Protestant Ethic and the Spirit of Capitalism (1976). Whatever the merits or defects of his argument, and Anthony Giddens discusses some still controversial aspects in his introduction to a recent edition of the book, Weber analysed, in a pioneering way, the negative effects of the process of rationalisation. Pessimistically, he described the tendency of European history as moving towards 'disenchantment' or a world stripped of meaning, in which the individual would be confined within an "iron cage" (1976:181) subject to increasing external order and lacking inner direction. To use a phrase of Gouldner criticising this despondency, Weber's analysis is imbued with a 'metaphysical pathos'. Weber clearly saw different orientations to social action in a world where traditions and emotions were in retreat from an assertive rationality which, in itself, took different forms. Weber (see 1947) distinguishes a rational orientation to discrete ends (zweckrational) from a rational orientation to an absolute value (wertrational), distinctions which he uses in his analysis of the formal and substantive rationality of economic action. The concern for Weber was that values would become subordinated to the logic of rational action which would itself

become a value. The pursuit of wealth, for example, would become an end in itself.

In the same way political action may be stripped of ethical meaning and be guided by expediency. The problem for the modern state can, therefore be couched, in Weberian terms, as a tension between formal and substantive rationality. The modern state legitimates its activities by a legal-rational authority which becomes increasingly problematic as the values underwriting state intervention become less absolute and more debatable. Traditional values are undermined by the invasion of an all-pervasive rationality to create a continuing problem for a moral dimension for state intervention, a morality continually constructed to legitimate intervention itself.

For Poggi, depersonalization of power possesses a distinctive moral significance and thus "a true if perhaps weak, legitimizing force" (1978:107). Additionally, the notion of law being the product of reason rather than will implies a distinctive moral design. Poggi, whilst acknowledging the moral claims of legal-rational authority itself, argues that the state seeks additional legitimation for the exercise of power; in effect to counter the feeling of 'disenchantment'. This argument recognises the problem of the decline of the normative legitimacy of the modern Western state and 'legitimation crises' (see Habermas 1976) have become an increasingly common area for sociological analysis.

Without addressing the complexity of his propositions at length, Habermas argues that 'legitimation deficits' arise in the political system because the activities of the state extend beyond previously accepted boundaries:

During the course of capitalist development, the political system shifts its boundaries not only into the economic system, but also into the socio-cultural system. While organisational rationality spreads, cultural traditions are undermined and weakened. The residue of tradition, however, must

escape the administrative grasp, for traditions important for legitimation cannot be regenerated administratively (1976: 47).

For Habermas, there is no administrative production of meaning. To compensate for a legitimation deficit, to avoid a crisis and to ensure a firm base for its ever increasing penetration, the state appeals to universalistic value systems. Invasion of social activities is, thus, limited by the 'residue of tradition' and a 'communicative ethics'. In brief, at the 'seam' between state and socio-cultural order, the state is resisted by the ideology of democratic discussion. However, as Habermas admits, ideology has changed and its new form is expressed as a 'technocratic consciousness'. Just as pessimistically as Weber, he concludes that the distinctive feature of this new form of ideology is the repression of ethics. For Habermas, the positivistic ideology of technocratic consciousness masks the possibilities of a genuine emancipatory rationalisation (see Pusey 1987).

The point is, of course, as Habermas argues, that the modern state is not necessarily engaged in an emancipatory project. The position taken here is that the state is a mechanism of ordering relations, a system of rule, whose agencies not only preserve its function but also extend its activities. To do this, however, a cultural legitimacy, an ethics of action, is required to sustain invasive activity. The ideology of a technocratic consciousness, for example, must be articulated by the rhetoric of ethical behaviour. The rightness of state intervention, its legitimacy, depends ultimately on social acceptance of such rhetoric which continually encompasses new concepts. In this way economic rationality, efficiency for the good of all, may replace the 'routine of tradition' as a just basis for action.

Finally, I emphasize two points regarding the adoption of a rhetoric of ethical behaviour. Firstly, it would be a mistake to view any group as furthering its ends by adopting values from an abstract, ideal and moral world 'out there'.

Rather, relations between societal groups are ordered within already articulated value frameworks. Secondly, a rhetoric adopted for instrumental purposes may be not only an aid in confrontation, but also used to achieve an integration of opposing groups, to further the order of the state without conflict. The correlation between rhetoric and ideology and the multiple functions of ideology, including its integrative facility have been elegantly analysed by Paul Ricoeur(1986) and I summarise his argument in the following section.

Ideology, Rhetoric and Charter

Ricoeur begins his discussion with the notion of ideology as interpreted by Marx, as a systematic distortion caused by class interest. His paradigmatic model is the relation between superstructure and infrastructure. The dominant class maintains its dominance of the economic base by determining the social form of the superstructure, the kinds of ideas in society. These ruling ideas of society are the ideas of the ruling class. From this Ricoeur develops his second concept of ideology as legitimation, and the claim to legitimacy made by all forms of authority. Here the paradigm is Max Weber's concept of ideal types, which Ricoeur sees as playing the same role as superstructure in supporting a claim to authority. The function of ideology is to bridge the gap between a leader's claim and a follower's belief.

The more relevant feature of Ricoeur's analysis to my thesis, is his third concept of ideology as integration or identity. Ricoeur invokes Clifford Geertz to speak of all action as symbolically mediated. This means that ideology is no longer a kind of superstructure. Rather, the distinction between superstructure

and infrastructure disappears because symbolic systems belong to the basic constitution of human beings. Ricoeur emphasizes the correlation between ideology and rhetoric. Because we cannot exclude rhetorical devices from language, "ideology is not the distortion of communication but the rhetoric of basic communication" (1986:259). Therefore, Ricoeur argues, there is no ideology without conflict; integration without confrontation is pre-ideological. A final point, is that ideology integrates a group both in space and time. Ideology has a diachronic, in addition to its synchronic, dimension. I elaborate these ideas at appropriate points in my study.

Ricoeur emphasizes the inter-relationship of all three functions of ideology. In addition, referring to Geertz, he observes that ideology is finally always about power. The problem of integration leads back to the problem of a system of authority:

Questions of integration lead to questions of legitimation, and these in turn lead to questions of distortion (1986:259).

Ricoeur argues that the problem is the problematic of the Hobbesian social contract. In the exchange between individual and society, the system of legitimation of authority plays an ideological role (see 1986:14). Hobbes argued that consent was the fundamental basis of the social contract. From consent, obtained under duress or freely, flowed all the obligations of the social contract. Hobbes saw no reason for a balance of power in such an undertaking.

The question arises, therefore, of the value to the individual of the social contract. According to Ricoeur, ideology bridges the gap between authority and domination but the question remains of how to sustain an unequal distribution of privileges in society. The term I have chosen to describe this, with particular reference to the medical profession, is 'charter'. By this I mean to emphasize the

contractual aspects of social negotiations. The original source is Malinowski, studying the exchanges of the Kula during his Trobriand days. He developed the notion of myths as 'social charters' which defined the correctness of social position and activity. He concluded that,

myth possesses the narrative power of fixing custom, of sanctioning modes of behaviour, of giving dignity and importance to an institution (1961:328).

This stance has been criticised as functionalist but here I extend Malinowski's usage rather than imitate it. I use 'charter' in the sense of a dynamic social transaction conferring rights and privileges but also responsibilities and obligation. The transactional element is reflected in the development, from the late-nineteenth century, of a contractual norm held as expressing the essentials of truly harmonious, reciprocal obligations and relations, contrasted with the notion of a supra-personal 'market'. The important feature was a laissez-faire economic system but state involvement could be beneficial. The state could grant privileges as well as protect a market gain but this was balanced by an increase in responsibility. There is, therefore, a dependence and a duality in the notion of charter. The concept of patient care, for example, may be used both as a justification for medical activity and, by measuring its results, as a judgement on that activity.

Finally, therefore, charters are multi-functional; containing, resolving and creating conflict. Charters are ideational arenas rather than ideological strait-jackets. Indeed, charters may easily be contradictory as, for example, "efficiency" versus "the best patient care". Charters may be chosen to support each protagonist, the result of such a contest being swayed by the balance of cultural values and, perhaps, legal sanctions. Thus, each charter also performs a social control function. One group in society may control or curtail the activity of

another group by pointing to activity which is inconsistent with a particular charter. Obligations are enforced as much as privileges allow. Whilst medical authority may be legitimated by the charter of patient care, the same charter-rhetoric may be used to evaluate medical activity. In a sense, charters, in distinction to the past/present axis of myths, provide a present/future grounding which informs present activity and constitutes a judgement and guide to explicitly future-directed action. Thus, my use of the word charter conveys more than the idea of a language of rhetoric: it is rather, a way of seeing and behaving. At this level there are affinities with the concept of 'discourse' developed by Michel Foucault.

For Foucault, discourse is a way of perceiving and expressing ideas within a given framework of knowledge. Medieval medical discourse, for example, was carried out in terms of the humoral theory of disease. This reflected a wider cultural attitude to individual and societal balance and harmony - an episteme, as Foucault might call it. Reflecting a more technical age, modern medical discourse might be expected to have more mechanical imagery, for example, the heart as a pump, the brain as a computer. Discourse expresses the assumptions of society universally. Furthermore, discourse is the language of reality, creating reality and giving it meaning, but with a bias so that discourse determines a politics of inclusion and exclusion and the state is central to this discursive reality (see Yeatman 1990).

Anna Yeatman discusses the idea of discourse in relation to the emergence of statecentric modes of management.

Political activity itself becomes preeminently a politics of contest over meaning: it comprises the disputes, debates and struggle about how the identities of the participants should be named and thereby constituted, how

their needs should be named and thereby constituted, how their relationships should be named and thereby constituted (1990:155)

Politics then becomes a 'politics of discourse' wherein the struggles and negotiations for resources occur and this is characteristic of the 'interventionist' state. Following Kress, she points to the dynamics of discursive reality where a discursive multiplicity constitutes the identity of an individual. In brief, salvation lies in the production of polycentric discourses which oppose the state's monopoly of legitimating ideas.

The state, however, may employ a number of strategies to limit the politics of discourse. These include, firstly, the conversion of core values into 'ritual litanies' to be invoked on all symbolic occasions to become, in the terms of Yeatman, a "double think fuzz" (1990: 173); secondly, the subjection of claims to technicist modes of administrative rationality - similar to the technocratic consciousness of Habermas; thirdly, the commissioning of grand works of discursive policy statement by intellectuals which remain within the circles of the state-oriented intelligentsia; and fourthly, the commodification of claims to render them subject to market-oriented discourse (see Yeatman 1990: 173-174).

These strategies will be evident in the Adelaide Hospital in succeeding chapters. The effect of central legitimating discourses on the activities of the medical profession at the periphery forms a central motif of this thesis. These peripheral activities are themselves a result of similar discursive practices. Yeatman, drawing upon the work of Melucci, locates such practices in a plurality of discursive forums created by the activities of a state which is itself dispersed (see 1990: 170). The result is a multiplicity of partial governments which is also a discursive multiplicity. The important point for this thesis is that multiple discourses form motives for social action. Yeatman uses the argument of Kress

that unresolved tensions in an individual's discursive history motivate the individual to produce a 'text'. This becomes the location wherein resolution of tension may be achieved. She argues that these texts are dialogical and always contain contradictions. Whilst in general agreement, my view is that similar discursive strategies create a common ground for dialogue and so, returning to Ricoeur, the integrative properties of discourse are just as important. The coincidence of discourse between the official bureaucracy and the medical profession, as for example, 'the good of the patient', allowed an increasing penetration by the state into hospital organisation. This promoted the ordering of hospital society to the disadvantage of the medical staff, a process disguised in the multiplicity of discursive realities.

In summary, the state can be conceptualised both as a central structure of power and as a peripheral expression of that power. The apparatus of state bureaucracy achieves its fulfilment in the ordering of peripheral relationships. This expression of domination occurs within the framework of a discourse - of a charter - legitimated not only by the assent of the dominated but also by the concurrence of discourses among individuals and among groups of individuals. Therefore, as Foucault argues, the modern state, is both totalizing and individualizing. Its power is expressed within and by a political discourse to facilitate an ordering of society.

Although my text has developed from the ideas of Max Weber, a number of writers have pointed to affinities between his ideas and those of Michel Foucault (see, for example, Gordon 1987 and Turner 1987). Most commonly, the point of contact addressed has been rationality although Poster (1984) argues that

perhaps the examination of reason in domination is their only point of contact.

The view taken here is best described by O'Neill:

Foucault's studies, however controversial, may be seen to extend Weber's concept of rational-legal discipline through studies of the discursive practices that construct a physiology of power/knowledge which deserves the attention of social scientists (1986:42).

O'Neill sees Weber as anticipating Foucault's conception of a disciplinary society whose definitive feature is a physiology of bureaucracy and power. However, Foucault's way of analysing power phenomena is through the study of language and discourse is given a central place in his analysis.

Through this stress on language and discourse, rather than a Weberian stress on the individual actor, Foucault radically transforms the analysis of power. Firstly, when power is conceptualised not as the effective action of the actor but rather as a flow in lines of communication, then power can no longer be seen as coming from above but as a property of these horizontal or vertical lines. It is immanent in **communicative** social relations and, therefore, should be analysed at the level where discourses become meaningful, through the peripheral, "capillary" quality of power flows.

His second main point is that because power is a flow, it is therefore, independent of individuals and not a possession. Power is revealed in its expression and power relations permeate all levels of social existence. The consequence for society is the reproduction of the relations of domination.

Domination is not, however, an end in itself because power has its positive or productive aspects in addition to restraint and domination. The relations of power give rise to "docile bodies" which work together in the interests of increasing the efficiency of the social system. The efficiency of this expression of power depends upon knowledge. For Foucault, an important relationship is that

between power and knowledge, being mutually supportive. So intimate is this relationship that he views them as two aspect of the same process. The focus of the power/knowledge nexus is the body both as an individual and as population. As O'Neill points out, Foucault "never loses sight of the body as the ultimate text upon which the power of the state is written" (1986:45). Foucault describes both an anatomo-politics of the body and a regulatory bio-politics of the population. He proposed a new way of viewing the body arising from clinical medicine which I discuss in more detail in chapter seven. In Discipline and Punish (1977) he described a system of power based upon surveillance. The idealisation of this is 'the Panopticon', an architectural arrangement developed by Bentham wherein a permanent visibility of inmates in an annular geography of cells was complemented by the permanent invisibility of a guardian in a central tower. This new technique of power, a strategy where it was more useful to observe than punish, was continuous, disciplinary and anonymous. As Foucault said in an interview,

What developed, then, was a whole technique of human dressage by location, confinement, surveillance, the perpetual supervision of behaviour and tasks, in short, a whole technique of 'management' of which the prison was merely one manifestation (Kritzman 1988:105).

These ideas are central to Foucault's work. Thus, he both compliments and, in important ways, moves radically beyond Weber whilst working within the problems identified by Weber as problems of the modern state.

This brief summary scarcely indicates the complexity and depth of Foucault's oeuvre. Fuller discussion will be found in the work of Dreyfus and Rabinow (1983) and critical but not unsympathetic assessments of Foucault's work are presented by Hoy (1986). Foucault's philosophy remains a matter of vigorous debate. The Foucaultian ideas which I have selected serve as a sub-theme to my

main analysis and are intended to facilitate my use of ethnographic material. In particular, the notion of the micro-physics of power lends itself to ethnographic methodology. At another level of analysis his ideas on surveillance and panopticism show how the observation of everyday activity can throw light on the grand design of a 'managed' institution.

Bryan Turner (1984) and David Armstrong (1987) have both used an explicitly Foucaultian approach in their different analyses of medical activity. They argue that 'the problem of the body' has been submerged (Turner 1984:34) or "poorly theorised" (Armstrong 1987:69) in sociological analysis and attempt to redress this deficiency. Their work epitomizes what I would term an orthodox use of Foucaultian ideas. That is to say, Foucault's concepts are used to locate the patient in a system of surveillance (see Armstrong 1987:70). The surveillance of the doctors has not been taken up to any significant degree in the work deriving from Foucault's analysis. Foucault emphasized the completeness of systems of disciplinary power which incorporated everyone. Thus, whilst the director "may spy on all the employees" (1977:206), an inspector arriving unexpectedly at the centre of the Panopticon can see the result of the director's work. In a sense, hierarchic layers of panopticism are created and I intend to emphasize the totalising characteristics of this system of power which so organizes the participants.

I have taken up considerable space in dealing with Foucault's ideas because they are not so accessible, despite a fashionable popularity, and, in some ways, not so clear as those of Weber. This attention does not mean that this thesis is more Foucaultian than Weberian. I take the view that there is an affinity to be exploited. My purpose is to use the insights of Foucault regarding the regulation

of populations in my analysis of the medical staff at the Adelaide Hospital. I do not mean to argue for the establishment of conditions identical to a Benthamite Panopticon but rather to emphasize monitoring of the medical staff as part of the rational expression of power within the order of the hospital.

Methodological Note

The narrative of the thesis discusses both current events and the historical background which informs the ethnographic present of my approach. This is not to present a continuous story of the development of the hospital and its medical staff. Rather, the aim is to record and analyse a series of 'incidents' in the recent past and the ethnographic present which, individually, form the intrinsic 'problem' of each chapter, but have broader implications. My purpose is to structure the sequence of chapters so that the analysis of each intrinsic problem is cumulative to the main argument. In this way, therefore, my methodology owes much to the approach of Max Gluckman, an approach which he termed 'situational analysis'. In his, now classic, monograph (1958) he analysed what he called a 'social situation', in his example the opening of a bridge in Zululand, to arrive at structural principles from the activities of the local event. Gluckman's addition of analysis to ethnographic description was developed by his followers, such as van Velsen (1967), who discusses the extended-case method and situational analysis at some length. One of the assumptions of analysis, van Velsen holds, is that the norms of society do not constitute a consistent and coherent whole.

Situational analysis therefore lays stress on the study of norms in conflict. The most fruitful source of data on conflicts of norms is, not unexpectedly, disputes (1967:146).

In this thesis, therefore, I present, in an attempt to follow Gluckman's lead, a series of extended case studies relating to disputes at the Adelaide Hospital.

My sociological perspectives, therefore, are informed and enhanced by a number of concepts borrowed from anthropological theory. For example, I borrow additional notions from Gluckman which will become clear in the text but, briefly, they relate first to his continuing insistence on the inter-relationship of micro- and macro-analysis and second, to his concept of social cleavage. Gluckman saw conflict as a fundamental but not necessarily disruptive feature of social systems. Conflict was expressed as a dominant cleavage, as analysed in his Zululand material, which ran through all social relationships. At the same time, conflict was defused by cohesive mechanisms and, for my purposes, similar to Ricoeur, his idea of ties cutting across social divisions is valuable for analysing the processes at issue.

In any social system there tends to be co-operation across all lines of cleavage. Therefore in a changing social system, until the dominant cleavage is radically resolved in a new pattern, there is co-operation across that cleavage and every new cleavage tends to be compensated by a new form of co-operation (1958:70).

This is specifically not to accept any concept of an equilibrium model. On the contrary, I propose to examine conflict as part of a social dynamic; as part of the process of transformation of the hospital's social order.

One aim of the notion of cleavage and conflict is to depart from Durkheimian notions of solidarity and consensus. Durkheim argued that society progresses from a system of mechanical solidarity, where everyone is more-or-less capable of every social function, to an organic solidarity which characterises modern societies. Organic solidarity is a result of the division of labour in society, which is a source of social cohesion.

It makes individuals solidary, as we have said before, not only because it links the activity of each but also because it increases it. It adds to the unity of the organism, solely through adding to its life (1933:395).

Durkheim writes that labour becomes more continuous as it is more divided but the division of labour encourages solidarity only if it produces a law and a morality. Solidarity occurs, not only because of economic ties but because,

it creates among men an entire system of rights and duties which link them together in a durable way. Just as social similitudes give rise to a law and a morality which protect them, so the division of labour gives rise to rules which assure pacific and regular concourse of divided functions (1933:406).

The development of the hospital medical staff does not support Durkheim's comfortable conclusion. The fragmentation of the medical profession, which I document in succeeding chapters, leads to a collaborative effort only in part. The relationship of individual medical specialists in their hospital activity is only in a limited way based on Durkheimian 'rights and duties'. It has been suggested that it is useful to analyse the hospital as an acephalous tribal society (see Richman and Goldthorp 1977). In other words, the hospital reflects a mechanical rather than an organic solidarity. Again, this is only partly true. The hospital demonstrates, to an extreme degree, a division of labour. Furthermore, this is complicated by the division of labour producing a hierarchy rather than equal standing within the medical staff. Medical officers are graded not only by degree of training but also by type of work. The social order of the hospital medical staff was expressed as hierarchical rather than egalitarian.

Despite its fragmentation, the hospital works as a collective enterprise but the kind of solidarity which this represents requires further explication than the duality offered by Durkheim. The collaboration represented by the hospital is a managerial or administrative solidarity, an institutional solidarity. By this I mean that the institution of the hospital is comprised of widely differing categories of

staff gathered together in a common cause. This does not necessarily mean co-operation or consensus. On the contrary, the administrative framework allows divisions and oppositions as long as the aim of the institution is not obstructed. The corporate aims of the hospital unite all categories of staff by transcending factional conflict. It is in this sense of aims institutionalised by the hospital, the state or the medical profession that I use the term 'charter'. A charter is a shared responsibility for an undertaking and is articulated as a motive for activity.

These constructs of institutional solidarity have been taken up in the more recent work of Mary Douglas (1987). She attempts to clarify the extent to which group thinking depends upon institutions and, thereby, to address the nature of the social bond. She argues that the clue lies in a double stranded view of social behaviour.

One strand is cognitive: the individual demand for order and coherence and control of uncertainty. The other strand is transactional: the individual utility maximising activity described in a cost-benefit calculus (1987:19).

Douglas focusses mainly on the role of cognition in forming the social bond. In general terms, her argument offers fertile ground for further research. This thesis analyses both the cognitive and transactional element of the social bonds of the medical staff of the Adelaide Hospital. It analyses the ordering of medical society within the hospital, and, to return to the opening comments in this chapter, it analyses the position of the medical staff in the hospital order.

It is often difficult to obtain information from within the medical system because of its own protection by a powerful rhetoric of privacy. However, as Hafferty (1988) points out, there are a number of areas where theories can be tested empirically. These include the issue of physicians who perform administrative tasks, the influence of computer technology on medical

knowledge, the emergence of patients with newly-discovered rights, the emergence of medical organisations representing interests other than medical practices and how medicine can meet the challenges to its traditional rhetoric of practice for the good of the patient in particular or the public in general. In particular, a lack of internal cohesion, a fragmentation, would mark a diminished capacity for effective political organisation on the part of medicine and, in Freidson's terms, weaken its ties to state policy-making and institutional chartering. Processes of rationalisation and formalization detrimental to medical dominance may be encouraged by future conditions.

My purpose then is to address 'processes of rationalisation and formalisation' and so provide an analysis of the medical profession which questions a number of common assumptions. My specific aim is to organise the empirical evidence which is lacking in many analyses, to test the question whether there is a decline or maintenance of medical power. The material is drawn from both historical sources and the ethnographic present and the analysis is drawn from diverse theoretical positions, but particularly those taken by Weber and Foucault. The result is a reassessment of the concept of medical dominance in the light of events at the Adelaide Hospital and the counter proposal of the idea of a 'supervised autonomy' of its medical staff.

CHAPTER 2

HOSPITAL MANAGEMENT AND THE BUILDING DISPUTE

Introduction

The specific task of this chapter is to analyse the decreasing influence of the medical profession over the governance of the Adelaide Hospital. At the hospital, control of the board, and influence over the development of the hospital were progressively excluded by the government from the legitimate arena of medical decision-making. This is revealed in the focus of my main enquiry which is the relationship between the State government and the hospital medical staff during hospital reconstruction in the 1950s and 1960s. This thesis as a whole draws upon the modern history of the institution for its analysis. It is important, however, to locate these slices of time, these multiple ethnographic 'presents' in the continuum of history. Accordingly, throughout this thesis due recognition is given to the historical process leading to the events recorded. Again, I should emphasize that my intention is not to relate the public history of the Adelaide Hospital. Rather, I intend to provide a historical context for the dispute through which I analyse the institution as a socio-cultural structure. First, it is essential to place the hospital in the history and design of the city of Adelaide.

The colony (later State) of South Australia was proclaimed in 1836 on a model distinct from the other Australian 'colonies'. It was based not upon convict transportation but upon free settlement, land purchase and the ideas of civil and religious freedoms of its English founders. The economical base of the state was primary produce with land as the essential asset. Within the cultivable land area, a 'yeoman proprietary' developed which remained a feature of South

Australian politics for a century. Until the second world war, land was the major form of investment in South Australia (see Pike 1957).

Shortly after foundation, the first hospital, the Colonial Infirmary was established, to be replaced by an Adelaide Hospital which opened its doors in 1841. The hospital moved to its present site on North Terrace in 1855. This wide boulevard is one of the four terraces marking the original square-mile of a planned city, but a central artery in its overall civic functioning. The hospital is one of a line of public and semi-public buildings extending eastwards from the railway station. The north side of North Terrace accommodates Parliament House, the State Library, the Museum, the Art Gallery, the University of Adelaide, the Institute of Technology (now a university) and, the Adelaide Hospital. Travel further eastwards would encounter the boundary of the Botanic Gardens and, eventually, a major private school in Adelaide. Within the square mile of the city, are the government departments such as the Health Commission. The South side of North Terrace was, until recently, the pre-eminent position for the establishment of 'rooms', the offices for private medical practice.

As a public institution it was intended that the hospital should repeat the English model of voluntary hospitals supported by contributors. The transplantation of this model to the colony was a self-conscious attempt at civic philanthropy. The South Australia middle class, however, failed to invest in this area of public life and the hospital became a financial concern of the state. This pattern also occurred in Victoria, for example, where the foundation of the Royal Melbourne Hospital was delayed by a lack of public subscription (see Inglis 1958). The South Australian government was forced to support the hospital but, in common with other colonial governments of the day, it did so reluctantly (see also

Mitchell 1977 and Dickey 1980). As Inglis points out, colonial governments tried to avoid extending their authority into social welfare. Inglis argues that the perceived role of the state at that time was only to support voluntary philanthropy (see 1958:160). States throughout Australia, although intending a non-interventionist role, were obliged to fund their public hospitals.

In South Australia, two thirds of the cost of the original building was met from State funds. The large fiscal presence of the government became a permanent feature of the hospital's history. With some variation through the years, the government contributed at least seventy percent of the hospital's expenses. By 1950 the total expenditure was \$1.6 million and at present (1990) is over \$160 million, of which nearly ninety percent is covered by State revenue.

The Management of the Hospital

The financial involvement of the government was reflected in the management of the hospital, which created continuing discord between the government and the senior medical staff. From the beginning, as Walker (1960) emphasizes, the State government was unwilling to see effective control of the hospital pass from the government to private doctors (see 1960:29). The first board of management was comprised of three government officials and three 'private gentlemen', none of whom were to be doctors. Three months later, an extended board of twelve, six of whom had to be government appointees, did not have a medical staff representative. Vigorous attempts by the hospital medical staff to gain seats on the board were unsuccessful. Thus, at this very early stage, a group of doctors sought to influence managerial control on the specific ground

that management could be conducted only by those with professional knowledge. The argument was that only professionals working with patients should decide the management of the hospital.

This aim was denied to the medical staff but achieved by the government in 1842 when the hospital came under the direct control of the colonial surgeon. The colonial surgeon was a medical practitioner, employed by the government at an annual salary. He had the responsibility of caring for government employees and overseeing the institution of the goal, the hospital and the asylum, whilst keeping a watch on the port for epidemic disease. Later, he was also president of the medical board. In such official roles the state demonstrated its capacity to co-opt sections of the professions such as doctors, thereby denying them a monopoly on the 'medical point of view'.

Private medical practice in South Australia at this time did not guarantee a secure income and in a period when social closure, in a Weberian sense, had not yet been achieved by the medical profession competition was fierce. The advantage gained by a hospital appointment, although unpaid, was important. Honorary posts were a mark of medical competence to catch the attention and the pocket of private patients, apart from the later medical benefits of resources and education. These appointments became essential for a successful career and the hospital rapidly emerged as a central arena for the competition for medical status, wealth and power. Consequently, the medical profession achieved a victory in 1867 when the supervisory authority of the colonial surgeon was replaced by a reinstated board of twelve, nine of whom were medical.

The hospital board had extensive powers over the administration of hospital finance, regulation of admissions and, importantly, nomination for

appointments. Medical dominance of hospital management had thus been achieved. Given the individuating consequences of competition, it would be wrong to interpret this success as the result of a concerted act by a uniform profession. On the contrary, a small medical elite had persisted in its claim to manage the hospital. For the next twenty years or so the medical establishment flourished at the Adelaide Hospital. Formal medical dominance of the hospital board, however, came to an end in 1884 when the medical representation on an enlarged board of sixteen was limited to eight. Five years later, a non-medical member of the board became its chairman. Finally, the board appointed by the government in 1896 during a major dispute at the hospital contained no member of the hospital medical staff for the first time in almost thirty years.

If the composition of the hospital board in the nineteenth century reflected the authority of the medical staff at this formal level of administration, then the changes introduced by a parliamentary Act of 1921, confirmed a dramatic decline. The board of management was to consist of the Inspector-General of Hospitals, a government employee, who would be chairman, and two prominent public figures appointed by the Governor. The first Inspector-General was originally a resident assistant surgeon at the hospital and then held a number of government posts. This progression also signalled a change in the distribution of power. In the twentieth century, government medical officers gained increasing influence by virtue of their administrative positions and developed an identity separate from purely clinical activities. This is discussed more fully in the next chapter.

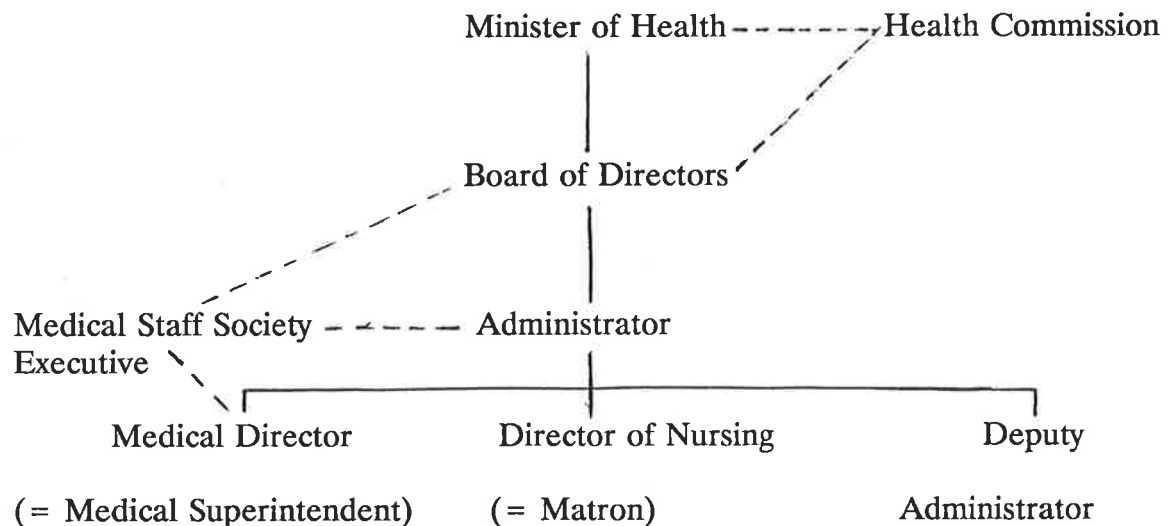
The most enduring feature of the management of the Adelaide Hospital was this three person board. Despite repeated attempts by the hospital medical staff to gain representation, this formation remained for over fifty years. In 1979

the hospital became an incorporated body under a new parliamentary Act and once again a multi-person board was constituted, following a review of the management structure by consultants. There were, however, significant departures from the previous boards. Firstly, the board was drawn from a wide cross-section of Adelaide and hospital society so that, at present only one of the nine members is a doctor. Secondly, the board is now a board of directors bringing it into line with the terminology of industrial enterprises.

The board of the Adelaide Hospital occupies a functional position between the internal organisation of the hospital and the external structures of government departments, to which it has always been accountable. The relevant points of government contact have been both bureaucratic and elected officials; at present the South Australian Health Commission and the Minister of Health respectively. At the level of the hospital, government employees accountable to the board have organised the daily activities. Although this task was originally undertaken by a non-medical employee, a medical superintendent was appointed in 1890, as a result of an enquiry into hospital management, to take general control of the hospital. He was the senior member of the paid medical staff and deputised for the honorary members of staff in their absence. For many decades this was the established pattern and, thus, despite losing control of the board of management, the honorary staff still possessed a considerable influence over the administration of the hospital through the medical superintendent. In 1959, however, after a government assessment of the methodology of management elsewhere, an administrator was appointed as chief executive officer of the board and he was non-medical. This is discussed more fully later in the chapter. For the present, the diagram shows the main features of the current administration of the Adelaide

Hospital, with the addition of the medical staff society executive which takes a prominent place in the events described later.

Administrative Structure of the Adelaide Hospital:



The Intervention of the State

This historical overview of the development of the senior management of the Adelaide Hospital, whilst brief, does draw attention to the variable success of attempts by the medical staff to control the hospital. The degree of medical authority over its organization was influenced by the extent of the government's involvement in this field. Until approximately 1890, this was, on the whole a limited concern although, as I have noted, there was an early and continuing fiscal dominance. The attitude of the government and the activity of state institutions during this period was reflected in their reactions to major problems at the hospital. Each disturbance generated an enquiry, a point which I have mentioned before. Many of the changes documented were the result of enquiries of various levels of formality into the management of the hospital. The highest level of these

was the Royal Commission of 1895 which reported on the 'hospital row'. This incident has been given its own chapter by Hughes (1982), provoked many pamphlets and articles and furnished material for academic theses. Whilst no further consideration is given here, it is noteworthy that the antagonism at the time between the government and the hospital medical staff occasioned the resignation of all of the latter.

This marked a watershed in state/medical relationships. Up to this point the state had been reactive; afterwards it became more active in hospital affairs which was signalled by the constitution of the boards from 1921. Nevertheless, this involvement remained limited to the senior management level, at the junction between hospital and government. Although still receiving its main financial support from the government, the hospital was run by a medical staff free from serious control until after the second world war, with the expansion of an administrative state. I return to this point shortly.

These changes in the state's involvement in hospital affairs in South Australia reflect the stages identified by Willis (see 1989:29) working with Victorian material. He describes a period of minimal state intervention in the health arena until 1900 and, thereafter, an increasing intervention but maintaining the autonomy and dominance of medicine. After the second world war, however, the nature of state intervention changes and the state, argues Willis, is less willing to patronise medicine. Conflict with the profession emerges.

Since the war, the state has increasingly penetrated civil society, a development, according to Yeatman (1990) based upon increasing control of the economy during the Depression and increasing regulation of the population during the war. The significant post-war factor was,

the development of the modern welfare state which brought into being the modern social security system, expanded the reach of the state further, and developed the highly bureaucratised and professionalised sector of state-sponsored human services (health, education, welfare) (1990:40).

Work on the welfare state in South Australia is not yet available as a corpus of analysis but using the available material Yeatman points to the eventual development of 'scientific management' in the Australian public service. This takes the form of "the effective, efficient and economic management of human and financial resources" (1990:14). The initial basis for such management is information so that a rational, technical approach to public services could be grounded in the knowledge of available resources. In the case of welfare services, such as health, this implies not only an assessment of the present but also predictions for the future. Thus, apart from efficient use of current resources, planning becomes a major feature of managerial discourse.

In South Australia, immediately post-war, the means to acquire managerial information took the form of government reports and an expanded bureaucracy. The Shannon Report (1947), the first of the post-war enquiries, was addressed to the 'consolidation' of health services as a result of their increasing expense. This initial report was an indication to the medical staff at the Adelaide Hospital of the changed situation. Firstly, the public hospitals were to be considered as only part of the wider provision of health services. Secondly, government enquiries originated from a government intent on increasing state management of health services. In contrast to the previous state/medical relationships the state had become pro-active, that is, enquiring into areas of management which might disrupt its goals of efficiency and economy, problems defined by the state.

The other aid to information gathering and monitoring of services was the expansion of the Hospitals Department bureaucracy from 130 in 1939 to 338 by

1953. This could, however, be justified by factors other than the information required for the growth of an interventionist state. Over the same period there was an increase of 42% in the number of public hospital patients (see Reid et al 1960) as a result of radical changes in the post-war demography of South Australia. Firstly, against a background of unprecedented party political stability, the longest serving premier, Sir Thomas Playford (1938-1965) introduced a programme of industrialisation to this rural-based state. In part this was to correct the balance of the increasing cost of government services and the inadequate revenue sources. Secondly, the post-war population of South Australia grew rapidly, faster than the national average. This was partly due to internal migration which also resulted in a greater urban concentration in Adelaide (70% of the state's population of one million in 1965). The main increase, however was due to a deliberate policy of external immigration, of assisted passages from mainly European countries. The result was that the population of South Australia increased by 60% between the census dates of 1947 and 1966.

The Building Dispute

The consequence for the public hospitals of population growth in the 1950s was an increase in the number of patients, many of whom were young. This increase was most evident in two areas; in the number of accidents due to both vehicles and industry and an increasing demand for maternity services. It became obvious during these years that the Adelaide Hospital was unable to cater for this change in demand. Consequently, the Medical Staff Society, the official voice of the senior hospital staff and the source of some of the material quoted later,

directed its attention to convincing the government of the need for a new hospital building to deal with trauma victims. There were, however, rival claims on the limited state finances. For example, one aim of the Hospital Auxiliary, a volunteer organisation formed in 1924 to provide patient comforts, was to raise funds for a women's hospital with assistance from the government. At the same time, the government felt a political need to provide a hospital for the new industrial workforce, populating the western suburbs. From 1950, the Medical Staff Society records the opinion that a casualty hospital was required more urgently than a women's hospital, while senior doctors advised government that the proposed western suburbs hospital was either unnecessary or should be subsidiary in its function to the Adelaide Hospital (Hicks 1987). As in the case of most major public works projects, the new hospital was to be handled by the Architect-in-Chief's department.

In late 1951 it was reported to the Medical Staff Society that the architect-in-chief could not proceed with the plans until he knew what was wanted. The Medical Staff Society replied that the architect-in-chief should read the chapter on the modern casualty hospital by Sir Watson Jones (a surgeon)! Furthermore, the plans should be scrutinised by the hospital medical specialists. At this early stage, therefore, the medical staff viewed the rebuilding as a medical undertaking. In addition, there was a unity in the statements of the Medical Staff Society which was not always maintained in political action.

In December 1954, plans for building an accident centre, which were supported by the board of management, were submitted to the Public Works Committee of the state parliament. The plans were described as the "keystone to the whole master plan" of re-building (Hughes 1982:55). This was probably the

first time that the concept of a master plan had been used as a term for the development of the hospital. The implication was that overall development should follow a rational and controlled path. The plans were rejected, however, because of conflicting and confusing opinions from, amongst other sources, the medical staff, and the Public Works Committee could not clearly see the 'master plan'. The earlier unity of the medical staff was now less certain.

The following year (1955) saw the foundation of a building which would be the home of the radiotherapy unit. The treatment of cancer had entered a new phase and both radiology and radiotherapy had become more effective. An appeal by the Anti-Cancer Committee of the University of Adelaide had raised sufficient donations to buy special equipment and appoint staff for treatment of cancer patients. A special building was, therefore, necessary at the Adelaide Hospital to accommodate this civic enterprise. This building would also have gynaecological wards and theatres and hence the funds of the Hospital Auxiliary could be appropriately used. In a sense, voluntary subscription and charitable works had finally found expression in concrete terms at the Adelaide Hospital. This was, however, not the direction proposed by the Medical Staff Society.

In February, 1957, at a Medical Staff Society meeting, the professor of medicine spoke of the need for urgent planning for the rebuilding of the hospital. He believed that the Adelaide Hospital had suffered because the government's attention had been distracted by work at another hospital (in the western suburbs). He argued that the Adelaide Hospital should always be regarded as the chief hospital in the state because of its connections with the University. He added that, in view of the social trend, private beds would have to be included in future building. A colleague, supporting these remarks, blamed the inaction

over rebuilding on the fact that there was one board for both the Adelaide and the western suburbs hospitals. These complaints were repeated by the executive committee of the Medical Staff Society at a routine 'Conference' with the hospital board in March. The emphasis was laid on the fear of obsolete buildings and overcrowded wards undermining the hospital's function of teaching. The complaint was that the government's limited resources were being channelled to the other hospital but political sources were quoted as saying that one of the reasons for delay in planning was the divergence of opinion of the medical staff.

The management theme was added to that of teaching by the professor of medicine in June 1957. He told a special meeting of the Medical Staff Society that,

From the teaching point of view there was a long list of deficiencies mainly stemming from the management as it was at present (Medical Staff Society Minutes 24/6/57:949).

The solution proposed was a separate board of management for the hospital, which should include a nominee of the honorary staff and a representative of the university. In September, the local press repeated the claim that overcrowding and deficient buildings were detrimental to teaching at the Adelaide Hospital. Three weeks later, at another special meeting on conditions at the hospital, the Medical Staff Society decided to release a statement to the press. This statement added the notion of patient care to that of teaching. Objectives to be pursued "in the interest of our patients and the status of the medical school" (Medical Staff Society Minutes, 8/10/57:994), were to abolish overcrowding, rebuild the hospital as a teaching hospital, and, significantly, to widen the composition of the board to include university and honorary staff representation. In other words, medical

attempts to regain control of management of the hospital were invested with social charters.

The medical staff had already achieved a powerful voice on the committee convened to advise the government on the rebuilding of the hospital. This Building Advisory Committee was constituted by the three members of the board, three representatives of the University and three members of the honorary medical staff. But the main point of contention remained - representation on the board of the hospital. The statement from the Medical Staff Society implied that the solution to some of the problems of the hospital lay in more control by medical staff of managerial affairs. By inference, only the people directly involved in patient care and teaching could act in the best interests of both. The government's response was to increase the authority of the non-medical staff.

Early in 1958, the Minister of Health, after studying hospital organisation overseas included, amongst other proposals, the appointment of a full-time administrator to both the major hospitals. In a press release, the honorary staff welcomed these appointments but reaffirmed the belief that the appointees would require close direction by more widely representative boards of management which should also have financial and executive autonomy. The appointments were less welcome in March when it was indicated, in a press statement, that the administrator was to have authority over the medical superintendent. When the advertisements for the hospital administrator appeared, the medical staff were outraged. The invitation to applicants included a job description which was to organise, control and direct the medical staff. This provoked not only alarm in the honorary staff but also the formation of a subcommittee of the local branch of

the medical association to examine the administration of teaching hospitals and the control of medical professionals by lay people.

The agenda of a meeting of the Medical Staff Society in October 1958 also addressed the specific nature of the control of medical professionals by lay personnel. Whilst a government report had favoured lay control of the hospital, concern was expressed over the position of the medical superintendent vis-a-vis the lay administrator. It was felt that these appointments should work in parallel with both having direct access to the board. A deputation was sent to the Minister of Health with this and other requests. In November the results of this meeting were conveyed to the Medical Staff Society. In brief, the government was not prepared to give financial and executive autonomy to the hospital board as long as it supplied the revenue; the minister was not prepared to increase medical representation on the board; and the medical superintendent would not have access to the board except via the lay administrator. Whether by default or design, the government had interposed a non-medical professional administrator between the medical staff and the board.

In February, 1959, the new administrator, Mr. C.G. Rankin, took office. Rankin had been manager of the Alfred Hospital in Melbourne and spent six months studying hospitals in Britain, America and Europe. His appointment represented a further and decisive movement away from hospital management by medical practitioners to one by professional administrators. He was immediately embroiled in the rebuilding discussions, becoming chairman of a central co-ordinating committee and, thus, a focal point of planning. In May, at a meeting of the Medical Staff Society, complaints were heard of the contrary views of Rankin who had submitted his own report on rebuilding to the

architect-in-chief. In the following month, the Medical Staff Society heard that certain difficulties had arisen in co-ordination and planning since the advent of the the new administrator. There followed a number of discussions at meetings of the Medical Staff Society and its sub-committees concerning the weakened position of the board. Once again, in a correspondence with the Chief Secretary, the local medical association questioned the place of the administrator in relation to the medical superintendent and the board.

Delays in planning were blamed on the administrator but other reasons were acknowledged. Later in the year the Medical Staff Society attributed delays to the architects dividing their thoughts between the building committee, the independent activities of the administrator, and the intrusion of outside architectural interests. Administrative delays were, however, emphasized as the main problem. Whatever the truth of this, it was evident that the government appointment of a professional administrator was not welcomed by the honorary staff or the medical establishment. In addition, this influential post had not only upset the relationship between medical staff and board but had also devalued the medical strategy of representation on the board. From now on it was evident that the major control of the hospital lay through the administrator.

In the middle of the following year, 1960, the Building Advisory Committee submitted its report and plan for the hospital's rebuilding. Also in the middle of the year the medical association, through its subcommittee on administration, sent a deputation to the Minister of Health to discuss its concern at the uncertain position of a board of management with limited executive powers. The comments were aimed partly at the continuing government control of the hospital and partly

at the continuing disturbance caused by a non-medical administrator. Whilst the Medical Staff Society still had access to the board in the periodic 'Conferences', it was becoming apparent that this was not the valuable arrangement that it had been. The independence of the administrator was again demonstrated at the end of 1960 when he opposed some features of the building plan on the grounds that they presented serious handicaps to effective administration, including large capital and maintenance costs (see Medical Staff Society Minutes 12/12/60:1437).

The blame for delay in rebuilding was placed by the Medical Staff Society first on the government and then on the administrator. Many government officials, though, noted that there was a lack of clarity in the objectives of the medical staff. During this period, at Medical Staff Society meetings, there were continuing appeals for unity. In that context the subcommittee on teaching hospital administration formed by the local medical association was a public statement by an official organisation that the profession as a whole was concerned and united in its concern about the government management of hospitals.

In November, 1960, while the medical staff were adjusting to the new power locus of the administrator, a small demonstration of the new order occurred. The administrator informed the Medical Staff Society of a revised plan of responsibility in the hospital. The matron would henceforth be directly responsible to the administrator. The medical consensus was that the matron should be generally responsible to the medical superintendent and this view was put to the board at the conference in February, 1961. The result was a 'clarification' of responsibilities by separating the nursing and the medical care of patients into two lines of authority. At the following Medical Staff Society

meeting the point was made that "the medical superintendent should be matron's superior in all matters concerning the medical management of patients" (Medical Staff Society Minutes 27/2/61:1464). The importance of this development, however, was that not only was nursing accepted as beyond the authority of the medical staff but also the access of the matron to the administrator independent of the medical superintendent was established. In management terms, matron and medical superintendent now occupied equal levels in the hospital hierarchy.

The medical staff were also experiencing setbacks to the 1960 building plan which they had adopted. In March, 1961, the architects submitted an 'alternative' plan incorporating some of the criticisms made by the administrator. The building advisory committee compared the plans and noted their general agreement but considered the 1960 version superior. The committee also noted that private wards had been retained but modified. A comment, therefore, of the chairman of the Public Works Committee, that there was no community demand for private beds which mainly benefited doctors, was explosive. The August meeting of the Medical Staff Society expressed anger at the Public Works Committee. The Medical Staff Society was concerned not only that the 1960 plans were viewed unfavourably but also that unpaid work of honorary staff of public hospitals was unrecognised and ill-understood. This needed correction before the public could understand the subtleties of rebuilding. Finally, it was stated that,

the presence of private beds is completely fundamental to improvement in standards of a teaching hospital (Medical Staff Society Minutes, 28/5/61:1528).

In the following month, several comments from the Public Works Committee alluded to a lack of support for a private floor in the new building. For the Medical Staff Society it became vital to proceed with the 1960 plan, which included private patient beds.

A strategy was worked out at the November (1961) meeting of the Medical Staff Society to appeal for a wider-based support. Sympathy from the press was anticipated and two statements were formulated. As the anonymous author of the South Australian Newsletter in the Medical Journal of Australia stated,

members of the profession sought publicity in the local press on two matters which they felt were of concern to all South Australians as well as the medical profession (1962:186).

The first public statement was a complaint by the medical staff over the delay in rebuilding the hospital. The second statement, criticising the administration of teaching hospitals, was issued the next day, under the authority of the local medical association. This strategy disconnected the two arguments and indicated the 'official' concern of the wider medical profession over the running of the Adelaide Hospital. The solutions proffered were, as before, removal of direct government control with its implications regarding medical representation on the board, financial autonomy and so forth. The medical association considered that in the present conditions,

decisions were not always in the best interests of the hospitals and that there was much evidence to show that the health, comfort and treatment of the sick had been adversely affected (see Hughes, 1982:59).

The delay in rebuilding had once again provided an opportunity to propose publicly that the management of the hospital was not in the correct hands.

Both the chairman of the parliamentary Public Works Committee and the Minister of Health responded to the criticisms but neither response satisfied the

honorary medical staff because it did not address the administration 'problem'. They issued a further statement three days after the first. This publicity provoked an angry response from the chairman of the Public Works Committee who was the target of a number of derogatory remarks. The chairman of the honorary staff was summoned to appear before the Committee in December. During the second of his interviews, later called "the inquisition", the honorary staff and its chairman were criticised for their statements to the press. Distress over this attack, which was seen as unjust, was not allayed by legal counsel invited by the Medical Staff Society to their meeting in December, who pointed out that,

the public at large was not interested in the future of any one doctor or doctors as a group. He felt that the Public Works Committee could well manoeuvre so as to appear as a body protecting the innocent public from an Honorary Medical Staff seeking palatial quarters for private patients and additional means of earning further remuneration (Medical Staff Society Minutes, 13/12/61:1578).

He went on to emphasise that it was important to establish that the medical staff was promoting a cause in the interests of the public good. The meeting decided to pursue press publicity with statements concerning the needs of the public in terms of treatment of patients, facilities for teaching and research, deferring complaints about administration and numbers of private beds until later.

Early in 1962, the government's architect-in-chief, now renamed the Public Buildings Department, submitted another plan to the Public Works Committee. This, the '1962 plan', had the major advantage of costing about half of the '1960 plan' by reducing both the number of beds and the area of each department. Whilst the financial savings had an obvious appeal to the government, concern was expressed by the medical staff over the allocation of beds but they were reassured by the chairman of the board in February, 1962 that it was not the intention to exclude private patients.

Throughout this period there was a general agreement in the Medical Staff Society on the lack of understanding by the Public Works Committee of matters which bore directly on the standard of medical practice. They expressed horror at the piece-meal planning of rebuilding and restated the importance of the building advisory committee. Later in the year the position of the building advisory committee was clarified. In August, the Minister of Health met a deputation from the Medical Staff Society to discuss rebuilding. The Minister described the future working arrangements whereby an architect would be installed on site with only one client, the hospital administration.

Neither board, University representatives nor Honorary Staff would have any direct access to the Architects (Medical Staff Society Minutes:1693).

In particular, the staff's approach would be through the board, thus demoting the function and the power of the building advisory committee. More importantly to the medical staff,

it would appear that the Public Works Committee, a group of laymen, had now taken over the advisory function which was properly that of the building advisory committee (Medical Staff Society Minutes:1678).

The administrator was in future to be the point of liaison between the government and the medical staff.

The 'virtual dismissal' of the building advisory committee marked the end of the direct influence of the Medical Staff Society on the plans for rebuilding. This was appreciated by the Medical Staff Society which debated the action it should take including an approach to the press because of the 'intolerable situation'. In September, the executive committee recommended delaying any course of action and no press publicity. The final connection with the 1960 plan was severed in December, 1962 when the Medical Staff Society received a letter from the board of management which included the statement that,

provision of private and intermediate beds was deferred for the time being but consideration will be given later as building develops (Medical Staff Society Minutes:1756).

The argument for the provision of private beds recurred at least twice over the subsequent six months but to no avail. It was commented that the Premier's promise of 1958 seemed to have vanished.

In 1963 the medical staff sought to distance itself from the 1962 plan. The chairman of the Medical Staff Society was invited to give evidence to the Public Works Committee in May of that year. The meeting was more congenial than the scene two years earlier. In a prepared statement, it was recorded that the honorary staff had co-operated fully through advisory committees on the internal planning of the hospital, that is nursing units and so forth, within the framework of the 1962 scheme. It was made clear that this scheme was regarded as a decision of the government. Its merits as a whole had not been analysed and thus comments were directed totally to internal planning. Fears had been expressed by the chairman of the Medical Staff Society prior to facing the Public Works Committee that the medical staff might be held to blame if the hospital as a whole did not function properly. The statement to the Public Works Committee absolved the medical staff from this responsibility but also silenced future criticism.

The Reinforcement of State Authority

The honorary medical staff, in the organisational context of the Adelaide Hospital, suffered a resounding defeat over its planned rebuilding. In the 1950s they were thwarted by the origin of funds from donations and charitable works

which determined the order of priority. The new building housed radiotherapy and gynaecology despite advice from the Medical Staff Society that other demands were more pressing. Planning for the second main building resulted in the 1960 plan which had the support of the medically dominated building advisory committee and contained a provision for private beds. The plan which was finally accepted, the 1962 scheme, by-passed the building advisory committee and included no private beds.

Above all, the management of the hospital was taken further away from the medical staff. The appointment of the administrator provided a counter-balance to the medical staff in terms of professional expertise in management. Furthermore, the administrator became the central representative of the interests of the hospital as a whole as opposed to only medical interests. Whilst the medical staff attempted to maintain their administrative influence, justified in terms of patient care and so forth, the managerial framework imposed by a determined government was not successfully challenged.

There were two reasons for this. First, it was evident that the medical staff were not sufficiently united to pursue their interests firmly. The Medical Staff Society did not represent the junior staff or all of the full-time staff. Within the Medical Staff Society itself, which for heuristic reasons I have treated as an unproblematic whole, severe internal dissension were exposed at some meetings. A building for radiotherapy and gynaecology was not opposed by the advantaged specialists. The Medical Staff Society could speak with only a limited voice for the professional totality of the hospital. The heads of various departments, University appointees, senior honoraries, by virtue of training, specialisation and status did, however, form a strong lobby group.

The second reason for the medical defeat was the differential access to resources between the state and the hospital staff. It is evident that the internal resources available to the medical staff were insufficient to combat government policy. The policies of the hospital administration had become the determinant feature of control. The state, via its bureaucracy had become a more intimately ordered network of power, able to express that power speedily. Deployment of strategies of medical resistance through the cumbersome committee apparatus of the hospital and local medical association was slow. By contrast, the Public Works Committee could demand the attendance of the Medical Staff Society chairman five days after an offending announcement. The Medical Staff Society's attempt to co-opt external sources met major limitations. The press was not totally reliable and edited many of the statements by the Medical Staff Society, occasionally to the latter's embarrassment. Deputations to the responsible Ministers were of limited value. Finally, the most powerful resources of the medical staff, the continuing appeals to the medical charters of patient care and teaching, counted for nothing with the state authorities.

In the building dispute the sources of influence available to the medical staff were limited. The state could mobilise more powerful sanctions more rapidly. The question arises, therefore, of the nature of the working relationship between the state and medical professionals in a public hospital.

The Hospital and the Medical Professionals

The relationship of health service professionals to the organising forces of the institution within which they work is always likely to be problematic. A

contradiction exists between the provider of the workplace, in this case the state, and its users, the medical professionals. At the same time as the state supplies facilities, a location and a population of patients, the medical staff demands, as part of its representation of professionalism, autonomy in its work. The crux of the matter is the organisation of that work, the relation of delegated state officials to the medical leaders in the various fields constituting the hospital at a given point in its history. The organisation of a profession based upon autonomous decision-making appears to be in opposition to the formal rigidity of bureaucracy, yet the profession is also a 'legal-rational' structure which has significant elements of bureaucratic organisation in its professional apparatus.

The question in the disputes I have detailed was who should take the decisions in the areas of concern. The problem, as Freidson and Rhea put it,

revolves around the issue of control - namely whether or not conventional bureaucratic methods are appropriate or practical for controlling the work of scientists and professionals (1972:185).

From their study of a clinic, they used a Parsonian concept to conclude that,

the elements involved in the process by which control may be exercised in this company of equals are fairly un-bureaucratic in character (ibid:196).

Parsons proposed, in distinction from the classic Weberian model, a medical organisational structure of 'a company of equals' with minimal hierarchical differentiation where supervision was the appropriate model (see Freidson 1970a:24). The medical profession was assumed not to correspond to a hierarchical structure of authority and responsibility. In later chapters I will explore the usefulness of these assumptions particularly with reference to medical hierarchy. The point at present is that a standard analysis of professionals working in institutions is one of two contradictory systems of control.

This traditional approach to professional/bureaucratic work areas as it applies to hospital medical staff is exemplified by the work of authors such as Smith (1958) and Goss (1963) who argued that there are two lines of authority in hospitals; administrative and medical. Smith's emphasis on dual authority, however, did not address the problem of how administrative and medical systems may co-exist in a single institution. Indeed, he noted that the formal bureaucratic structure of hospitals implied built-in conflicts with physicians. Goss, on the other hand, pointed out that

where there might have been conflict between bureaucratic standards and the professional values of physicians, there are instead institutionalised structural mechanisms that served to reconcile potentially discordant elements in ways that were approved by physicians as well as functional for their work (1963:175).

Reconciliation was achieved

by virtue of the fact that the hierarchy of positions entailed two different types of control relationships that varied according to whether the area of work was professional or administrative in nature (ibid:176).

Essentially, administrative decisions were separated from medical decisions to avoid conflict. The former were enforced by the authority relations of office; the latter by the advisory relations of expert judgement. The mechanisms which prevented collision are, however, under-analysed and this relatively crude dichotomy is inadequate as an analysis of medical/administrative relationships.

The separation of different structural mechanisms for handling administrative and medical decisions merely begs the questions of how to distinguish between the two and who should make the distinctions. At the level of practice the notion of a dual authority obtaining in hospital hierarchies is less helpful than it initially appears. The distinction between administrative and medical spheres of interest and action may be delineated formally and embodied

in personnel and their functions but almost all of the actions in a hospital compound the two so inextricably that viable rules of separation are difficult to formulate.

The concurrence of bureaucratic structures and medical work has often been poorly analysed because of a lack of information about grass roots activity. What is required is an evaluation of this activity of the medical profession to analyse the development of a particular kind of social order of the hospital, a *modus vivendi* which is continually constructed and reconstructed and in which relationships of certain kinds, especially those between administrators and doctors, are regarded as unresolved and unpredictable. In addition, account must be taken of a constant unpredictability maintained by the presence of powerful and influential forces external to the hospital. For example, in the Adelaide building dispute, the medical staff were unprepared for each move of the government. The tactics of the medical staff were reactive rather than initiatory, necessarily so in view of their limited knowledge and, thus, authority which was thereby exposed. Within this unpredictable setting a working relationship was established, eventually, between the government, the hospital administration and the medical staff but staff were obliged to adopt a subordinate role in the organisation and management of the bureaucratic hospital.

Fielding and Portwood's (1980) analysis of the role of professionals in bureaucratic structures, suggests the concept of a bureaucratic profession. They identify types of bureaucratic profession according to the degree of dependence upon the state. They choose as the major definitional characteristics of a bureaucratic professional,

the dependence on the state for provision of clientele, provision of workplace and licence to practise (1980:44).

The relevant criteria here are the provision of a workplace and a clientele. The dependence upon the state for a workplace has at least the potential of compromising and, perhaps, jeopardising professional autonomy. Control of the workplace, the hospital, was a central feature of the disputes in this chapter. The critical relationship of the medical profession and the state was influenced, in the case of the Adelaide Hospital, by the state's continual role in funding the workplace, which from 1950 to 1970 remained at approximately two thirds of the expenditure of the hospital which had increased from \$1.6 million to \$18 million in the same time. Decisions over its organisation and control could be easily justified by the state. The limitation of medical power in the hospital arena was a result of conflict between a state unwilling to concede significant ground and a medical staff unable to exert significant leverage. The weakness of the medical position lay in the importance of the state-funded hospital to medical practice. In brief, the medical staff depended upon the state for their elite position.

The provision of a public clientele by the state was of vital importance for medical practice. At a symbolic level, the honorary staff could publicly demonstrate their altruistic role and their charitable behaviour. At a practical level access to the hospital improved clinical practice and, thus, the hospital became a place for training. Finally, whilst the wealthy doctors could more easily afford unpaid visits to the hospital, an appointment to the hospital and association with a small group of elite practitioners would in itself provide a boost to status and, therefore, income. The medical staff at the Adelaide Hospital depended upon the state to a greater degree than they might have wished or admitted and successful resistance to state control required more than the rhetoric of professionalism. A dominant role for the medical staff in hospital

decision-making was undermined by the state/professional relationship, that is, by the medical dependence upon the state.

Ann Greer (1984) examined a number of American hospitals in the light of the professional dominance hypothesis, with a view to analysing the decisions taken. She looked at their mechanisms for adopting new technologies, and whilst technology will become important in later chapters, her analysis of decision systems and resources of influence is relevant here. She describes three systems of control: medical-individualistic, fiscal-managerial and strategic- institutional. Medical-individualistic systems pertain to decisions by medical practitioners about medical practice: the structure is that of the hospital's 'second hierarchy' - the medical professionals. The fiscal-managerial decision system was appropriate for the costs and services of an institution and only involved medical staff with organisation skills: the logic of this system, is that of accounting and marketing. Strategic-institutional decisions are related to long term goals and reflected hospital missions. The key people are the board members and chief executive officers and, although medical staff might be involved, "implementation demands the attention of a full time administrative head who has a mandate from the governing board" (1984:816). Greer concludes that professional dominance is not the main factor in the last two systems and,

traditional hospital domination by the concerns of clinical medicine are greatly complicated by separable concerns with the management of institutional growth and development (1984:817).

In effect, she constructs a hierarchy of decision systems with medical opinion becoming less relevant as the organisational and financial implications of the decisions expand.

Greer points out that arguments before medical committees become persuasive by incorporating the concept of maximising patient welfare.

During the building dispute, a strategic-institutional decision, the medical staff made attempts to incorporate medical ideology and transfer decisions to the medical realm. In addition, they attempted a managerial challenge arguing that they had involved themselves from the beginning in total management of the hospital by noting trends for the future:

Surveys of these trends were begun by the medical staff in 1950 and continued for some years. These provided a reliable guide to the future needs of the hospital (Hughes 1982:54).

The medical staff, it was argued, were in the best position to predict future hospital needs. This claim was not developed and the main attempt at control lay in the combination of statements from the professor of medicine, the honorary staff and the local medical association that in the interests of patient care and teaching, the administration of the hospital should be reorganised. More specifically, direct control by the government should be removed and the board should be more representative of, and, presumably, more responsive to, the medical staff.

During the building dispute, the senior medical staff invoked the symbols of medical altruism: the concern for diminishing standards of patient care and the need to train medical students. The implication was that underlying their actions were universal matters of professional expertise which transcended parochial vested interests. The present and future care of patients was the prime concern. This discourse, with its cultural dimensions of care of the sick, charity and dedication, enabled the medical staff to present repeated claims for increased representation on the board in terms of both morality and state welfare rather

than allow the argument to be seen as a continuing fight against the *bête noire* of state control.

Proponents of a dual authority system in hospitals reach different and often opposing conclusions when discussing the relationship between professionals and the institutional authorities. For example, Hall concludes that,

an assumption of inherent conflict between the professional or the professional group and the employing organisation appears to be unwarranted (1968:104).

whereas Smith (1958) writing a decade earlier, had decided that conflict was inevitable. He argued that the formal bureaucratic structure of hospitals involves 'built-in' conflicts, with physicians and their professional norms more often than not emerge the victor. Stephen Green (1975) questions the utility and assumptions of professional/bureaucratic conflict because its theory has remained static. He suggests that conflicts are not a result of differences between principles of organisation behind the two groups, rather:

professional status is seen as one of the political bargaining resources which groups might use in the pursuit of their aims (1975: 138).

As a new basis for analysing interaction in the hospital context he proposes a concept of negotiated order, following the work of Strauss et al (1964). Within this analytical framework, the social order of the hospital emerges from a process of continuous negotiation. This framework emphasises the behaviour of the actors and their construction of a dynamic social order but, in the final analysis, it is too micro-analytical. Structural limitations and powerful agencies, such as the state, are not sufficiently addressed.

The dispute which I have detailed illustrates the power of the state in South Australia in deciding the outcome of a confrontation. The state authorities refused to acknowledge the relevance of the professional rhetoric and the

resources available to the state outweighed those of the medical staff. Administrators could be appointed, despite medical opposition. The state, funding the hospital, could ignore the attempted medicalisation of administrative decisions, which were determined by managerial and fiscal constraints. Medical dominance was, therefore, restricted by the limited resources available to the medical staff, in the conflict documented.

In Greer's (1984) discussion of the resources available to medical staff to influence hospital decisions there is first a medical authority, which she defines in terms of clinical authority over patient care decisions. Clinical knowledge tips the balance of power in favour of doctors in the area of patient management. Second, there is patient leverage. Her argument is that hospitals depend upon patients for some of their revenue and these patients are admitted under the authority of a physician who decides on procedures to be undertaken. Because of this control over admissions, the medical staff hold the key to institutional control. Patient leverage was never available as a resource of power to the medical staff at the Adelaide Hospital. From the beginning the hospital was never financially dependent upon the admission of patients by its medical officers but rather served as a hospital of last resort, initially for the poor and homeless. Paying patients were admitted to private hospitals which often had as board members medical professionals who might also hold an honorary position in a public hospital. The attempt to incorporate a private section in the redevelopment plans of the 1960s followed from the imminent closure of some of the private facilities. There was thus an interdependency of private and public practice articulated by the medical profession through the public hospital. The charitable function of the Adelaide Hospital needs to be emphasized because,

in general, loss of patients did not mean loss of significant revenue. Moreover, there was no shortage of indigent patients in the community.

The third resource advanced by Greer is the substantive expertise of specialists. Specialisation may be interpreted as, and represent one definition of, expertise but the implication is that the field of legitimate commentary becomes more limited and more easily defined. In the building dispute, specialisation had a double relevance. It meant that not only did specialists in different fields of medicine have different perspectives on the future of hospital development, but also that medical specialists were confronted with specialists in administration.

Greer's final category is organisational skill which presents a difficulty to the medical professional. Mary Goss (1963) put it succinctly when she wrote that the demand for physicians as administrators

conflicts with a professional norm, in that to engage in administrative work represents a departure from the professional ideal of patient care, teaching, and research as the major types of work appropriate for a doctor (1963:180).

This 'norm' has, as its origin, the cultural definition of vocation as the most valuable form of labour. Goss believes that a partial resolution of the problem lies in the institutionalisation of administration as a part-time role for a minority of physicians. In the context of the Adelaide Hospital, full-time administrators developed from such part-time roles. These developments form part of the substantive material of the next chapter. Suffice it to say at present that organisational skills were not a foundation for medical dominance at the Adelaide Hospital in particular and did not further the authority of the medical staff.

Conclusion

The analysis of a dispute which exposed some of the growing weaknesses of the medical staff in its attempts to maintain a position of power, in effect, revealed a transformation of the hospital medical staff which will be explored further in subsequent chapters. Some of the reasons for this transformation lay both in the disunity of the medical profession and the importance of the hospital to medical practice. Different factions with different aims and motives weakened the stance of the honorary staff and this was compounded by competition for hospital appointments. In practice the resources of power available to the medical profession to exert leverage within the Adelaide Hospital were limited. Attempts were made, therefore, to 'medicalise' each dispute. By this I mean that the rhetoric of a medical charter was used to support the medical position. Thus, for example, changes unwanted by the medical profession were criticised in terms of their adverse effects on patient care.

On the one hand the purpose of the medical rhetoric was to impose not merely a medical authority over the situation but one supported by a moral viewpoint. Medical professionals were the appropriate interpreters of the needs of patients and, thus, the concern over patient care legitimated the extension of medical activity beyond immediate clinical contact. Moreover, statements concerning the interests of patients bridged divisions within the profession and transcended the vested interests of different medical groups by an appeal to values of cultural importance, such as care of the sick. At this level, statements of concern over patients expressed an idealization of professionalism. On the other hand, the need to appeal to cultural values was symptomatic of the declining

power of the medical profession beyond the sphere of direct patient care. The recurring attempts to legitimate the positions taken should be interpreted as a defence of areas of authority which had not previously been problematic. The power acquired through medical knowledge was insufficient and inappropriate to achieve dominance over other autonomous groups in areas which were becoming definable as non-medical.

By 1962 the medical staff at the Adelaide Hospital, had lost significant authority in their relationships with other groups, especially with the state bureaucracy for at least three reasons. First, the hospital was always a financial responsibility of the government. Therefore, any measure of reducing costs, as in the reduced expense of the 1962 building plan saved corresponding taxes and won a political point for the government. Second, the notion of planning as a motive of hospital administrators gained increasing credibility during the building dispute. Third, the importance of management as both a full-time occupation and one with authority, was crystallised by the appointment of the first administrator. Reorganisation of the hospital's managerial structure altered the relationships between managers and medical staff and, therefore, the distribution of power. The result was that managerial techniques gained increasing legitimacy at the Adelaide Hospital. Economy, planning and efficiency, tapped into cultural values with the same intensity and legitimacy as patient care. With these developments the hospital administrators acquired a charter of their own - economic rationality.

CHAPTER 3

THE HOSPITAL AND COMPUTER-BASED INFORMATION SYSTEMS

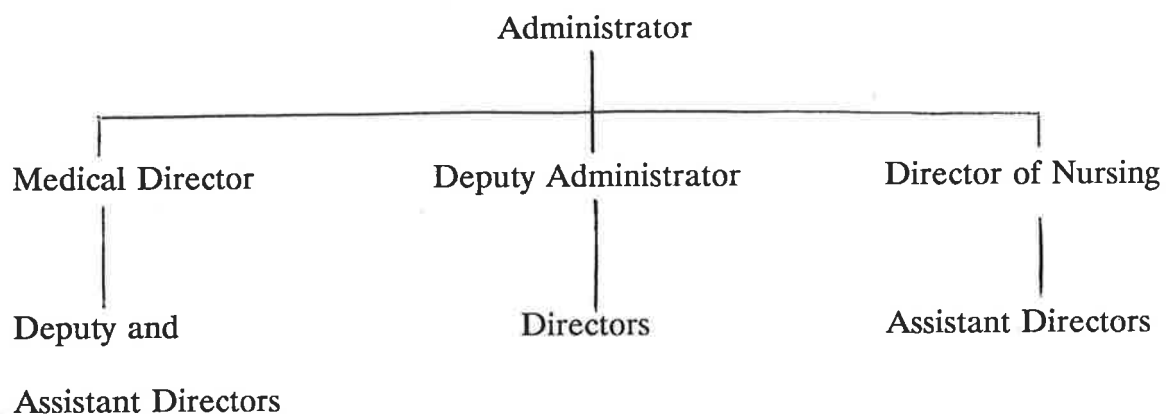
Introduction

The analysis in this chapter centres upon the structural position of medical administrators, paying particular regard to their multiple and complex relationships with other occupations in the hospital. I emphasize, at the outset, that I would like to avoid the notion that the hospital workforce is constituted by administrators and others. Outside the formal category of 'administrator' there are a number of active administrative interests such as those vested in the heads of medical units. As I have pointed out in the previous chapter, many managerial decisions in a hospital have a medical implication and the managerial content of decisions made by medical professionals may be the influential element. Having said that, it is evident that there are professional administrators, it is important to locate the position of medical administrators in the hospital structure in relation to their nursing and non-medical counterparts.

The hospital executive is the senior managerial group of the Adelaide Hospital and consists of the administrator (who is chief executive officer), the deputy administrator, the director of nursing and the medical director. The deputy administrator, the head of the non-medical administration, is responsible for the general facilities of the institution through directors of departments which include catering, engineering, personnel and finance. The director of nursing, formerly called the matron or the superintendent of nurses, is responsible for the hospital nursing services with the aid of a number of assistant directors in charge

of separate nursing areas. The medical director is supported by deputy and assistant medical directors who have responsibilities in areas such as medical sciences, public relations and medico-legal problems, as well as medical staff organisation. The senior clinical medical staff are appointed to units or departments each with its own head. Thus, medical administration forms only part of the complex managerial and clinical structure of the hospital's organisation:

Administrative Divisions



This chapter, focuses upon the formal medical administrators, their context and the conflict created by their managerial interests both at the level of the routine and at the level of policy formation.

In the previous chapter, I supported Ann Greer's (1984) assertion that medical authority is not always the dominant element in decision-making within the hospital and far from the underlying dynamic for hospital change. Indeed, the hospital medical staff represent the more conservative face of hospital politics. By highlighting the increasingly complex relationship between medical and managerial goals in large public hospitals, Greer points to the opportunities apparently

available for medical staff with managerial expertise. Organisational skills, she argues, are more commonly found amongst hospital-based (full-time) specialists, having been acquired to support influential roles in decision-making within the hospital:

To manage these organisational complexities and in response to the organisational contexts in which they work, hospital-based physicians have developed managerial and financial skills very comparable to those of hospital administrators (1984:814).

Greer, therefore, views such skills as a defensive tactic in the struggle for medical influence over hospital decisions. In common with other analysts, she does not consider the possibility of medical professionals adopting a positive strategy of appropriating organisational skills to represent medical interests and to create a specialty in its own right - medical administration.

This apparent ambivalence constitutes a field of enquiry which not only is scarcely analysed but also is especially germane to my modification of the medical dominance perspective. The development of medical administration questions the distinctions normally drawn between professional and bureaucratic lines of authority. Freidson (1985) argues that whilst such changes might be interpreted as bureaucratization in a Weberian sense, they allow medical professionals to remain in charge of the supervision of the medical profession. This chapter discusses the adoption of a managerial perspective by medical professionals specialising in administration. In addition, it addresses the problem of the relationship of this medical bureaucracy to the traditional medical role of contact with patients and to the non-medical bureaucracy.

I will argue that much of the legitimation for the authority of medical administrators hinges upon their claim to an overview based upon knowledge of the hospital as a totality. Indeed, as other units of the clinical medical staff

became specialised within an increasingly limited medical field, this specialisation progressively excluded them from a broad perspective of the functioning of the hospital. This characteristic of fragmentation of the medical staff increasingly justified the role of medical administrators as co-ordinators in order to maintain the function of the hospital as a medical totality.

At other levels of organisation, the medical structure had to blend with the nursing, laboratory, cleaning and a multitude of departments in the interests of the institution and at the institutional level, the hospital itself was co-ordinated as part of the total health service. Administrators at all these levels also played the role of umpire in competition for resources and medical administrators adjudicated between conflicting claims of medical specialists. The decision process occurred within the rhetoric of the good of the patient but this was generalised to the public good to claim a moral legitimacy. However, the ordering of hospital society to achieve this was based upon an apparently more concrete objective. Within a discourse of management the public good was equated with an efficient organisation. Management of the hospital meant an ordering of hospital staff to achieve industrial objectives of increased turnover, cost reduction and so forth. The managerial key to this was numerical information not only to achieve nominated results but also to demonstrate the process of management.

In 1982, at the Adelaide Hospital, the old manual filing system was replaced by a computerised record. The introduction of this technology not only supplied a forum for long established conflicts among divisions of the hospital but also allowed an opportunity for reassessment of these power relationships. The singularity of this initiative lay in its origins in medical administration. The medical director began moves to technologise hospital information and to analyse

the information recorded. The ethnography of this chapter is devoted to this organisational event but, in order to locate the ethnographic present in the flow of events at the hospital, the historical origins of medical administrators at the Adelaide Hospital are first described.

History of Medical Administration

The chief executive officer of the board of the Adelaide Hospital had originally been the head of the non-medical staff, the Secretary. The first medical superintendent was recruited from England in 1890 at a salary of 500 pounds per annum (equivalent to approximately \$40,000 in today's terms). This appointment, although provoked by a local dispute, reflected a general move in Australia, the Royal Melbourne Hospital having appointed a medical superintendent in 1881. This new medical superintendent organised his increasing paid medical staff to supply care on behalf of the honorary staff between their occasional visits. The medical superintendent deputised for the honorary staff on occasions and served as a filter between the house officers and their seniors. In addition, he was responsible for a number of medical tasks which carried little status and were of no interest to the visiting consultants. For example, the giving of anaesthetics became the supervisory duty of the medical superintendent following problems arising from a technical flaw in an apparatus. Apart from illustrating the lowly status of anaesthesia, this also indicated the lowly status of the medical superintendent. The less glamorous, dirty work fell to his lot although compensated by an adequate salary.

During this first period of medical administration, which lasted for approximately 30 years, administration as a career or specialty held little appeal for the medical staff. The most talented administrators were seen as 'generalists' in big organisations or as specialists who added this onerous function to their duties. No separate specialised body of knowledge existed to define medical administration per se and it was viewed as a minor part of the medical decision-making process. Reputations were established by clinical contact, not by managerial expertise.

it is impossible to escape the conclusion that their influence and the mark they left behind them were due to the fact that, whatever their involvement in administrative work, they remained, above all, clinicians (Hughes 1982:96).

The superintendent assisted the honorary staff in the early days and was accountable to the board. This somewhat subservient role was acceptable for a short time because the post, as all paid appointments, was seen as an opening to future private practice. The first two superintendents resigned because of the hospital row in the 1890s but of the next eight, four became members of the honorary staff, with its positive implications for private practice.

Beginning in the early part of this century, there was a gradual change in attitude towards both paid government employment and administrative positions. This was partly due to the secure salary of a government appointment but also to the increasing status of administrative duties as the state extended its role. From 1921 the government had reasserted its direct control of the hospital board by reducing its membership to three appointees. The third chairman of the board was Dr. Rollison, who had held appointments at the hospital and became medical superintendent in 1937. He entered government service rather than private practice and was Director-General of Medical Services from 1949 until 1967.

Since 1951 the post of medical superintendent has been chosen as a career position in administration rather than an entree to private medical practice. Thus, career administrators slowly appeared within the medical profession.

The increasing importance and volume of administrative work was demonstrated by the appointment in 1945 of assistants to the medical superintendent. These assistants - one medical and one surgical - were to relieve the medical superintendent of supervising clinical work. In the pattern of the first superintendents, these appointments were often seen as a temporary stage towards a career in private practice and an honorary position at the hospital. Purely administrative fields were eventually separated from the clinical arena by creation of a single position of deputy medical superintendent without specific clinical tasks. As medical administrators accumulated more managerial responsibilities, clinical responsibilities became less easy to accommodate; reduced clinical experience eroded that particular basis for authority over the doctors. This created a degree of tension in the structural position of the administrators. The legitimation and status of the medical superintendent had always been achieved in the past by a demonstrable success as a clinician. Stripping the role of its clinical content meant that other sources were required to legitimate its executive authority.

One alternative means of legitimation was to construct a body of knowledge separate from clinical practice but constituting a specialised field. The ultimate aim was to create an academic credentialling process for medical administrators. In the 1970s a specialist qualification was introduced which followed the concept of admission to a select college of experts such as the more traditional medical specialties had established. A Fellow of the Royal Australian

College of Medical Administrators (FRACMA) was required to undertake a period of training and pass a written and oral examination in subjects such as accounting, law, management and statistics. Administration became firmly established as a career specialty for medical professionals. The position of medical superintendent could still be used as a temporary post but now en route to higher rings on the managerial ladder. At the Adelaide Hospital, a previous medical superintendent from the 1970s eventually returned to the key position of administrator in 1984, after a stint as deputy head of the South Australian Health Commission. The transformation of medical administration was encapsulated in the words of a present day administrator who was embarking upon the career structure:

Normally you would go into medical administration when you've had enough of general practice or a specialist career. It wasn't seen as an alternative career. Therefore, you were a failed clinician. The younger ones are different. I consider myself as a full-time staff member but more an administrator with a medical degree rather than clinical. Management comes first - medical interests second.

Despite its acceptance in management circles, such academic efforts did not impress the clinical staff. The lack of patient contact remained a sticking point in the reluctance of other members of the medical staff to accept administration as a medical specialty. One doctor summarised the comments of many when he said, "they (the medical administrators) have taken off their white coats".

Whilst, in the minds of clinical staff the clinical authority of medical administrators was questionable, other bases of their authority were obviously growing. Specialists with clinical commitments, less able to encompass managerial functions within their narrowing medical perspective, depended upon the decisions of medical administrators for budgets, staff, beds, equipment and so forth. It also

became obvious that administrators were the mediators between public needs, government policies and hospital demands. As one administrator expressed it,

We have a wider view of the system and contact with other bodies. We are at the interface of inside and outside. Our job is to look at how we should change the inside to accommodate the outside.

The importance of the "job" and the status of the appointee depended upon access to information about total hospital activity but, more than that, it was a particular type of information relating to a specific type of activity. Measures of costs, benefits and efficiency provided a framework for apparently unbiased decisions on the distribution of beds, staff, operating theatre time and other sensitive areas of medical territory.

The basis of the power of medical administrators lay in their possession of formal knowledge (see Freidson 1986). Formal knowledge, according to Freidson is elitist, academic and disguised by opaque techniques of discourse. Its main characterisation is rationalisation, in the Weberian sense, and it is intimately related to the scientific method. Formal knowledge is, for example, expressed in scientific management. Freidson argues that the rationalisation inherent in formal knowledge, "orders and structures the possibilities for choice and action" so that "true choice is prevented" (1986:6). Here he refers to the disciplinary concepts of Foucault - the connection between knowledge and power.

The power of formal knowledge lies in its use to order human affairs but, as Freidson points out, the critical feature in this is the translation of knowledge into action by human beings in their institutions. The role of formal knowledge can only be understood by attending to its embodiment, by an understanding of its creators and users, the agents of formal knowledge, for Freidson - the professions (see 1986: ch.1). The professionals central to the analysis here are medical

administrators and clinical medical staff. Freidson argues that, the difference in perspective between these categories, between administrators and practitioners, leads to differences in "the substance of the formal knowledge that is employed in exercising power" (1986: 227). There is, thus, a different transformation of formal knowledge into 'working knowledge'. Some of the reluctance of the clinical staff of the Adelaide Hospital to accept the legitimacy of its administrators was founded on this difference between types of knowledge. Managerial knowledge appeared formalistic and distant whereas the medical knowledge applied to decisions at the doctor-patient interface was seen as practical and immediate. The most important difference according to Freidson, however, "stems from the nature of the professions' clients and the relative power they have" (ibid). Doctors in public hospitals serve relatively powerless patients. In contrast, the client of the administrators is also their employer - the state. The aim of their service is to meet the demands of superiors, as technocrats, in Freidson's use of the word, as "advisers to those in power" (1986:229).

The relationship between the medical administrators and the clinical staff was, therefore, a reflection of the differences between two types of formal knowledge. Moreover, the bodies of knowledge differed not only in content but also in scope. Whereas, the clinical staff pointed to the importance of patient contact, the administrators emphasised a framework which transcended the individual context. The focus of administrative attention was the hospital as a whole. This focus highlighted the technical aspects of administration and implied the assessment of various parameters of the hospital process. Enumeration of these activities not only supported a concept of scientific management but also influenced the domination of the managed by the managers. Measurement of

hospital activity ultimately meant measurement of the activity of the medical staff. In this way, the formal knowledge of the administrators transformed their relationship with the clinical staff.

These points are illustrated and expanded by the following ethnography which relates to the better recording of information. The events described, whilst related to technology, to a computer, have implications in terms of how the hospital should be managed and, also, who should manage the hospital. At both a fundamental ideological, and a practical, level the relationship of medical professionals to the state and to the organisation of the hospital will be further explored.

The Computer Project

Computers had acquired a poor reputation amongst administrators at hospitals in South Australia in the 1970s. Computer applications at one hospital were limited to simple clerical chores and the results of an extension of their use in another hospital had been disappointing to the Health Commission. Despite this pessimistic attitude, the Public Accounts Committee was intent on obtaining efficient use of hospitals through the application of computers and prompted the Health Commission accordingly. This action was part of an increasing need to enumerate the Adelaide Hospital as a totality in terms which would convey meaning to senior managers in the Health Commission and, particularly, the Public Accounts Committee, eager to reduce the hospital's expenses. The idea was conceived of a project to unite three major hospitals. In the late 1970s

tenders were invited for suitable computer systems but the scheme foundered in indecision.

For four years events were at a standstill until the appointment to the Adelaide Hospital of a new medical director (superintendent). Dr. A., the new director, had gained experience of computer applications at a large interstate hospital and was enthusiastic about the potential of computers in hospitals in general. By June 1981, the idea of looking at a computer system for patient records, which would be common to all hospitals in the region had resurfaced. According to the medical administrators, it became important to convince everyone concerned that maximum flexibility was the significant feature. For example, the medical administrators at the Adelaide Hospital had maintained the important argument that "we wanted to add on patient things". After much soul-searching, a new computer system which had recently become available was offered by one of the companies tendering. This system could be modified by the user, had patient care applications, and had been installed successfully at Duke University Hospital, USA. This system was to be applied to patients and became known as the patient care system (PCS). To organise the introduction of this system a number of hierarchical committees were formed. Dr. A., the new medical director, became chairperson of a policy committee, Dr. B, an assistant medical administrator, became manager of a project team and an implementation team was formed under Dr. C to create a three- tiered system with reports flowing upwards to the medical director, and the policy committee thus:

Policy Committee - chaired by medical director, Dr. A.

↑
Project Team - chaired by assistant medical director, Dr. B.

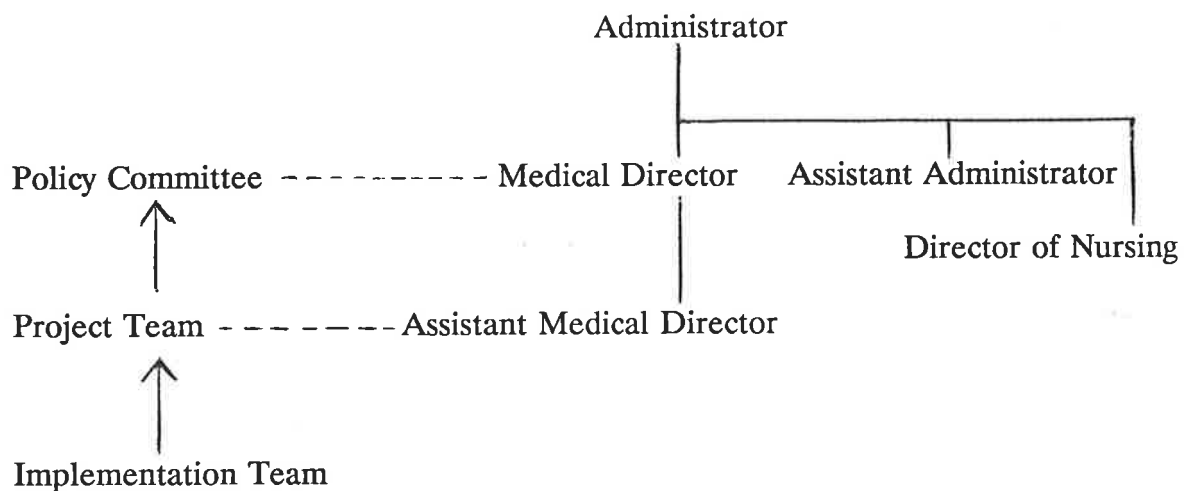
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Implementation Team - led by Dr. C.

At the beginning of 1982, I was approached by Dr. C., who was looking at ways to analyse the organisational changes brought about by the implementation team. After a number of discussions and negotiations, I became part of the team to evaluate the effects of the introduction of the computer on various categories of staff at the hospital. I draw attention in the appendix to the difficulties of my position as analyst in the hospital. My secondment to the evaluation team also created some ambiguity. This was offset, however, by the sheer size of the hospital. In many of the areas I was completely unknown and, hence, it was possible to generate some sense of anthropological strangeness. Consequently, I spent many hours interviewing, talking with and literally following representatives of most categories of staff. My evaluative brief opened doors which might otherwise have remained closed and my knowledge of the clerical and administrative areas of the hospital was increased immensely. The main bulk of the evaluation reports (submissions to the South Australian Health Commission) resulted from questionnaires which are discussed towards the end of this chapter. The following account, however, relies upon my personal observation and my information of the events accompanying the computer project.

Two problems had become apparent by the beginning of 1982. First, the time-table of the project was, at best, optimistic. Dr. C. was co-opted in August 1981 to implement a project with a proposed completion date of February 1982. In addition, the application of the computer to the Adelaide Hospital was to be a pioneering venture in technological management. Rather than using manual and computer systems in parallel for a trial period, as was normal, the first application was to be a total takeover of the clerical areas. This was to be achieved by an implementation team with no experience of the equipment to be installed. The

unreality of the time frame was compounded by the realpolitik of hospital organisation - the second problem. The three-tiered system created by medical administrators caused hierarchical difficulties. The project team, in the intermediate position, did not have a clearly defined role and Dr. C., who had been co-opted from a medical position within the hospital, occupied a less than clear managerial position in relation to the formal structure of the hospital.

Computer Installation Committees and Hospital Management



The reporting network and hence the control and organisation of the computer project was becoming a concern of other sections of the hospital.

A preliminary report, in November 1981, had commented that purpose and direction were needed for the project. The system, now known as ATS (admissions, transfers, separations - i.e. discharge or death), was seen as an appropriate and essential first step to the comprehensive patient care system (PCS). It was also stated that within the hospital, information systems should, in general, relate to the administrator but that ATS may be a special case for

relating more closely than usual to the medical director. The initial momentum of computer applications to the Adelaide Hospital was seen as provided by and identified with medical administration. The initial focus of the reports of the implementation team signified this. However, the formal hospital structure, which consisted of medical, nursing and general administrative divisions, could not fully accommodate the position of the implementation team which contained representatives of all divisions but reported to the medical administrators.

At this time many non-medical administrators were lukewarm towards computerisation. Furthermore, there was resistance from a powerful source to the introduction of a computer at all. The administrator (who was medically qualified) was reluctant to accept the project and doubted the success of many of the objectives proposed. Reservations were expressed from other areas, some about computerisation but most about the organisation of the control of the project in such terms as, "there has been a divergence of responsibility" and "ATS responsibility is not clearly defined because it is not hierarchical". This was inaccurate but the hierarchy was confined within medical administration. Importantly, criticism of the project was aimed at the apparent control by medical administration when "it should be a multi-divisional project". On the other hand, Dr.B., a medical administrator, maintained that, "the only way to control the project was by forcing information to one point and restricting decision-making". As a managerial strategy, this had a distinct Weberian ring. Weber points out that,

The bureaucratic structure goes hand in hand with the concentration of the material means of management in the hands of the master (1970:221).

The focus of the concentration of the means of management thereby defined the master and this became the point of the ensuing developments at the hospital.

The issue of control became more pressing when the implementation plan required alterations to be made to the work of clerical officers. The leader of the implementation team, Dr. C., separated the hospital reorganisation into organisational changes and computer changes, the two being conflated for a period:

There should be organisational changes to develop a place in the hospital where people would behave as if they were a computer (Dr.C.).

This was to be part of the casualty/admissions area which would be walled off and called, with a sense of military assault, the operations room.

Apart from being a public area of the hospital, casualty was also an arena where clerical, nursing and medical boundaries met and disputes arose and were perpetuated. An old complaint from the admissions clerks concerned the information given to them as regards bed availability. Short of travelling the hospital and noting empty beds, the clerks were dependent upon phone conversations with the ward nursing staff which were laced with a clerical patter of friendly persuasion, entreaties and thinly disguised anger, as appropriate. Apart from their persuasive ability over the telephone, the running bed-totals on their clip-board, and their knowledge of individual wards, the clerical staff had little authority and insufficient knowledge to allocate a patient to a particular bed. The control of information lay in the hands of the nursing staff rather than the clerks whose job it was to admit patients. In this complex situation the organisational change proposed by what was seen as medical administration was not welcomed by the clerical officers. Inevitably, the non-medical administration became more involved in the computer project.

A tripartite control representing senior levels of all three divisions - medical, nursing and general, was slowly developing. The project provoked a

cross-divisional cooperation which had been unfamiliar at the Adelaide Hospital and was accepted as a mark of flexibility and improved managerial style. A network of administration became the accepted view. This provoked an outburst of paper detailing organisational charts to locate the structural position of both the project team and the implementation team in this network. The important feature of these charts was that the project moved from a medical administration initiative into the general management arena of the hospital. This was, however, essential if the organisational changes were to be achieved.

The final move in shifting the control of the project occurred when the administrator intervened in its committee structure. The implementation team was dissolved by coalescing with the project committee. The project director, now Dr. C. would report directly to the administrator. The policy committee chaired by the medical director assumed a lower profile and its reports were to be addressed directly to the hospital executive. This was described variously as "a formalisation of structure" (a medical administrator) or as "getting the power structure that we want" (a non-medical administrator). Effectively medical administration had been divested of its authority over the computer initiative. The medical administrators were required to play a role on the same level as the two other hospital divisions, that is, only as a part and not the dominant part of the hospital. Despite the original aim of using new technology for patient care, the major input of information for the computer arose from the clerical and nursing not the medical divisions and the operations room was the key area.

The Operations Room

The inauguration of the operations room in April 1982 heralded the new system. In a small L-shaped area partitioned off from casualty, phones were installed, chairs and desks were moved and the future information hub of the hospital was created. Doors were closed, in some instances so pointedly that a handle was removed to separate the clerical work of computer clerks from the rest of casualty. The main feature of the L-shaped room was the bed-board, occupying a wall on the longer limb of the L, on which were written the names of each patient in each ward, coloured appropriately for male or female. The first day was chaotic, provoking an enquiry from the local newspaper. Thereafter, the new workings fell into a routine acceptable to Dr. C. as the operations room became,

the place in the hospital where people would behave as if they were a computer.

This aim was achieved quite successfully when the computer was introduced with markedly little notice.

In addition to exposing people, rather than technology, to criticism the simulated computer activity of the ATS system increased the base of clerical authority. Clerical complaints about lack of information from the nursing staff could now be validated by comparing the number of transfers occurring via the operations room with informal arrangements between wards. Previously, transfers of patients between wards had been arranged at the mutual convenience of ward sisters with a concomitant exchange of nursing knowledge (e.g. the patient has a drip, requires supervision, wets the bed). The new system required the intrusion of the operations room as mediator. Control of ward arrangements to some

extent passed out of the hands of the nursing staff as the centre of information control became the operations room.

Transfers between wards had been mainly a nursing event. Admission of patients has a larger medical content. In times of crisis, such as a full hospital, admission according to medical need did not always coincide with decisions from the operations room. This situation was ameliorated later in the year when a senior nurse, with experience in a sophisticated clinical area, became supervisor of the operations room. Her decisions over which patients should be admitted were more acceptable to the medical staff.

Discharges presented a more difficult problem. Successive protocols suggested that 'potential discharges' should be notified to the operations room by 10.00 a.m. This was not the established routine of most wards. Most clinical units were geared to operating sessions, teaching rounds, out-patients and the private commitments of their senior medical staff. Furthermore, junior staff were reluctant to list 'potential' discharges. This was interpreted by a medical administrator as the medical staff being unable to separate managerial and clinical concepts. A series of meetings between representatives of clinical units and medical administrators was arranged to explain that managerial requirements did not conflict with medical needs, that is, to explain the importance of the reorganisation for hospital efficiency. There was however a deeper motive for informing the operations room about discharges as soon as possible. Patients could perhaps be admitted earlier. This would mean that a significant proportion of the overtime claimed by junior medical staff for admitting patients after hours could be eliminated. It was, therefore, economically important to register potential discharges and arrange early admissions.

Admissions and discharges formed part of the increased accuracy expected of the hospital in the drive for increased efficiency. The success of the operations room and the subsequent computer system was assessed by its completeness of information. The information regarding movement of the patient was not only of clerical, nursing and medical importance but also a test of the managerial system. The fact required was the relationship of patients to beds. From this could be determined measures of hospital usage such as bed occupancy, average stay and so forth.

The objectives of the operations room were described by the Health Commission as the provision of more timely patient information and better co-ordination of patient services. The aim was to reduce delays and unoccupied beds so that more patients could be processed - the hospital could be made more efficient. This was stated to be improving the delivery of patient care without reducing the standard. Apart from benefit to patients, the hospital management would benefit by being able to demonstrate to the government an increased efficiency of resource usage at the Adelaide Hospital. The key to this was not only a source of reliable information but also a mechanism for using it. The administrator, outlined the problem of hospitals, "Hospitals are stuffed with information but it is difficult to do something with it". Medical administration initially and then general administration later had launched themselves upon an attempt to do something with hospital information, specifically in matching patients to beds efficiently.

The argument so far has established the salient features of the culture of management. Importantly these were common to both medical and non-medical administrators so that the medical initiative in pushing computer applications in

the hospital was absorbed in the general administrative framework. Medical administrators, therefore, reflected the needs of management rather than the demands of medical staff. Furthermore, the charter of patient care was incorporated into managerial perspectives. In this way the formal knowledge of management expressed in terms of efficiency could acquire additional legitimacy. Patient care was, however, expressed in discrete measures of time, numbers and percentages. The immediate aim was to justify reorganisation, the computer and managerial processes by showing an improvement in these measurements with technological innovation. Similarly, an attempt at sociological observations, what eventually became known as the 'soft' data, was envisaged in before-and-after terms, to be used as a tool to modify managerial tactics should an investigation reveal staff problems. Consequently, sequential assessments were aimed at reflecting staff satisfaction or otherwise with the process of technological improvement. The easiest way of supplying the requisite data was by successive applications of a questionnaire and this was achieved over a period of eighteen months.

Opinion Surveys

One of the repeated criticisms in the rhetoric of the managerial literature on evaluation of computer projects is that the effects on staff have been poorly analysed. The statement of Schmitz in relation to evaluation of such technology is typical:

An accurate assessment of employee attitudes toward the system might be the most important single contributing factor to the success or failure of a system, and therefore needs to be understood and evaluated in a way which

is meaningful to the organisation about to undertake the installation of a hospital information system (1975:215).

Dowling (1980) writes quite bluntly that sabotage by hospital staff might be avoided by appraising staff reactions. My specific task as described by the Health Commission was to assess the effect of the new technology on staff 'attitudes' and 'morale' and report back to the steering committee so that mistakes in managing the introduction of the computer could be rectified. In the words of the Progress Report of June 1982, this subjective evaluation was

pitched at assessing the impact of the system on the human side of the organisation.

Originally, these were meant to supplement the participant observation but time was limited. This impact assessment was required rapidly by the managers of the project, in one instance within six weeks after starting. Consequently, a questionnaire, originally intended as a minor part of an ethnographic analysis, rapidly became the main feature of the evaluation because of the demand for speed in the delivery of results. In addition, because of the methodology chosen, the results of the surveys gave a numerical value to the opinions expressed. Responses to a series of statements were entered on a Likert scale of five points from strongly agree to strongly disagree. The responses could be combined and analysed statistically.

The opinion surveys were carried out two months after implementation of the operations room (June 1982), immediately prior to computerisation of patient records, the patient master index (November 1982) and one year later (November 1983). From the ensuing reports I have selected brief excerpts which are not meant to convey a bias as much of the material is not relevant to the present

discussion. The results were compiled into three reports for the Health Commission (Williams 1982, 1983 and 1984).

As a tentative experiment, all medical administrators, senior non-medical administrators, and senior nursing administrators were combined in the group "administrators" for statistical analysis. An assessment of the clustering of responses amply vindicated this approach. Despite their origins in different disciplines, administrators responded very similarly to the same statement and constituted, at this level, a homogeneous group. In other words, administrators in the different divisions shared a common culture of management. For example, responses to statements about centralised information such as the operations room were consistently positive, and questions of decentralisation of authority produced a consistently negative response. The conclusion was that a centrally located surveillance was the best method of controlling resources. A crucial statement in the opinion survey for all groups was an open invitation to record which groups mainly benefited from the operations room. The responses from the administrators were that they themselves did not benefit but the patients, medical staff and nursing staff did.

The clinical medical staff disagreed. Opinions about the new computer system were canvassed from all grades of clinical medical staff of the Adelaide Hospital from the most junior to the most senior. Two points are worth making. First, the return from the medical staff was the poorest of all the groups (30%). Second, despite the wide disparity in age, training and status, a prominent feature of the medical responses was their homogeneity. Indeed, the medical group was the most united of the four 'target groups' in its responses. The majority of medical staff registered a consistent negative response to possibilities of the

hospital administration helping patients. The stance taken was best summarised by a senior physician as,

they are not necessarily doing a bad job but they have nothing to do with patients.

In total contrast to the administrators, the clinical medical staff did not think that the organisational changes would benefit the patients, the nurses or the doctors.

In a sense, the administrators and the clinicians were talking past each other. At one level there was a difference in scale which, as Freidson points out, is the difference between a 'macro' or policy-oriented perspective and a 'micro' or clinical practice perspective (1987:77). At another level, as I have argued, there was difference in the types of formal knowledge, between managerial and medical frameworks. The languages of these frameworks, the language of managerial practices vis-a-vis that of medical practice, are produced by and reproduce discourses which are not necessarily antagonistic but have a different content because they are addressed to different worlds. In this way the individual patient, a central feature of the discourse of clinicians, is excluded from the discourse of management relating to hospital efficiency. The difference in these discursive realities was expressed in the contrasting views expressed in the survey by the administrators and by the clinical medical staff.

This is not to argue for complete separation of these working worlds. On the contrary, the 'macro' impinged on the 'micro' in many areas, most obviously in the managerial allocation of resources to clinical areas. There was, however, a more subtle penetration of medical practice which resulted from the managerial perspective aided by the computer. The discourse of management treated individual items, in its measuring process, normatively: each individual item, patients, doctors, beds, operations, was treated as a standardised item conforming

to standardised behaviour. Aberrations from the norm were the focus of enquiry if they disturbed the pattern sufficiently. This idea could easily be translated into statistical analysis and become one of the functions of the computer. As applied to the medical staff, aberrations beyond accepted limits, determined by the activity of the medical staff in general, became immediately recognisable for managerial enquiry in the interests of hospital efficiency.

Medical Efficiency

Just as important as the overall efficiency of the hospital, was the efficiency of each medical department within the hospital. The medical administrators could compare similar units and comment on their efficiency. Early discharge of patients was documented and a difference in length of stay required justification in terms of patient care. However, any adverse demonstration of, say, significant difference in length of stay between two similar units in two different hospitals could easily be devalued on medical grounds by arguing that the patients treated by each unit were different and so required appropriately different times in hospital. The appeal to the special and individual needs of the patient was often a successful counter to attempts to measure medical efficiency.

Figures measuring bed occupancy and operating theatre utilisation were less easy to subsume under medical strategies. A low rate of occupancy implied the need for a reduction in beds available to a unit; a low theatre utilisation was an argument for a reduction in operating sessions. The allocation of medical staff and work could thus be matched. Reductions by one unit could and would be taken up by other units clamouring for expansion and for funds.

One unit in particular was threatened by the initial flurry of measuring hospital work. At about the same time as the computerisation of patient admission, transfers and separations (ATS) a small pilot study of the theatre utilisation of a specialised surgical unit was undertaken. This was proposed as an initial step to a full utilisation study of all theatres in the Adelaide Hospital and to regular production of these figures from the computer. A month or so later the medical director met with the heads of the surgical department to advise them of the result of the study which was, the theatres were under-utilised. The conclusions were that a reduction of weekly operating sessions from seven to five and an increase in length of individual sessions would accommodate the same demand. This rearrangement would save at least \$20,000 per annum, mainly because of a reduction in operating nurse salaries. The response from the department two weeks later emphasised the contractual obligations of the hospital to consultants apropos the time and length of their operating list. In addition it was pointed out that some of the figures were derived from a 'double bank' - a theatre used by the registrar adjacent to that of the consultant, essential as part of specialist training. Two months later the medical director, representing the views of the theatre committee, replied that the committee would continue with its considerations of re-organisation of theatre allocation.

The import of re-organisation became more clear when the administrator, citing uneven demands in surgical services, proposed a framework for discussion which included using the theatres of the department under review for other purposes. The import became inescapable when the head of the department was invited to attend a meeting of the theatre committee to discuss the proposed relocation of the department's operating sessions. The proposals were simple and

rational. The operating commitments of the department could be accommodated elsewhere in the hospital and the use of nursing staff could be rationalised. Dates for this move, which would be a trial, were set down. A written guarantee, that the department could retrieve its operating theatres if the trial were unsuccessful, was not forthcoming and this provoked the department's head to appeal to other sources of influence. He wrote to the Medical Staff Society to emphasise the need of flexible theatre time for registrar training, urgent cases and draw attention to a deterioration in standards. The Medical Staff Society, in turn, approached to the medical committee, a permanent committee of the board which makes recommendations to the board on policies related to medical matters.

The medical committee sustained the head of department's appeal - but with an accommodation: registrar operating lists would be reduced and unused operating sessions would be available to another surgical department. This partial victory for the department was, perhaps, helped by the national and international standing of its head. Another surgical department was less fortunate. An assessment of its bed occupancy and theatre utilisation led to a reduction in service of one operating list per week and a reduction in beds. Payments to operating nurses and visiting surgeons were saved and the beds were redistributed to expanding specialties clamouring for more facilities. Thus, despite some setbacks, the culture of management was becoming the dominant force in the arrangements of medical practice at the Adelaide Hospital.

Legitimacy of the Culture of Management

At the Adelaide Hospital, the delivery of health care remained a responsibility of the government: the government was responsible directly for the quantity of this care and indirectly responsible for its quality via the hospital staff. Since the honorary system had been replaced in 1971, with a medical staff who were all paid, the government was also responsible for its medical employees. It was important for political reasons that they were fulfilling their obligations to the hospital as much as to its patients.

In 1979 a report by a Harvard MBA graduate with rapidly growing influence in the bureaucracy had pointed out that the health system is run on public funds and,

It is essential that the government should have direct power to ensure that all funds and other resources are responsibly managed and accounted for. (Guerin 1979:5).

Arguments such as these legitimated the increasing intervention of the state bureaucracy in the running of the hospital. The Report states a clear role of the Health Commission to provide co-ordination, consistency and leadership and management information systems were an aid to achieve these objectives. At a simple level this view of the state's function was reflected in the efforts of the administration to achieve a "closer monitoring of the use of resources by medical staff". At more detailed levels, the matching of medical activities to patterns of demand and the identification of areas of under-usage became a feature of hospital measurement and management. The rhetoric of efficiency appealed to cultural values embedded in scientific management. The "cost" and "efficiency" terms in the discourse of management, had a universalistic appeal. The discourse



of management was addressed to the good of all. Inefficiency, therefore, was conceptualised as a loss for everyone, taxpayers, patients and doctors who are themselves paying for the inefficiency.

The rhetoric of efficiency, however, led to conflict between the interests of the medical profession, with its established authority relations based upon professionalism, and the innovative forces of administrators with new relationships based upon an economic rationality. Previously I have drawn attention to this conflict on a smaller scale, in the case of medical administrators who vacillated between clinical and managerial responsibilities. — The increasing move to specialise in management reflected the increasing recognition of the importance of these responsibilities. This specialisation, therefore, could be construed as an attempted 'medicalisation' of bureaucratic practices, in the sense that the medical staff, having lost direct control of the organisation of the hospital, relied upon the medical superintendent/director as their agent in the bureaucratic process. It was expected that medical attitudes would influence administrative decisions favourably since these would be made by a member of the medical profession.

Disappointingly for the medical staff, the appointment of a medical professional as administrator did not mean that he represented the opinions of the profession regarding its monitoring and control. On the contrary, his authority lay in his administrative power. For example, the current administrator, also medically qualified, wrote in 1991 that figures of occupied bed days, same day admissions and a decrease in average length of stay "suggest that the hospital is operating more efficiently" (Newsletter 2/4/91). Second, the non-medical administration was gaining authority and could present itself as untrammelled by a limited medical perspective and, so, more clearly representative of community

interests of which it was the guardian. Similarly, the state as actualised by its managerial appointees, could also be presented as responsible for better management of the hospital for the good of all, rather than for only the medical staff. Intervention required information and the computer supplied this, at the same time emphasizing the power of non-medical administrators within the hospital.

The implementation of the computer project by the medical administration provoked a reaction from non-medical administrators over control of organisational changes. The success of the project eventually hinged upon intervention by the non-medical bureaucracy. Medical administrators, were eventually confined to patient care applications, a role more easily defined as medical. In 1982 a patient care committee was set up consisting of representatives of both the hospital and the Health Commission. Suggestions were invited from the medical staff for computer applications to patient care.

Whatever the future plans for its medical uses, the computer initially provided information more appropriate to the efficiency of the institution rather than to direct patient care. The logistics of patient movement and hospital measurement were the main focus of the new technology, although it was also argued that a more controlled organisational environment would make for better patient care or at least allow more patients to receive the same standard of care. Thus, the discourse of management adopted key elements from the discourse of medicine, the language of patient care. In this way the legitimacy underwriting the activities of management was extended beyond the instrumentally rational to include an expression of moral values. Indeed these values could be woven into

the discourse of management. The aims of management, as stated by a member of the Health Commission were,

to continue to provide the same service in a contracting economy by more effective use of resources. The long term effects on patients will be positive in that they will be dealt with professionally and rapidly. But this does not mean that the scalpels will be any sharper.

The intent of hospital administrators was an increased efficiency in industrial terms involving the universalistic rhetoric of economic rationality but justified in terms of patient care.

One of the motives for computerisation was a more efficient storage of records, which could be retrieved at the touch of a keyboard. In managerial terms, "more timely information" could be obtained by a positivistic technological approach which would ultimately allow hospital management to quantify output. The basic foundation for investment in any industry, a competitive product, could be translated, in the context of the Adelaide Hospital, into allocation of funds not only within the hospital but also to the global budget of the hospital in competition with other hospitals. To prove itself worthy of continuing 'investment' by the state, the Adelaide Hospital as a whole was required to demonstrate an ever-increasing efficiency. As a recent newsletter of the chief executive officer made clear, compared with other teaching hospitals, the Adelaide Hospital was not performing efficiently.

As well as reducing expenditure, the hospital, if it is to remain a major force in teaching hospital services in South Australia, must improve its efficiency so that reductions in activity must be proportionally less than reductions in expenditure (2/4/91).

This positivistic approach to medical management has two specific corollaries. First, a positivistic methodology of management can be seen as a rational way of organising the hospital patients and employees. As an expression

of technical efficiency it also reproduces the objective medical view of the patient. There is, thus, an unstated covert resonance between medical and managerial ideology. Second, the system of measurement means an increased ordering of the hospital society as an expression of administrative power. The patient carers, the medical staff and others are scrutinised. The organisation of hospital society as a function of power encapsulates my borrowings from Foucault. Rather than concentrating on the results of patient care, my analysis examines a different level of the hospital whereby the process of patient care can be monitored. This I have termed hospital panopticism. As Dreyfus and Rabinow point out,

the Panopticon had the effect of focussing the practices of the culture; it provided a paradigmatic form for their visibility (1983:193).

The modern paradigmatic form is the computer. As an expression of hospital panopticism it adds a dimension to managerial power which extends beyond the simple documentation of patients. This dimension is the statistical ease of comparing the arrangement and needs of patients with the distribution of medical staff and facilities and had been totally under-estimated by the medical staff. Unappreciated by them, the computer and its figures become an important influence on medical activity. Measurements of bed occupancy and theatre utilisation formed the basis for reducing or increasing ward space or theatre time for a particular specialty. This was eventually reflected in the number of medical staff employed. In the short term, such figures were used to resolve inter-specialty competition for increased hospital space. Similarly, length of waiting lists could provide the basis of arguments for reducing or increasing facilities for appropriate modification of work. Waiting lists were also a political issue and the administrators, therefore, articulated these external influences with the internal arrangements of medical staff. In brief, the doctor in the hospital became as

much the object of panoptic methodology as the patient. Whilst a new vision of the patient was created, panopticism also provided a new visibility of the doctor, which is taken up in chapter seven.

At yet another level, the power vested in hospital panopticism is expressed over the administrators of the system. The controllers may themselves be controlled by it. Foucault writes that the fate of 'the director' is bound up with the mechanism.

An inspector arriving unexpectedly at the centre of the Panopticon will be able to judge at a glance, without anything being concealed from him, how the entire establishment is functioning (1977:204).

Surveillance of the directors is the function of state agencies external to the hospital which use the same numerical basis for decision-making as the managers. Thus, the figures for hospital activity also reflect the competence of its managers, as the chief executive's newsletter acknowledges:

the hospital is in a comparatively inefficient position according to the SA Health Commission's funding model (Newsletter, 2/4/91).

External assessment, therefore, determined increasing efforts towards efficiency and financial restraint.

Underlying much of the discussion above is an implicit theme of rationality. The rational application of disciplinary power should produce an organisation which is both efficient and productive in commercial terms. This theme of rational organisation is explicit in Max Weber's, rather pessimistic view of the meaning of discipline which anticipates the disciplinary control proposed by Foucault.

What is decisive for discipline is that the obedience of a plurality of men is rationally uniform (Weber 1948:253).

Discipline is impersonal and acquiescence is to a common cause. The authority of the hospital administration depends upon the fact that it was both legal and rational. It also gains from a consensus that its rules of procedure were directed to the good of the patient. The exercise of an authority based upon them is in the pursuit of a common cause.

At the Adelaide Hospital reduced activity leading to reduced demand for staff and supplies was consistent with "the right control on staff and goods" (Newsletter, 2/4/91), and this included the medical staff. Here, therefore, there is a link between the ideas of Weber and Foucault. The pursuit of economic goals could only be achieved through an ordered and disciplined hospital society. The state could impose this by appearing to transcend narrow sectarian interests and represent wider public concerns. As a result however, the activity of the state was guided by the morality of capitalist enterprise. It could legitimate its decisions by basing its actions on a scientific rationality and a patient morality. In the case of the Adelaide Hospital this was represented by the computer and its applications for the good of the patient.

Conclusion

At a superficial level, it appears that I have proposed an argument which supports the notion of a technological imperative (see Fuchs 1968). I have argued that a technocratic approach to decision-making within the Adelaide Hospital promoted the power of the owners of the technology, the administrators, at the expense of the medical staff. Medical influence was diminished in so-called 'global' decisions based on information which was collated by the computer. My

treatment of technology, however, addresses its important socio-cultural aspects and incorporates in the analysis the discursive reality which emphasizes the value of classification and measurement. In this way I distance my argument from a crude technological determinism. Whilst the possession of technologies is a sign of power in itself, the crucial analytical features are the relationships of power surrounding and transformed by the technology. It is not technology but rather the discourse of management supported by technology which is the critical focus for analysis.

For the medical staff efficient organisation of the hospital meant a reduction in their autonomy. The result of the introduction of new managerial techniques and technology was to increase the control of the managers. As Larson (1979), writes in her re-analysis of professionalism,

Science and technology do not enter capitalist production because of some transcendent concern with 'neutral' rationality and 'neutral' conceptions of efficiency, but rather as managerial weapons in the class struggle, as instruments for taming class resistance (1979:623).

Simultaneously, control of the work process is systematically encouraged by bureaucratisation of the institution. This was a direct result of the increasing adoption of a capitalist morality within the hospital and the consequent application of market principles to its organisation. The managerial charter legitimating these strategies was the good of all patients. The motive for organisational change was increased efficiency, a decrease in cost rather than an increase in profit. Efficiency, an important feature of bureaucracy, required control of the organisation and this implied a methodical system with centralised decision-making.

The crucial first step to attain control over the organisation of work, as Littler and Salaman (1984) point out, is the establishment of management as a

separate function with unique expertise and responsibilities upon which the efficiency of the whole enterprise depends (see 1984:67). The separation of this function institutionalises simultaneously not only control but also conflict and consensus. Control must be seen in relation to conflict and compromise (see Littler and Salaman 1984). Managerial strategies are chosen to defuse the possibility of worker resistance; to limit potential conflict, to achieve a compromise and possibly a consensus.

The competition amongst units for resources made it difficult for the medical staff to develop a united approach to a managerial analysis of the hospital. Strategic plans were embraced or opposed according to their effect on the unit in question. A loose representation of a consensus opinion could be given by the Medical Staff Society. The aim of the hospital administrators was "to combat this lack of corporateness" and give the hospital "a direction". Medical fragmentation made easier the imposition of direction by contributing towards a disunited opposition.

CHAPTER 4

THE FIBRE-OPTIC DISPUTE

Introduction

A main theme of this thesis is the consequences for the medical profession of its fragmentation, paying particular attention to the process of specialisation. The central problem of this chapter has been chosen to study intra-professional conflict resulting from the formation of a specialist network. The particular case-study analysed is the dispute which developed from a decision by the directors of the department of anaesthesia and intensive care to buy a fiberoptic bronchoscope, against the wishes of the members of the thoracic medicine department. Although, at first sight, a simple disagreement between two specialised departments, the opposing viewpoints of this brief but intense contest were argued before managerial committees at all levels of the formal hospital hierarchy. My analysis also focuses upon the role played by the hospital managers in this conflict. In particular, I address their involvement in a dispute over medical territory as an extension of their economic-rational authority discussed in the previous chapter.

Specialisation has constituted a fundamental division of labour in the medical profession for many years. As part of the professionalisation process within a cult of increasing expertise, specialisation has signified medical progress. However, drawbacks and contradictions have arisen within the professional framework. First, the division into specialist groups does not necessarily guarantee equality of status or authority. The relationship of specialists with

general practitioners and the position of specialists, dependent upon others, such as anaesthesia, become problematic. Second, specialisation makes the possibility of a united medical opinion doubtful. Consensus becomes unreliable even when, as in the case analysed here, the interests of both departments are defined in common professional goals, such as patient care: even the rhetoric of the common medical charter can be used to express disunity and competition. Thirdly, inter-specialist conflict occurs at the definitional boundaries of specialties. Defined partly in contrast with other specialties, new forms of competition between medical professionals are based upon new technical/scientific models and instrumentation. This is exemplified by the fiberoptic dispute. Finally, but not exhaustively, specialisation changes the definition of the prime object of medical treatment, the patient, with long-term consequences for hospital specialists. This last point is taken up only in a preliminary way here but receives more detailed treatment in chapter seven.

The fragmentary potential of specialisation has been addressed by most theorists of the medical profession but from different analytical viewpoints. Willis (1989) argues that the "internal dynamic" of professionalisation was directed towards regulating the occupation from within. The aim was a unified profession as a necessary precondition for establishing control over conditions of practice and thereby greater autonomy. Processes of unification took the form of a better organised profession by combining medical representative bodies. A national code of ethics was adopted in order to regulate, amongst other matters, professional relationships. Importantly, a mechanism was legalised whereby disputes could be discussed privately within the profession (1989:75). As I have pointed out, professional values of expertise and individualism compromise unification. The

process of specialisation gives rise to continual conflict only partly contained within a shared rhetoric of unity.

Bucher and Strauss (1961) draw attention to the existence of intra-professional segments and the conflict between them. They see professions as

loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history (1961:326).

They describe their approach as processual and argue that it focuses upon diversity and conflict of interest within a profession and, thus, the implications for change:

Segments develop distinctive identities and a sense of the past and goals for the future, and they organise activities which will secure an institutional position and implement their distinctive missions. In the competition and conflict of segments in movement the organisation of the profession shifts (ibid:325).

In addition, Bucher and Strauss specifically warn against accepting a 'spurious unity' inside the profession which may be evidence of the power of certain elite groups rather than internal homogeneity. This public face cloaks a disunity which becomes explicit within institutions such as the hospital.

Grace de Santis (1980) offers another approach to conflict within the medical profession. She argues that the high level of consensus which permits physicians to be professionally dominant is based on a value system that fosters continuous competition. This occurs at two levels of motivation: one theoretical, in terms of scientific discourse and new techniques, and the other practical, in competition for patients. Because hospitals have too many competitors for too little space and too few resources competition between specialties is more apparent in this setting. She concludes that,

the medical realm is not ruled by a single unifying organisational structure but by a powerful competitive process (1980:231).

Control of 'realms of expertise' owes less to consensus and more to the politics of professional competition. She emphasises the internal efforts to balance, by a process of negotiation, the competition sustained by medical individualism and definition of specialist boundaries. An important feature of her work is that the fact of competition is self-consciously attended to and its implications for intra-professional control are explicitly addressed. Social control is most likely exerted within the profession when the work of one sector is expanding at the expense of another.

The social control exerted by medical professionals in their relationships with each other is an important theme in the analysis of a model medical group by Eliot Freidson. He described the everyday work of physicians in this setting and analysed their self-regulatory controls. He found that the professional system of control, collegial accountability, was limited by medical rules of etiquette which discouraged criticism (see 1975:241). In my analysis I intend to develop a new model of professional control suggested by Freidson and supported by my ethnography.

In the group Freidson studied, the traditional professional model of control failed. Indeed, the administration contributed the most important centre of influence in the medical group being a repository of complaints and information.

Going to the administrators, then, constituted for the physicians the most natural and effective way of getting information and of getting informed advice about how to deal with colleagues who had offended them (1975:238).

The administration assumed a far greater role than expected from the limitations on its formal authority.

The relationship between medical professionals and administrators is full of ambiguity in the context of organised medical practice. This relationship becomes even more problematic within a public hospital because of the dependency of medical specialists on facilities provided by the state. Thus, historically, the state has played an important role in the production of specialisation, appointing specialists to a government hospital and supporting an appointment by supplying technology, wards, or beds. The state, in terms of both the tools (technology) and the materials (patients), financed the forces of medical production. The relationship between the state and the forces of medical production was not simple, however in the case of the Adelaide Hospital, the major part of the specialist medical care was underwritten by private practice until 1971. Only successful private practitioners could afford to donate charitable time, unpaid. There was a mutual dependence between public and private practice, fragile but more significant as specialist practice developed.

Appointment as a hospital specialist to a public hospital, paradoxically, facilitated access to private patients in three ways. First, beginning with the establishment of a medical school in 1887, an unpaid appointment at the Adelaide carried the prestige of educating future doctors. Specialists could 'advertise' their expertise and industry and the importance of their specialty to students. The students of the day would become the practitioners of the morrow with power to refer cases to favoured specialists. Furthermore, trainee specialists could be attracted to continue a specialty and popularise its importance.

The second factor was that access to patients could be made less contentious by avoiding competition with general practitioners treating hospital patients without payment. Antagonism could be avoided by carving out a niche

as an expert under these conditions whilst hoping for referrals of private patients from general practitioners for opinions and treatment. In a sense, competition was defused by creating a dependency between specialist and generalist.

Thirdly, an entree into private practice could be achieved without antagonising other specialist colleagues by creating a separate speciality. Attendance on a patient by one specialist was not necessarily at the exclusion of another and a patient could be referred among specialists without loss of income. Indeed, referral of a private patient could create income for more than one doctor. Just as importantly, this could occur without loss of prestige provided an etiquette of referral was institutionalised to regulate the circuit of specialists. The patient could now serve as a resource for a number of doctors. Referral and consultation, as Freidson (1975) points out in his American study, formed a network of cross-cutting ties opposing the potential divisions of specialisation. This was also true of the Adelaide Hospital and was eventually formalised in the consultation process and a multidisciplinary approach. This co-operative aspect of specialisation was seen by an official authority as appropriate;

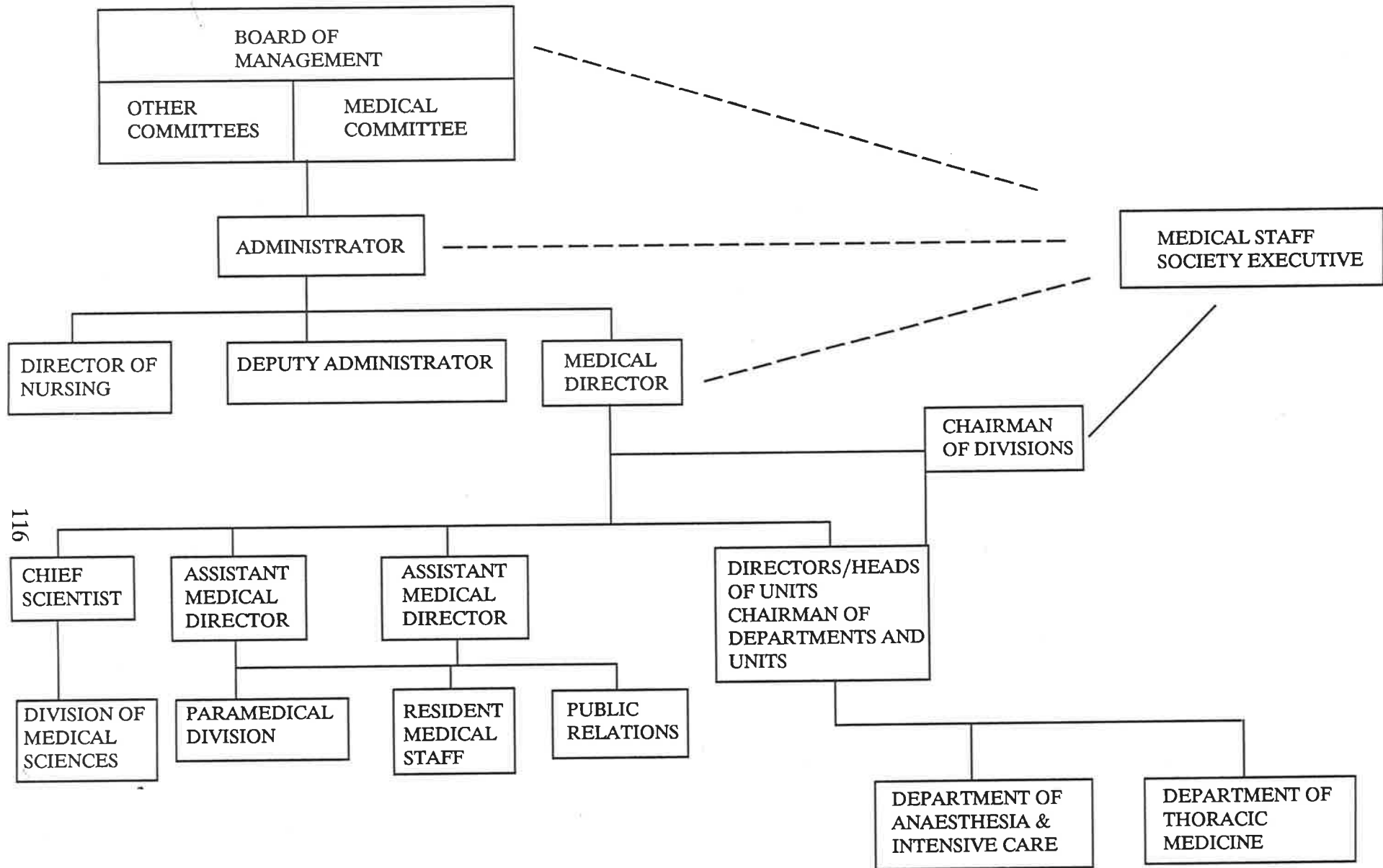
Neurosurgeons, cardio-thoracic surgeons and urologists need to work together in the same place because they must enlist each other's help (Bevan 1981:384).

In brief, specialisation led to a new form of co-operation which represented the main historical transformation of the profession in that period. This new form of enforced co-operation between separate specialties required an unchallenged monopoly of hospital resources but, just at the point of its emergence, the state began to tighten its grip on the hospital and to channel this need for co-operation through its structures of control.

The Adelaide Hospital became increasingly important in the organisation of the work of specialists. Apart from a hospital appointment, legitimacy of a speciality could be concretised, quite literally, in hospital buildings. In addition, the status of a speciality could be reflected in the size of the department, the beds allowed, the support staff allocated and so forth. Access to these limited resources provoked keen competition rather than co-operation. Co-operation owed much to the hospital administrators who were to allocate resources and co-ordinate medical activities. The notion of scarcity and the regulation of resources provided the administrators with a strong lever for manipulation of the medical staff. The state control of resources meant that the relations between specialists were increasingly made to conform to a model of competition for these resources. Competition and conflict were grounded in limited resources and remained endemic amongst the specialist staff of the Adelaide Hospital. Conflict surfaced at the edges of specialist territory and my case-study records a dispute over the limits of territorial authority. First, I locate the two departments at issue in the historical and structural framework of the Adelaide Hospital, the latter illustrated by the formal organisation chart (overleaf).

The Protagonists

The first honorary (unpaid) anaesthetists were appointed to the Adelaide Hospital in 1922. Up to this time anaesthetics were given by members of the resident staff supervised and accredited by the medical superintendent. Because of the commitments of honorary anaesthetists to general practice, the resident



FORMAL HOSPITAL ORGANISATION

staff continued in this role (see Hughes 1982). The first full-time anaesthetist was appointed in 1948 and in 1956 the department of anaesthesia was established with a director, assistant director and two full-time anaesthetists. In 1963, able to invoke increasing knowledge and the available technology for resuscitating patients who had a breathing problem as in tetanus and poliomyelitis (see chapter seven), the department assumed the care of managing cases of acute tetanus and took over resuscitation throughout the hospital (see Nicholson 1990). This extension beyond the fairly restricted field of anaesthesia in support of surgery was acknowledged formally in 1963 when the title of the department was changed to include respiratory resuscitation. In the following year a respiratory failure panel was formed of representatives of the specialties of anaesthesia, pulmonary function and thoracic surgery. In 1969, the present intensive care ward was opened and in 1974 the department acquired its current title of Anaesthesia and Intensive Care. By 1990 the department consisted of the professor and chairman, four directors, sixteen full-time staff, twenty part-time visiting anaesthetists and fourteen registrars. In 1990, 18,000 anaesthetics were performed and 1150 patients were admitted to the intensive care ward. Thus, anaesthesia had not only increased rapidly but also greatly extended its field.

The department of thoracic medicine had its origins in the Tuberculosis Clinic. Tuberculosis was a major disease of the nineteenth century, accounting for a major part of the deaths in the colony of South Australia including its planner (see Woodruff, 1984). Despite Koch's discovery of the causative agent, little treatment could be offered except for the provision of consumptive homes or sanatoria. In 1935 a Tuberculosis or Chest Clinic was opened at the Adelaide Hospital with a physician, assistant physician, and two clinical assistants. This was

before the advent of streptomycin and, ironically, after the start of a decline in tuberculosis mortality. The combination of these two events undermined the specialist ground of chest physicians but an area of increasing concern was lung cancer, the diagnosis of which became part of the function of chest physicians. A pulmonary function unit to investigate all lung disease was formed in 1962. The unit became the Department of Thoracic Medicine in 1976 with a director and specialist physician. The tuberculosis services of the state were incorporated in 1979. At present the department consists of eight full-time specialist physicians with supporting nursing and technical staff. It is the largest unit in thoracic medicine in South Australia and offers a range of clinical services. In particular, its diagnostic services have been greatly extended by the introduction of fiberoptic bronchoscopy, which was the spark for the dispute between the two departments of Thoracic Medicine and Anaesthesia & Intensive Care.

The Fiberoptic Dispute

Prior to the 1970s, internal visualisation of body cavities had been accomplished by stainless steel tubes with a single bulb as a light source. The inflexibility of these various 'scopes' could cause damage, limited vision to a small area, was unpleasant for the patient and the procedure was often time-consuming because it required a general anaesthetic. The introduction of fiberoptic technology to medicine meant that a number of these drawbacks were overcome. The examination of patients became easier, quicker, safer and more thorough. Fiberoptic endoscopy became a routine for certain specialists to investigate the anatomical area of their expertise - for example, gastro-enterologists used the

gastroscope, bowel surgeons used the sigmoidoscope and thoracic physicians the bronchoscope. Thoracic physicians and anaesthetists both worked in the airway.

In 1976 a request for their own fiberoptic bronchoscope appeared on the estimates of the department of anaesthesia and intensive care. These estimates are a list of requests for equipment, staff etcetera, for the forthcoming year, together with reasons, degree of priority and estimated cost. The reasons for seeking the purchase of this instrument came from both sections of the department. First, anaesthetists periodically faced the problem of a difficult intubation, that is, the insertion of a tube into the airways to control breathing during general anaesthetic. Second, the intensive care unit had a perennial problem of clearing airway secretions from their patients which could require more active measures than suction. A fiberoptic bronchoscope could help to solve both of these problems. Whilst the request for a fiberoptic bronchoscope incorporated applications from both halves of the anaesthetic department, specialists in intensive care were more vocal in their support. Difficult intubations had been resolved by this writer, amongst others, on more than one occasion by requesting assistance from the thoracic medicine department. In a sense, this informal co-operation between the specialists was threatened by the elaboration of anaesthesia into intensive care as a specialty. There was a feeling in both anaesthesia and intensive care that the department ought to have a fiberoptic bronchoscope.

When this request became known, the head of the thoracic medicine department presented to the medical director a written statement which pointed out that thoracic medicine provided a perfectly adequate bronchoscopy service. It would, therefore, be redundant to allow expansion by another department. The

point at issue was that intensive care practice would overlap with treatment of chest problems normally undertaken by thoracic physicians and not involving the anaesthetic department. The anaesthetic department's request was not granted by the hospital administration. At a time of severe economic constraints, the cost of this initiative (approximately \$8,000) needed more justification. This refusal did not appear to create resentment in the anaesthetic department since estimates were prioritised and this had not achieved a top priority even within the department.

The two departments interpreted the failure of the request differently. According to the intensive care unit it was pure economics; "The hospital were not prepared to put the money in". To thoracic physicians the main factor in the decision was the duplication of resources, the efficiency of the hospital:

Intensive care said we want one but administration said we don't see the reason for this because you would be duplicating.

The thoracic physicians, however, broadened the argument to more fundamental problems. They said that they were prepared to talk to the anaesthetic department about conceptual issues such as the control and independence of hospital departments.

I don't think you can have everyone in the hospital doing what they think is right because it's not necessarily in the best interests of the patient.

In addition to expressing the charter of patient care, the issue here is the implicit acknowledgment that specialist activity in the hospital requires monitoring. Whether the hospital administration refused the purchase on grounds of simple fiscal considerations or in opposition to duplication of services was of secondary importance. The interests of the patients, the thoracic medicine department was asserting, were served best by regulating the extent of anaesthetic practice. They

accused the anaesthetic department of being unwilling to discuss such matters because it was an area of sensitivity. Meanwhile, the anaesthetic department had more pressing priorities in its annual estimates.

At this point, I wish to draw attention to the use of discourse even at this early stage in the dispute. The anaesthetic department, in prioritising requests to the hospital administration, entered into a managerial discourse which it did not control. The criteria for deciding future equipment and activities were condensed to a numbered scale which included the reasons and the cost. There was, thus, a pressure to request items which were easily justifiable or inexpensive. The notions of scarcity and economic rationality were accepted without question. The comments by the thoracic physicians invoked ideas of collegial control attached to the charter of patient care but there was also assumed a managerial discourse of duplication of services and the aims of the institution. This point became more explicit as the dispute progressed.

The anaesthetic department let the matter rest until 1981, when a new private practice scheme for full-time specialists was introduced. Out of fees collected by the hospital from private patients on behalf of specialists, deductions were made for a service fee, a trust fund and an equipment fund. The relevant feature of the new formula for this chapter lay in the equipment fund, which could be used to buy instruments beyond the hospital budget. The case for purchase of a fiberoptic bronchoscope was put to the equipment fund trustees by the anaesthetists. The unstated argument was that the anaesthetic department was applying for release of money earned by the private practice of its members who had contributed proportionally to the fund, that this was rightly anaesthetic money. The fund accepted the application and referred it to the medical director for the

assumed formality of official sanction. Despite the origin of these funds in private practice, managerial approval of their use was still required.

By these tactics, the anaesthetic department had not claimed a proportion of the hospital budget for purchase of the instrument in competition with other departments. Another source of money had been found and, by this strategic manipulation of funds, the department sought to avoid dispute. Avoidance of competition for hospital funds could in this way reaffirm an occupational culture of professional unity. Fiscal nicety, however, did not resolve the issue for the department of thoracic medicine. The public position taken by thoracic physicians in opposing the anaesthetic request and the hardening of anaesthetic resolve to obtain the bronchoscope committed both departments to conflict.

A member of the department of thoracic medicine found out about the anaesthetists' new development during a casual conversation 'in the corridor'. Representatives of the department approached the medical director with their objections. They also put these to the anaesthetic department, which rebuffed them. The medical director, however, agreed that there was room for discussion. The stated concern was the care of patients but, for thoracic medicine, a practical consideration was protection of a monopoly. This technique meant a supply of patients and to some degree a dominant relationship with some other specialties as expressed in requests for assistance from thoracic medicine, for example, by anaesthetists. For the anaesthetic department, the argument referred to the varying rights a specialist group had to influence, comment or disagree with the practice of another. As articulated by one member, the acquisition of the fiberoptic bronchoscope was,

To do with the way anaesthetists practice. Thoracic medicine or any other specialists have no right of influence. It's a tool, like intravenous therapy, that does not necessarily belong to any discipline.

Explicitly emphasizing the neutrality of the 'tool' and ignoring the loading of professional and specialist identity, the rights of individual medical practitioners were underlined. In this manner, the discourse of professionalism articulated the argument of anaesthetists and intensivists.

Another important issue for both departments was training, in particular, the training of intensivists. The key point was that intensive care had been recognised as a separate speciality since only 1980, with a qualifying examination organised by the Faculty of Anaesthetists, within the College of Surgeons. The Faculty not only organised the examination but also set guidelines for training. One of these was described by an intensivist:

The Faculty suggested that people for intensive care training should have access to a fiberoptic bronchoscope.

Both the intensivists and the thoracic physicians were members of the Australia and New Zealand Intensive Care Society where, according to the Adelaide intensivists, "thoracic medicine had had ample opportunity to object to use of the instrument by other people". Training requirements suggested by the faculty of anaesthetists for intensive care had not, therefore, been disputed by thoracic medicine in this mutual forum. That is to say, decisions over appropriate training did not create conflict between the official bodies. The significance of this was that at an academic level, the guiding control of activities normative for particular specialists favoured the stance of the intensivists.

Furthermore, the establishment of intensive care as a specialty, was supported not only by academic argument but also by state funding. The government was able to respond easily to a concept of intensive care, which had

social and emotional values as well as political implications. The intensive care unit, for example, is at the centre of much of the state emergency services.

On the other hand, fiscal sources were limited and an extension of any specialist activity was translated, in hospital terms, into a competition for resources. The efficient utilisation of resources was at the forefront of hospital budgets. The concerns of the hospital administration, which were the control of resources, and the concerns of thoracic medicine, which were control of competitive activities, coincided.

As a consequence of the approach to the medical director by the thoracic physicians, approval for the purchase by the anaesthetic department was withdrawn. This department protested immediately and a meeting was arranged between the medical director, two representatives from each department and the chairman of the Medical Staff Society, a formal organisation of the senior medical staff of the hospital. Its chairman supported the anaesthetic department. The medical director accepted the majority opinion and, after limited discussion, a memorandum was written with the recommendation that the request be approved. This was criticised by thoracic medicine as being, "incomplete, obviously simplistic and didn't grapple with the real problems". The 'real problems' were articulated as being related to clinical privileges and the boundaries between specialised fields. Boundary lines defined not only the privileges of an inclusive field but also determined the criteria for exclusion of unacceptable competitors. Privileges and boundaries were, therefore, inclusive and exclusive and important in identifying a category of specialist staff with its attendant resources, techniques and patients. Rather than expressing the argument in these terms, however, the justification repeatedly offered was 'the interests of the patients'.

The recommendation of the medical director was passed to the medical committee - a committee of the board of management constituted by representatives of the medical staff, the hospital administration and the board itself. It is the final common pathway from the medical staff to the board of the hospital (see organisation chart). The medical committee accepted the recommendation of the medical director. There were a number of factors influencing this decision. Importantly, some surgeons were on the brink of their own fiberoptic dispute with related medical units. Undoubtedly, surgical members of the medical committee saw this problem as having implications for their own position. Surgical specialties were extending their field of practice and the consequent testing of previously accepted boundaries questioned the definition of the field of practice of neighbouring specialists and threatened the stability of the patient market.

Within this general context, the dispute entered a new round. The decision of the medical committee was contested by the thoracic physicians. They considered that the medical committee had dealt poorly with the problem and that it was not the appropriate body to adjudicate anyway. Whilst the question of the legitimacy of the process was provoked by an adverse decision, the thoracic physicians had some grounds for their challenge. The medical committee reviews research and advises on medical matters. It also ensures that standards are set for medical performance but does not impose standards on an individual specialty, nor does it usually decide between the conflicting claims of specialties. Consequently, a letter of protest was sent to the chairman of the board, with the result that the problem was discussed for a second time by the medical committee. A solution satisfactory to both opponents remained impossible. By this time the

anaesthetic department had also officially brought the dispute to the notice of the hospital board. This was a high level of authority and the move antagonised the hospital administrator, who felt by-passed. As phrased by an anaesthetist:

The administrator was angry that we went above him. It upset the board but identified that the medical director and the administrator had not appreciated the whole problem.

The anaesthetic department saw the 'whole problem' as an attack on its specialist independence and emphatically told the chairman of the board that:

Under no circumstances would we be defeated. We are determined to have use of the instrument and our position is non-negotiable.

The rhetoric of conflict had, thus, been heightened by both departments. To maintain its relevance, however, rhetoric has to maintain contact with a reality immediately identifiable as such by all the important actors. Part of the reality was the attention paid to the dispute by other managerial and medical groups. The fact that the dispute had rippled beyond the limits of the two departments was made clear to the author while struggling with a difficult intubation on a patient. "What you need is a fibre-optic bronchoscope", the surgeon observed. This comment was typical of a number which were expressed by disinterested members of staff watching the social performance from the sidelines. The departments of anaesthesia and thoracic medicine did not receive or appeal for colleague support in the hospital. The dispute was kept as a clear competition between bordering specialists. The recruiting of outside legitimisation represented, however, another dimension. Its growing importance for hospital activity was signalled by attracting the notice of increasing levels of hospital authority. This was reinforced by the appeal to medical and academic bodies external to the hospital. In its submission to the board, the department of thoracic medicine had emphasised the potential complications of the use of fibre-optic bronchoscopy.

This was supported by guidelines drawn up by the Thoracic Society. These were viewed by the anaesthetic department as an educational framework for diagnostic bronchoscopy by physicians and, therefore, irrelevant to the dispute. The point that the anaesthetists were increasingly making was that they had no intention of entering a diagnostic field which was part of the realm of thoracic medicine. The anaesthetists, similarly, began to canvas supporting opinions externally. A number of interstate anaesthetic departments were contacted and it was found that "virtually all of them had fiberoptic bronchoscopes for intubation and for clearing soiled airways". These were the uses proposed by the Adelaide department. Additionally, an appeal was made to the dean of the Faculty of Anaesthesia who replied with a statement on the rights of specialist practice that it was appropriate for anaesthetists and intensivists "with reasonable skill" to use the instrument. The dispute had now entered a public phase beyond the confines of the hospital in the full sense of a conflict extended.

The response of the board was to set up a new committee to deal with what was a growing embarrassment. The committee was to consist of two people from the board and a representative of each department. This was rejected by both departments. The plea from thoracic medicine was for direct discussions between the two departments and not through mediators. The declared aim of this appeal was now to keep the dispute on a clinical level and out of the jurisdiction of the administration, "which hadn't happened and that was our basic reason for discontent" (thoracic physician). Whilst thoracic medicine had originally sought the support of the administrative structure, it had no wish to leave decision-making to the administrators, particularly when the decision might be adverse.

Finally, the Advisory Committee was asked if it would be prepared to consider the whole matter. The Advisory Committee is another board committee and functions essentially as the appointments committee of the hospital. Therefore, in a limited way, it was related to clinical responsibilities and privileges through the appointments system. Because clinical privileges formed part of the dispute, both sides thought that a suitable approach to the problem had been achieved. The stance of thoracic physicians who complained of the fact that,

it took us six months to get around to organising a method of dealing with a specific problem relating to clinical privileges

thus appeared to be vindicated. The anticipated resolution did not follow. The members of the advisory committee were unwilling to tackle the question of clinical privileges, because they did not see themselves in that role. The committee did, however, offer to act as a mediatory body and proposed that two neutral arbitrators external to the hospital should be appointed to look for common ground.

Two arbitrators of high public standing were co-opted. A phone call to one of the departments suggested that both should talk to each other. Within the day, a senior specialist from this department arrived in the other to request face-to-face discussions. The reasons given were that the dispute had gone on long enough, that both departments were making themselves a 'laughing-stock', and that resolution could be achieved without involving colleagues, administrators and, more importantly, external arbitrators.

A discussion group was arranged of four specialists, two from each side. In a matter of two to three hours, areas of agreement were found and circulated back the advisory committee. In the words of the one of the main actors, "From then on everything became simple. A sort of concordat was signed"; a statement

in marked contrast to the previous discord but resolution was rapid and successful.

It was established that intensive care was interested in treatment, not diagnosis. The anaesthetic case basically dealt with difficult intubations. "The part we are interested in takes 30 seconds. From then on, it is nothing to do with us" (anaesthetist). Thus, not only were the uses of the fiberoptic bronchoscope divided conceptually as diagnosis versus treatment, but also the patient was divided physically. As one thoracic physician put it, "The upper airways are your problem, the lower airways are our problem". There followed an offer by thoracic medicine to train anaesthetists and to advise on logistics, support and equipment. Finally, an inter-departmental meeting was arranged to discuss the subject of fibre-optic bronchoscopy and its teaching.

The Dispute in Retrospect

A decision that there were anaesthetic uses (a procedure of brief duration on two inches of anatomy) and thoracic uses, and that intensivists would be concerned with treatment rather than diagnosis, had resolved a conflict which had consumed half a year, involved and created many committees and meetings and which had drawn in national bodies. Each step in the dispute had taken the two departments further away from the original point, the purchase of a piece of equipment and undermined acceptable grounds for mutual discussion. The principle now was clinical privileges and who should give ground over them. The final level of disputation had incorporated members of the social elite of Adelaide and, thus, the conflict had reached a level of absurdity.

The two departments drew their own different conclusions as to what the dispute was about and the sections of the anaesthetic department also had separate opinions. To the intensivists it was an attack on their professionalism, their newly-acquired independent specialist status:

It was about professional judgement in what you think should constitute your role in patient care.

The anaesthetists ever mindful of their specialised technical role, saw an ignorance of their field of expertise and its particular problems:

The administration didn't understand what we wanted it for.

Thoracic medicine, similarly to intensive care, vocalised the problem as a question of professional status and patient care:

The common denominator is the question of clinical privileges. We want to be assured that it is in the best interests of patients that this new step be taken.

Professional judgement and clinical privileges were conflated with patient care. As in other disputes, the patient care charter was used to underpin arguments over pragmatic professional issues.

The opposing positions had, in the eyes of the participating clinicians, drawn attention to the ineffectiveness of hospital administration. Each committee decision faltered and was occasionally reversed in the face of strong medical protest. This view of administrative impotence, accepted by and acceptable to the medical staff, was reinforced by the escalation of the dispute through the committee structure to the hospital board.

Protests were heard by various committees around the hospital and, at the end of it, we were left with a group of clinicians who have sorted out their administrative problems amongst themselves (thoracic physician).

The solution was seen to lie in a mutual agreement over the division of medical labour and not in a decision by an arbitrator. Indeed, in a retrospective view of the dispute, the administrative mechanism was portrayed as obstructive:

It was unhelpful to transfer the decision to the Advisory Committee and the sorting out was interfered with by the administrative structure.

One factor in this perception of 'interference' may have been the large number of committees involved in the dispute. To paraphrase the words of one anaesthetist, the meetings engendered were frightful. The other criticism was the lack of understanding shown by other groups especially the hospital administrators. As one thoracic physician said, "a number of administrative committees struggled with it because they didn't understand what it was about". The essence of this criticism was that the administrators were ignorant of 'the real work' of the hospital which was medicine with its clinical problems.

On the one hand, therefore, it appeared to the disputing departments that the administrative structure of the hospital was incapable of solving disputes of this nature. The merit of competing claims by clinical departments could not be routinely assessed by administrators and thus, it appeared, this practical level of clinical experience was beyond the influence of non-clinical experts. In part, this was due to the fact that the dispute was elevated to the level of a moral discourse by invoking the charter of patient care. Throughout this thesis I have shown that this always occurred at a certain level of conflict. The result was that the medical staff could affirm that they could handle their own problems. The successful resolution by the clinicians, showed that the hospital organisation was inadequate and it was a mistake to involve administrators. In effect, the dispute was used to emphasise the fundamental incompatibility between clinical and administrative perspectives.

On the other hand, from the point of view of the administrators, the dispute was irrelevant to the organisation of the hospital. The administrators were not concerned with different departments squabbling over the boundaries of their particular realms of expertise, as long as the hospital as a whole was undisturbed and the treatment of patients remained unaffected. Only at a late stage in the dispute were there indications that the breakdown in informal relations between departments might delay appropriate consultation over patients. The main spur to the rapprochement was the embarrassing public extension of the argument and pressure from colleagues and administrators alike. Initially, committees and meetings proliferated both as an index of the growth of the dispute and as a formalisation of the process of disputation. The successive committees signified the process of the conflict rather than immediately providing a solution to conflict. By this, I mean that in the early stages the hospital administrators played the role of linesman to ensure that the boundaries of behaviour acceptable to the hospital were not transgressed. Only later did they force an end to the game.

Specialisation and Control

The formal position taken by the hospital administrators, therefore, was that of 'facilitators', offering help to resolve the conflict between the two departments without entering into the medical debate itself. The assistance was offered mainly in terms of managerial structures, of committees and discussion which did not question the medical perspective. The grounds for the dispute remained unchallenged by the administrators. Their stance, in essence, was one of

servants of the medical profession, medical auxiliaries, whose job was to make easier the conditions for clinical work. This stance was consonant with medical attitudes towards the role they perceived for administrators. The neutrality of this role became evident to the clinical specialists and was expressed in their frustration that administrators were neither supportive of nor antagonistic towards a particular medical unit. The administrators avoided direct instructions to the medical staff of the two departments although unresolved conflict and appeals for an acceptable solution continually invited them into the medical realm. Despite the slow resolution, a bureaucratic solution was not imposed by administrators on the medical staff.

The separation of bureaucratic and professional modes of relationship has been noted in previous chapters. The issue here was the mechanism of control of the organisation of the medical staff in the hospital. Freidson (1975) describes two main conceptual models of the social control of human services. The 'bureaucratic model' is based upon the classic Weberian characteristics of formal rules, regulation, hierarchy and supervision. This model is relevant where the work of one group is formulated, directed and co-ordinated by a different group, the managers. This is in contrast with the 'professional model' whereby work is directed and controlled by the people who do the work. In health services, these two models are juxtaposed in a special way (see Freidson 1975:10).

The bureaucratic model as a whole is unacceptable to the profession and its work. Bureaucratic management, as Freidson argues, exercises largely indirect social control over medical work. The administrators, at best, fulfil 'house-keeping' roles only, not the function of command. Direct bureaucratic control by administrators is opposed by the professional model which conventionally

emphasises worker-control. The direct form of social control over work is exercised by,

individuals controlling their own behaviour conscientiously by virtue of the training and dedication they gained from a long period of schooling. In interacting with one another, individuals are also presumed to exercise direct control over one another's behaviour (Freidson 1975:9)

Control over professional activity is presumed to be exercised within the professional model as a result of collegial surveillance. However, as Freidson concludes, collegiate control rarely works in practice.

The obstruction to effective collegiate control is a strict rule of etiquette which limits any criticism of fellow practitioners and discourages collective social control. Furthermore, confrontation is "distasteful even in private and almost unthinkable in public" (Freidson 1975:242) The internal values of the social order emphasize the virtue of individualism and, thus, allow a latitude of behaviour for practitioners which is constrained by colleagues only the event of "gross deficiencies in performance and inconvenience to colleagues" (ibid 241). Evan Willis points to the private nature of self-control of the medical profession which occurred when it adopted a national code of ethics.

The decision was also taken at this time to stop airing its dirty linen in public by ceasing to publicise details of disputes (1989:75).

The rules of etiquette, part of Willis' 'internal dynamic' of professionalisation, assisted unification of the profession by guiding the behaviour of its members. Regulation of relationships helped to forge a medical community which 'closed ranks' to protect its members from external criticism. The process of unification also put limits to the degree of internal criticism in the interests of group cohesion. In this way, the medical profession could be both unified and individuated.

Thus intraprofessional mechanisms of social control are problematic. On the one hand, the bureaucratic model is unsuitable and unacceptable to the medical profession, on the other hand, the professional model is largely ineffective. Individual self-discipline is insufficient as a reliable basis for social control, in the absence of collective evaluation. Collective evaluation, argues Freidson, is the prime requirement for "a true system of collegial social control" (1975:257). An effective system must involve,

the formation of a dynamic consensus among colleagues about the boundaries of discretion, a consensus formed in the course of constant interaction over differences of opinion about proper performance (ibid).

This notion of Freidson for the operation of a responsible, self-governing collegium is seen more clearly than the professional model during the fiberoptic dispute. My ethnography highlights 'the boundaries of discretion' and describes the eventual forming of a consensus. The consensus, however, was formed over boundaries of discretion within a state hospital. Significantly, and here I incorporate a feature of the bureaucratic model, administrative authority in this context could be exercised over more than 'housekeeping' functions. Final release of the money for the fiberoptic bronchoscope still required the medical director's approval. The influence of the administrators was also expressed in concrete terms by appointing adjudicators but mainly their institutional facilitatory role was emphasized by encouraging the department to 'get on with the job'. The consensus was formed under external pressure from the administrators.

A bureaucratic judgement in the end was avoided. Nevertheless, the possibility of direct administrative intervention was a spur to final resolution of the conflict. Grace de Santis notes that,

The realization that a decision made by the institution may not be as satisfactory as one derived through personal negotiations serves to encourage private solutions (1980:203).

There were further implications, both bureaucratic and professional, of the private solution to the fiberoptic dispute. In effect the institution via the members of its committee structure had forced a decision, which was a stricter definition of jurisdictional boundaries. The committees were constituted by various mixtures of non-medical and medical, administrative and clinical staff. The very openness of the dispute, in contrast to the traditional professional model of privacy, allowed, even encouraged, not only collegial scrutiny but also a collective hospital evaluation. There was a collective participation in the social control of the medical work of the hospital.

My analysis has built upon Freidson's suggestions for an effective mechanism of collegiate control, including the participation of non-medical observers. My final point extends this model to relate collegiate control to state intervention in the hospital. The critical dimension in this dispute was what aspects of specialist practice were subject to the scrutiny of another group of specialists. The freedom of specialists to determine their responsibilities and the content of their work were challenged by other specialists. The position eventually arrived at was that a final decision could be made only by the specialists in conflict. The lack of an informed judgement by the administrators appeared to justify this stance and to validate a clinical attitude towards non-clinical medical staff who apparently had divorced themselves so much from medical practice that they could not make a decision on clinical matters. In effect, the position taken was that it was appropriate for specialists to scrutinise each other and be permitted their own mechanisms of internal control. Similarly,

this was the position taken by the hospital bureaucracy. By allowing the departments to maintain a clinical independence, by advocating internal monitoring of specialist activities, the administrators encourage a system of control favourable to the state but enforced by the medical staff. The use of resources, the distribution of patients, the allocation of funds can be monitored by the medical staff. The ordering of hospital medical society is a consequence of this new and effective mechanism of social control. The state, by promoting an effective collegiate control in the hospital, achieves a system of monitoring administered by the medical staff themselves.

An incidental but important consequence of the final resolution of the fiberoptic dispute was that the use of the bronchoscope was extended by fragmentation of the patient. The anatomical and conceptual areas of interest to each specialty were preserved by a more careful definition of appropriate 'realms of expertise'. Fragmentation of the patient accommodated and individuated specialties and decreased conflict between them. I address the fragmentation of the patient specifically in chapter seven. I turn now to discuss the ideas of individualism and community, highly valued by the medical profession, in the light of my ethnography and the subsequent modification of the professional model of social control. These concepts are discussed at the level of individual specialties although constituted by individual specialists.

The basic issue of the fiberoptic dispute was the relationship between competing specialists. Bucher and Strauss (1961) argue that all specialties are in a state of development, always looking for opportunities to extend their field of practice and expand their patient markets. The development of intensive care out of the specialty of anaesthesia illustrates this point. With developments in medical

knowledge and, more importantly technology, intensive care was created as a subspecialty in its own right, drawing from other specialties its population of patients who were often *in extremis*. A separate unit signified this expansion of anaesthetic territory. The colonising ambitions of one specialty however are resisted by others divided by a common boundary. In the fiberoptic dispute, thoracic medicine reacted to the perceived territorial incursion of anaesthesia and, in particular, intensive care. In the final agreement it was important to state that intensivists would not "go around the wards looking for patients". At this time, intensive care was itself expanding into ward work via consultations for intravenous feeding and urgent airway problems.

The mobility of specialist boundaries was also explored by other specialist departments. I have mentioned already that some surgeons were involved in extending their range by fiberoptic technology. In addition there were skirmishes between medical and the surgical units which had developed around areas of interest out of general surgery. The advent of coronary angioplasty by physicians (dilation of coronary arteries by a small balloon) caused anxiety to the cardiac surgeons. The most recent vehement row between two surgical units at the hospital led to a formal external enquiry. De Santis (1980) gives various lists of specialist encroachments which, in one way or another, had their counterparts at the Adelaide Hospital.

Freidson (1975) argues that there is no consistent logic guiding the content of specialised work. The substance of specialisation reflects conventional institutional distinctions which are, themselves, a product of the particular marketplace within which specialisation arose. Gritzer (1981) similarly emphasises a market model for specialisation. In particular, he emphasises the dynamic

aspects of occupations, not only with respect to historical situations and market needs, but also to internal changes in response to market opportunities. The definition and redefinition of work is of critical importance in deciding the boundaries and defining the work area of disputing specialists.

Freidson distinguishes the factors ordering specialisation as not only substantive but also normative:

That is, specialisation is not delineated solely by the limitation of work to a particular organ, technique, procedure, or whatever; it is also delineated by the limitation of work to tasks that have been evaluated normatively as appropriate to the person involved (1975:71).

This was an important point at issue in the fiberoptic dispute. Monopolisation of the fiberoptic bronchoscope by thoracic medicine presented a problem to the substantive and normative definition of the speciality of anaesthesia. Intubation, in particular, was a hallmark of the practice of anaesthesia and the request for assistance from another department to carry out a core definition of the specialty compromised its normative basis as a speciality. Such requests could be avoided by owning a fiberoptic bronchoscope which consequently was transformed from an instrument that was useful to anaesthetic practice to one that was essential. In the same way, it became essential for the treatment of patients by intensivists who were establishing their position as specialists.

The core definition of specialists can be described in sets of practices. Here, however, I wish to draw attention to the technical symbols of those practices. Anaesthesia had already been symbolised by the laryngoscope, the routine instrument for intubation, but with limited invasion of the airway. In the same way, the mechanical ventilator had become a symbol of anaesthesia and, as a modality of treatment, intensive care; the bronchoscope was a technical symbol of thoracic physicians and surgeons; the computer was a symbol of

administration. Without extending the analysis, it is fair to say that a specialist field was partly defined by its instrumentation. New sets of practices could be signalled by new instrumentation. Possession of these technical symbols, therefore, not only designated competence but also defined the specialist practice. Definition was the crux of the dispute not in a static or rigid sense but rather as a dynamic process. The fluidity of specialist boundaries was expressed in the transformation of both the substantive and normative features of the work arena of the speciality. There was a process of continual redefinition of separate areas of expertise for individual specialties.

This dynamic aspect of specialisation is pointed to by Bucher and Strauss (1961) and in a later and greatly-extended discussion, Strauss et al. (1964) propose a model of negotiation to analyse institutional relationships among different groups. In their view, accommodations and compromises within the organisation arise from interactions between groups of participants which require continual renegotiation of their position. This approach attends to the dynamic nature of hospital conflict and the fluidity of mutual boundaries but can result in insufficient attention to external restrictions on the tactics and strategies available to the main actors. The other group of actors in the fiberoptic dispute was the hospital administrators - external to the medical professionals but part of the hospital order. As I have discussed in previous chapters, their position in the hospital arose as a result of pressures to organise the hospital efficiently. A secondary role, within the brief of efficient management, was the co-ordination of the medical work of the hospital in the face of increasing fragmentation of the medical staff. Littler and Salaman (1984) write that the need for co-ordination is partly a consequence of the increasing division of labour, but specialisation and

fragmentation increase the difficulty of the task. Specialisation, however, legitimates the application of mechanisms of control to assist coordination. Fragmentation makes essential the role of hospital administrators in organising the institution as a community of separate specialties.

Institutional specialisation at the Adelaide Hospital means that tensions between specialists can be mainly subsumed beneath a rhetoric of co-operation at two levels. Firstly, co-operation is part of the professional culture of medical specialists. Secondly, co-operation is part of the aim of the hospital expressed as a corporate enterprise. As a thoracic physician said.

The concept of self-sufficiency is incompatible with the function of the hospital which tends to bring disciplines together.

At this point the discourse of professionalism and managerialism overlap. The abstract idea of the aims of the hospital extracted from the managerial discourse, supported a particular medical position but also appealed to professional and managerial values of co-operation.

By achieving a 'private solution', the competing departments re-established a sense of community with boundaries redrawn and the patient divided. As Gluckman points out with reference to his analysis of social situations, such co-operation,

shows that they form together a community with specific modes of behaviour to one another (1958:9).

The resolution of the fibre-optic dispute reinstated the idea of a community of clinical medical staff, in the end of one mind, and in distinction to non-clinical administrators. The hospital however, provided an environment to the dispute and allowed competing claims to be debated. Furthermore, the institution controlled much of the conflict by guiding the disputants through the committee

structure. The hospital structure allowed an autonomy of medical staff but it was an autonomy which was supervised by the administrators. Indeed, the solution achieved was comprehensible at an administrative as well as a clinical level. The crucial feature of settlement was that divisions and boundaries between specialist segments were evolved within the view of hospital administrators. Conflict resolution, therefore, establishes more than a community of medical specialists. It establishes an institutional community of the hospital.

The social functions of conflict have been addressed before - notably by Georg Simmel and in the reformulation of his propositions by Lewis Coser. Simmel writes that society,

in order to attain a determinate shape, needs some quantitative ratio of harmony and disharmony, of association and competition, of favorable and unfavorable tendencies (Wolff 1950:15).

Coser paraphrases Simmel and notes that:

A certain degree of conflict is an essential element in group formation and the persistence of group life (1956:31).

In this classically functionalist view, Coser argues that conflict sets boundaries between groups, establishes identity and maintains a hierarchy of subgroups. The social system is maintained and sustained by a balance of separation, unification and continuing definition. Grace de Santis reformulates this approach and relates it to medical dominance.

In essence, the high level of consensus which characterizes 'medicine and permits physicians to be professionally "dominant" is based on a value system that fosters continuous competition (1980:181).

She concludes that,

the final outcome of this elaborate system of competition which is balanced by the process of negotiation, is a network of separate but tightly knit realms of expertise (1980:231).

Conflict, therefore, for these authors is in part an institutionalised system of balance, of forming and reforming groups. The situation is defined within the rules of institutional behaviour.

The institutionalisation of conflict is an important point in this chapter and a prominent place is given to the administration, not necessarily as a dictator to impose decisions but as a mediator to see fair play. In the fibre-optic dispute, managerial expertise was directed mainly at orchestrating the disputants, rather than adjudicating between specialist realms of expertise. Adopting the medical perspective, hospital managers argued that their role was merely facilitatory, trying to supply the conditions of optimal medical efficiency. An institutional solidarity was, thereby, continually constructed. Integration of separate and different segments was achieved not only by the rules of medical behaviour but also by the administrators advocating organisational aims. Institutional arrangements to attain these ends were a means of control or authority, and the rules of medical behaviour, aimed more at colleague relationships, contributed to an overall institutional solidarity.

Conclusion

My analysis of social control within the hospital medical staff and its relationship with managerial frameworks has drawn from Freidson's proposal of two models of the organization of social control - bureaucratic and professional (Freidson 1975). A free market model included in his later work is inapplicable here and not discussed. Freidson recognises an effective collegial system is required to organise inter-specialist relationships in an accountable way.

Combining elements of both managerial and medical discourse, the eventual resolution of the fiberoptic dispute expressed such a mode of control - a 'true' professional control. Managerial or bureaucratic control is irrelevant if the medical profession can organise itself sufficiently. External control is thus continually internalised

The dimension added here is the relationship of self-regulation by the medical staff to the broader forces of the state as expressed within its institutions. It is crucial to take account of the mediation of relationships amongst specialists by the state through the agency of its hospital administrators. Furthermore, whilst this mediation is carried out in the interests of co-ordinating hospital activity, co-ordination itself implies an element of control or, at least, guidance.

This is not to say that the power of the state has been expressed overtly during the fibre-optic dispute but rather that the process of competition within the Adelaide Hospital has been influenced by control of patients and technical resources the distribution of which depended upon hospital administrators. Furthermore, this is not to argue for active collusion between government and administrators but rather that opportunities for intervention presented continually and these were successfully exploited at a distance without obviously challenging medical expertise. As Gritzer writes,

Government focus on fragmentation and the corresponding solution of more co-ordination, seeks to extend its influence without confronting the essential feature of the system (1981:278).

Resolution of intra-professional conflict was, therefore, partly a result of increasing external supervision.

Monitoring and control of resources of the medical staff which I introduced as a theme in the previous chapters, has been extended in this chapter to analyse

the mechanism of one internal dispute. Internal segmentation led not only to internal boundaries and mutual observation but also highlighted the presence of external mechanisms of control, giving rise to what I have termed a supervised autonomy of the hospital medical staff. Resolution of the dispute reflected both internal and external constraints resulting in a finer division of labour.

CHAPTER 5

UNIONISM AMONG MEDICAL PROFESSIONALS IN THE ADELAIDE HOSPITAL

Introduction

At this point in my analysis of the Adelaide Hospital, I depart from concerns with the state's allocation of resources to the hospital and their distribution among departments and direct my attention to the conditions of employment of its medical staff. I have emphasized previously the advantages of a hospital appointment in terms of public status, specialist recognition and the provision of facilities to enhance a medical career. In these ways, the medical profession was dependent on the hospital; there was, as I have noted earlier, a symbiosis between profession and state. This chapter analyses the conditions of employment determined by this relationship and, thus, the degree of economic dependency upon the state.

My main focus is on the process of unionisation adopted by the medical staff as a strategy to control their terms and conditions of appointment. In this chapter I shall present a case-study of the growth of a professional union. It is an account of uncertain and contradictory development and I shall be concerned particularly with showing the source of these characteristics. The increasing identification of hospital staff at the Adelaide Hospital as state employees, combined with a sense of individual powerlessness, stimulated in them a unified defence against what were seen as incursions by the state as employer. The difficulty they experienced was that the idea of unionism is opposed to the ideals

of various medical charters and the interests of those who are among the most articulate defenders of these charters. My argument is that the use of union activity necessary to sustain the economic standing of the medical staff made problematic the concept of professionalism espoused by its members. Contrariwise, their idea of professionalism made problematic their strategy of unionisation. Caught in this double bind and faced with increasingly adverse financial conditions, the medical staff sought to accommodate the conflicting positions.

Control over the financial arrangements and the conditions of work, that is, the terms of employment has been categorised as economic autonomy by Evan Willis (1978). Following the work of Eliot Freidson (1970b), Willis distinguishes this from judgemental autonomy which is the ability to decide the course of patient treatment, from control over the content of work (see 1978:3). The distinction is useful because, as Willis argues, failure to separate the two ideas has furthered medical claims that certain forms of financial arrangement give better medical performance (see 1978:9). I address judgemental autonomy as a separate issue in chapter seven but its conflation with the economic occurs at a number of points in this chapter as the charter of 'patient care' is invoked to support this position. The rhetoric of professionalism thus, spills over into an explicitly economic arena.

A number of authors have directed their attention to the problematic of unionisation of the professional. One of the first was Oppenheimer (1973) who challenged Freidson's notion of professional dominance with his claim that a process of proletarianisation was occurring among professionals. This was taken

up by McKinlay (1976) amongst others, and Noel and Jose Parry (1977) who concluded from their analysis of the events of the 1970s in England that,

doctors themselves have been engaged in industrial disputes which have involved the withdrawal of their labour or, at least, limiting their services to a strict work-to-contract. The outcome has been a thrust towards unionism among doctors themselves (1977:839).

The events of the 1970s in South Australia produced a similar outcome which forms the ethnographic material of this chapter. In analysing this, I shall return to the proletarianization thesis later.

Finally, I shall continue my analysis of the fragmentation of the medical staff by addressing their different employment characteristics. These cut across professional lines and distinguished, before 1971, three separate groups - the resident full-time staff who were salaried, the senior full-time staff who were salaried and the honorary staff who were unpaid. These divisions and occasional conflicts reflecting both employment and professional locations were present from the early days of the Adelaide Hospital as described briefly in the following section.

The Development of the Medical Staff

Almost from the hospital's inception there were two tiers of staff, paid and voluntary; in career terms the former proceeding to the latter in the normal course of medical training and experience. The first paid resident medical officer was appointed in 1851 to a post which proved attractive by presenting an opportunity for young or unknown doctors to establish themselves and make professional contacts for future private practice and a voluntary appointment at the hospital as an 'honorary' (see Hughes 1982). Twenty years later an additional

resident post was created and eventually the two were differentiated as junior and senior, so that the junior moved to the senior post when it became vacant. The establishment of the medical school in 1885 imposed a time limit of two years on junior residents so that with an increase in these positions, new graduates could readily acquire resident hospital status.

In 1922, the first registrar post was created as a superior to the resident staff and as specialist training schemes were established the grade of senior registrar was created. This was filled by an experienced junior medical officer with a specialist qualification awaiting a suitable vacancy in specialist practice. The climb from student to specialist had become increasingly long and arduous.

In addition, the contradictory elements of the medical profession within the hospital had been established. The importance of exclusive contacts, the attention to formal rank, the promotion within the hospital and payment by the state characterised the situation of the junior medical staff. Although 'professionals', each one had an allotted place in the hospital framework. This was reinforced by two overlapping schemes of advancement. First, for many years the junior posts remained as training positions for private practice. Second, with the increasing demands of specialisation, the junior posts became training positions for a specialty. The aim was the eventual emergence into private practice as a specialist with an honorary appointment at the Adelaide Hospital.

The resident staff, funded by the state, were a valuable asset to the honorary staff. They formed the foundation of a 24-hour service at the public hospital, supervised by the senior member of the salaried staff - the medical superintendent. They were both willing and able to look after patients for long hours at low pay and, therefore, served as a reliable source of labour to reduce

unplanned visits to the hospital by the honorary staff. Some of the boring or unacceptable 'dirty' work, was carried out by the house officers. Consequently, there was a feeling of sacrifice in relation to the work undertaken for long hours at unsociable times for low pay, albeit always with a view of better times ahead. Junior doctors chose to accept these conditions of work in order to achieve an honorary specialist appointment. Although unpaid, the rewards in status and contacts for private practice were worth the sacrifice.

In 1957 it became compulsory for all new medical graduates to spend a year as an intern prior to registration as a medical practitioner and embarking on a chosen medical career. This 'pre-registration' year in hospitals was required even if the chosen field of medicine was non-specialist and outside the hospital, for example, general practice. The practical results of this requirement were that junior doctors formally and compulsorily became a cheap source of qualified labour for the state hospitals.

Whilst the majority of medical graduates embarking on a specialist career considered salaried posts as stepping stones to an honorary appointment, the training ladder also led to a limited number of senior paid positions. Such posts did not carry quite the same status as that of honorary medical officer. Outside the hospital, salaried employment was not perceived as the same mark of success as an honorary appointment. Within the hospital, salaried specialists were not automatically permitted access to the medical staff society. The first salaried senior position was the medical superintendent which not only was a low status administrative position but was also used originally as a starting point for a career in private practice. Gradually, however, salaried senior positions were established in other areas of the Adelaide Hospital after the second world war. The list given

by Hughes (1982) of the paid medical staff in 1965 indicates the characteristics of these specialties. They were either new or technology-based and included, for example, anaesthesia, cardio-thoracic surgery, cardio-pulmonary investigation, radiology and radiotherapy. From 1965 to 1980 full-time salaried specialists increased from nearly 5% to 25% of a total specialist staff at this time of approximately 200. Salaried employment, despite its lack of traditional status became more popular as a career option for a number of reasons.

First, many of the new specialties demanded the advanced technology and facilities which could only be afforded by a state-funded hospital. Because of this, many specialties could not easily be practised in the private sector. Second, recently qualified specialists, having acquired further sophisticated training abroad returned to the Adelaide Hospital in order to "try out new techniques and establish themselves at the sharp edge of the profession" (physician). A full-time appointment offered more opportunities for research than an honorary position. In addition research and technology supplied a different but equally valid type of status on the full-time appointee. Finally, the financial security of a regular although limited income compared with the uncertainty of establishing a private practice were conditions which appealed to an increasing proportion of specialists. As general economic problems impinged on the medical profession, the fringe benefits of state employment such as the government-supported superannuation scheme, paid leave for sickness and holidays and long service leave were factors which became important and increasingly envied by the honorary staff.

Thus, the changes in the pattern of medical employment at the Adelaide Hospital occurred in movements within three separate but over-lapping areas. At the junior level the first year of low paid employment had become compulsory and

increasing time was spent under these conditions by specialist trainees. At the senior level there was an increasing proportion of the specialist staff who were full-time and depended upon the hospital for their income. Thirdly, from the early 1960s, an increasing proportion of the honorary staff whilst valuing their economic independence from the hospital changed their attitude towards unpaid time. The time spent at the hospital in the tradition of philanthropy deprived the specialist of earnings from private practice. This became a significant economic factor and led to the decay of the honorary system.

The Decay of the Honorary System

The idea of paying honorary staff for their services had been proposed at staff meetings at the Adelaide Hospital on a number of occasions in the past. In 1939 the honorary anaesthetists had requested payment for hospital sessions but on review in 1940 this request was refused, partly in view of the stringencies of World War II and partly because it was not widely acceptable amongst other members of the honorary staff. Following the war, however, attitudes changed with the economic climate. At a staff meeting in October, 1947, a surgeon pointed out that it was no longer possible to recoup easily the earnings lost in the successful establishment in an honorary position. He partly blamed the high rate of post-war taxation. He concluded that the days of pure honorary service had gone but "full-time service was undesirable, because the staff would be civil servants with no incentive" (Medical Staff Society minutes 20/10/47). Other speakers expressed fears of a reduction in staff and loss of control over future appointments should a part-time paid system be introduced. The motion to

abandon the honorary system was defeated but raised again just over a year later. Again, the anxieties expressed about a paid system related to the potential loss of executive power and the dangers of intrusion by lay administration and staff, particularly in deciding appointments. It was feared that the method of staff appointment might approach that operating at the Brisbane Hospital where the selectors were two members of the board, the medical superintendent and a trade unionist. Finally, the fear of a reduction in numbers if the honorary staff were paid was expressed as a concern of the effects on "a teaching hospital where students should have a wide range of teachers" (Medical Staff Society minutes 14/2/49). Once more the proposal for paid time was rejected.

In this immediate post-war period the perceived threat to the status and autonomy of the honorary staff counted for more than the financial gain of paid attendance at the hospital. The medical rhetoric expressed this in terms of the need for medical staff to control medical appointments and the interests of medical teaching. In the following years, however, proposals for sessional payment met with an increasingly favourable response. There were significant economic reasons for this change of heart and these became pressing in the 1960s.

The Commonwealth National Health (Medical Benefits) service introduced in 1953, known colloquially as the 'medical benefits schedule', formed the financial basis of private medical services and was, essentially, a system of government subsidies supported by voluntary insurance. Amendments made in succeeding years retained the important point that medical services were itemised and a 'common' fee recommended by the Commonwealth Department of Health. For services which could be described discretely, such as surgical procedures, this

was satisfactory but for other specialties particularly physicians it was less successful. This is reflected in the following comments:

Physicians had a difficult time because their fees were for specialist consultations and, relatively, they gave more time to this hospital. Their gross incomes were a lot less than the equivalent surgeon (Surgeon).

Most of us spent a third of a week here. Surgeons could make this up but for physicians it was more difficult. Presumably surgery was more remunerative than medical practice (Physician).

Surgeons could derive the same consultation fee as physicians but commanded a greater income from operation fees. Specialisation nominally of equal status was not reflected in economic terms. Because of the differing nature of the work of each specialty and the itemisation of medical services, some doctors were more heavily penalised than others for unpaid time at the hospital. Time spent away from private practice was more financially damaging to some specialists. Honorary physicians pressed for payment for sessions worked and sections of the other specialist staff supported them, especially the anaesthetists. "We thought it was important, particularly for someone like myself who did more than just two nominated sessions" (Anaesthetist).

At the end of 1962, in a newsletter circulated prior to a staff meeting, a motion from the 'Physicians Luncheon Meeting' asked the executive of the medical staff society "to consider if the time was not opportune for the abolition of the present honorary system" (Medical Staff Society minutes). The luncheon meeting, whilst an informal gathering, for mainly academic discussion, offered a forum for the views of physicians in general and, thus, an informal representation. The newsletter pointed out that the demands of practising and teaching modern medicine and surgery required more time to be spent at the hospital, time which should therefore be remunerated. This became an important focus for discussion

with the other teaching hospitals in South Australia and an inter-hospital committee was formed of representatives of each hospital. The results of its deliberations and questionnaires were made known in 1964 but a year previously, the honorary staff at the Adelaide Hospital had voted that the honorary system was inadequate and payment for service in some form appeared to be necessary. In 1966, the hospital Board received a request to review existing methods of staffing with the intention of achieving a sessional payment for honoraries. Many still resisted the concept but, despite misgivings, the radical change was pursued with the support of the Australian Medical Association. The reasons for the change in viewpoint were given by a past president of the association as the increase in medical insurance cover and the complexities of modern medicine because specialists were forced to give more time to their hospital visits to maintain proper patient care. He reaffirmed the value of staffing hospitals by,

part-time visiting staff who as leaders in their profession, were also available to provide services to the public in a private capacity (The Advertiser 13/9/66).

The responses of the board and the government were slow.

The demand for payment for time spent at the Adelaide Hospital became more vigorous and reached a climax in September, 1969. A motion appeared on the agenda of a staff society meeting, again originating from the physicians, expressing "grave concern" at the unwillingness of the government to consider staffing changes, especially with reference to sessional payment. The critical point made was that the medical staff were unwilling to continue under the present system and some were "seriously considering" whether or not they would seek re-appointment in 1970. The implication of this was that, if sufficiently

widespread, it would be equivalent to a withdrawal of medical services without categorising it as industrial activity which would disable areas of hospital work.

A local newspaper, *The Advertiser*, publicised the growing dispute in December and listed the medical aims as more time for teaching students and residents, more time to teach trainee specialists and encourage research and more time to treat patients. The inability to achieve these aims was due to "the increasing complexity of modern medicine" (*The Advertiser* 20/1/69).

The argument was essentially economic but could only achieve legitimate social attention when articulated in moral terms. Furthermore, as in previous disputes, this discourse was typically constituted by a cluster of related but distinct charters which included teaching and patient care. The concept of patient care was used in the same newspaper a few days later when "a collapse of care" was described by the local branch of the Australian Medical Association as the potential scenario if re-appointment was not sought by physicians.

Negotiations between the government and the honorary staff proceeded amid various claims and commentary, the physicians again supported by the anaesthetists. By February 1970 the state cabinet had agreed 'in principle' that the 'honoraries' should be paid, "it was merely a question of who accepts the financial burden" (*The News* 26/7/70). In October the government reached an agreement with the Australian Medical Association which affected over 250 specialists. From January 1971 all honorary medical officers would be employed by each hospital with individual triennial contracts at an annual half-day sessional rate of \$1650. They were also reclassified as 'visiting' medical officers.

Compensation by the state for time lost to private practice and, hence, the decay of the honorary system was the result of a trade-off between autonomy and

income. As I have argued previously, they were already indirectly dependent upon the hospital for income. Developing and maintaining a successful private practice was greatly assisted by the status mark of a hospital appointment but honorary work reduced the time available to reap the financial benefits of private practice. Sessional payment for time spent at the hospital resolved this conflict but created another. The inability to maintain total financial independence from the hospital compromised the autonomy of the medical staff. The move towards a direct economic relationship with the hospital marked a shift in the power base of the visiting medical staff. The traditional reasons for a visiting appointment at the Adelaide Hospital remained. As a senior surgeon said,

it is absolutely essential for private practice to be doing this work. It was really essential to keep your hand in practice, teaching, and access to colleagues and to gain experience which you can't outside a hospital. No individual has got the same kudos that just a few had in the past. But it is still there.

In this way, the rhetoric of medical professionalism spills over into the economic in a different way to my previous discussion. Here, it accommodates increasing economic dependency of the visiting staff within the concept of a professional, and in this case specialist ideology. Visiting appointments remained attractive within this framework of state intervention. There had been a fundamental transformation in the autonomy of this section of the medical staff of the Adelaide Hospital.

The majority of medical staff were already economically dependent upon the hospital. The full-time specialists had a small independent income from private practice but, for the junior doctors, economic dependency was total. The first postgraduate year had to be spent in a hospital and this period was greatly extended if the graduate embarked upon specialist training. During this time,

private practice was not permitted and, therefore, trainees were especially dependent upon the hospital, economically and professionally. Furthermore, they occupied a dual subordinate position being subject to both the hospital as employer for salary and their seniors as employers for recommendation to advanced appointments. Given the vulnerability of their position, the junior medical staff, in an effort to exert more control over their working conditions, eventually resorted to somewhat radical tactics by forming a union.

The Formation of SASMOA

In 1969, some of the junior medical staff of the Adelaide Hospital, together with a number of their colleagues from other hospitals in the city, joined the union which represented Public Service clerical workers - the Public Service Association (PSA). This was the first move by South Australian doctors to become 'unionised'. Whilst occurring within the context of the general radicalism of the 1960s, the specific origins of this venture lay in the conditions of service for junior staff. Later in the year about 150 junior doctors lodged a claim through the PSA with the South Australian Industrial Commission seeking salary increases and better conditions, including a basic 40 hour week. Residents and registrars considered themselves poorly compensated for the long hours worked. It was claimed that a junior resident at the Adelaide Hospital worked 131 hours per week at 53c. per hour. Their salary "was about the same as a hospital porter" (The Advertiser 22/12/69) according to the State president of the Australian Medical Association which gave its support to the claim. Reassurance was given that the 40 hour week was not to reduce doctors' hours but to serve as a basis for

penalty payments. The basic salary claim was a huge increase to \$7,460 from \$3,622 per year for the junior residents and at the other end of the training ladder, \$11,600 (from \$6,926) for senior registrars.

The idea of professional dedication, hard work and low salary with the prospect of future recompense had become less appealing. Future rewards were less certain and the immediate rewards following medical training had become progressively inadequate. Post-graduate resident life produced some comfort in a sense of shared adversity and an informal solidarity but junior medical staff began to confront the possibility that a formal industrial unity was required even in the medical context. This was not articulated as an economic argument but given the kind of rationalisation expressed by a junior doctor,

some sort of industrial negotiation was required to handle increasing infringement by medical administration and government on the practice of medicine in a teaching hospital.

The move to join the PSA was not popular even among the juniors themselves. Initially, very few felt committed to any level of industrial activity, as an early union activist said,

medical officers were naive. They thought that many problems could be solved by gentlemen's agreements. Very early they discovered that this wasn't the way industrial relations were being run.

Joining a union seemed to many to be 'unprofessional'. More pragmatic doubts were raised over the issue of representation. Within a large clerical union, doctors feared that they might be subordinate to the directions of others who bore no allegiance to the idea of medicine as a profession. In particular, the medical officers could become involved in the wider union movement. Anxiety over such a possibility was expressed in this comment by a junior medical officer,

During a threatened strike the Australian Workers Union was going to support the residents. This sort of thing might reverberate!

Despite these reservations the PSA performed creditably as industrial advocate on behalf of the junior doctors. Initial pay rises were to \$4,500 (1970) and by 1972 to \$5,600 for a junior resident. Ironically, the first claim in the industrial court for a pay increase for junior staff coincided with the announcement by the honorary physicians of their claim for sessional payments. The PSA thought it important to publish a disclaimer to any suggestion of collusion and thus pre-empt any adverse publicity which might portray all doctors as being concerned only with money.

Membership of the PSA was, to some extent, an easy option - the PSA being seen as a 'soft' or non-militant union - but it was soon realised that a broadly-based union might be insufficiently responsive to recognise the 'special needs' of doctors, which were considered unique.

Our concerns were not related to those of other groups. It was important to realise that there was no relationship between our profession and all the other people who worked in this hospital (junior doctor).

The idea of a separate association reflecting special medical needs became more widely debated in the early 1970s. There were, however, inter-hospital differences. The Adelaide Hospital favoured a separate organisation whereas the juniors in the other teaching hospital were satisfied with the PSA and its advocacy.

The junior staff at the Adelaide Hospital felt that their conditions were more rigorous and had not been taken sufficiently into account by the PSA. In addition, the growing interest of senior full-time staff in industrial representation influenced opinion in favour of an association distinct from the clerical union.

The inaugural meeting of the South Australian Salaried Medical Officers Association (SASMOA) occurred early in 1974. After adopting a constitution with the help of the industrial advocate of the Australian Medical Association, it applied to the Industrial Commission for registration as the representative body

for hospital medical officers. Opposition from the PSA was immediate and received a sympathetic hearing from the Industrial Registrar. In particular, SASMOA's claim of a 'distinct community of interests' for the medical profession was questioned. The Registrar said that salaried medical officers in government hospitals were 'servants of the public' and as such formed an integral part of the overall community of 'public servants' (see Industrial Commission, No. 109 of 1974: March 1975). The Registrar concluded that 'breakaways' from responsible organisations should not be encouraged. The extent of 'the breakaway' was minute. The total membership of the PSA was over 17,000 of which 212 were medical and 42 of these sought to resign. The PSA, however, was jubilant at the Registrar's rejection of the application as the headline, "Medicos Breakaway Bid Fails" in the Public Service Review of April 7, 1975 illustrated. Restraining the medical profession in this manner, reflected both government and PSA interests. For the government it was easier to deal with doctors as public servants through the well-established machinery of the PSA than through an independent medical organisation. For its own part the PSA was reluctant to lose a new and potentially lucrative field of membership.

The ensuing legal battle between the PSA and SASMOA for control of the medical field came down to questions of membership and constitution. Despite resignations from the PSA, the membership of SASMOA did not represent a majority of salaried, medical officers and its constitution, although similar to that of the PSA, did not fulfil all industrial requirements. The majority of the members of SASMOA at this time were senior full-time staff and a large proportion were based at the Adelaide Hospital. The efforts of the president of the embryonic union were directed towards attracting the junior doctors, especially

from the PSA, and uniting the senior staff of all the hospitals. This meant 'softening' the more confrontational stance which SASMOA appeared to have adopted. A newly-developed affiliation between SASMOA and the local branch of the Australian Medical Association helped to construct for SASMOA an image which was acceptable to the medical establishment at large. The constitution was modified and a new claim for recognition put before the industrial court. This, in the end, was successful. In 1977 SASMOA achieved registration and eventually became the organisation exclusively representing salaried doctors.

Early gains were immediate, hinging on the establishment of the payment for overtime hours. At the Adelaide Hospital the attainment of overtime payments was expected to be a just reward for unsatisfactory conditions which were considered to be undeservedly harsh. However, in practice, overtime payments were not easily obtained. Documentation of overtime hours was necessary and required a confirmatory signature by a senior specialist who had, in fact, little idea if the hours had been worked and usually some reluctance over accepting the idea of 'overtime'. Two strategies developed, one of which was collective and the other, individual. First, it became known which seniors would refuse to sign overtime claims and they were avoided - a collective evasion of traditional power and attitudes. Second, despite a grudging acceptance of this chore by some seniors, a proportion of juniors forfeited overtime claims for fear of a negative reaction - an individual strategy practised by those with no particular commitment to the idea of collective action. Future jobs were dependent upon reports from senior medical staff who were not to be antagonised lightly.

The issue at stake was the 'traditional' definition of a doctor. The reasons for the refusal of senior staff to sign for overtime payments were expressed by a visiting medical officer criticising SASMOA.

I've rather resented their approach - their initial approaches in particular to overtime for residents. I think it's disastrous. That to my mind is not being a doctor. You work until you finish and that's that. You don't think of overtime as a doctor.

The concept of overtime was attacked in similar terms by another visiting medical officer:

As a doctor one has a duty to patients, obviously, and a responsibility to treat the patient to the best of one's ability at the expense of one's personal time, family and all the other things that other people take for granted. If the patient needs something you do it whatever the time. Full responsibility is still there. That's just, as far as I'm concerned, being a doctor.

The establishment of overtime implied a limited commitment to the patient which was regulated by time and industrial awards rather than the demands of patient care.

The establishment of a second medical school in the city served to complicate the overtime issue. At first, posts at the new hospital were filled by graduates from the old university but eventually the number of medical graduates increased at a greater rate than the work available in both hospitals. This revolutionised the way work was rostered. The hospital administrators could reduce the amount of overtime. Wage increases and penalty payments negotiated by SASMOA for junior doctors had made them expensive employees. From the mid-1970s the Adelaide Hospital had been experiencing increasing budgetary pressure from the government to reduce expenses. By 1979 the hospital's total operating costs were \$73.3 million of which \$6.5 million were attributable to medical salaries (almost 9%). In that year 'cost-saving initiatives' having a

'significant effect on the level of expenditure' included the reduction of overtime payments to medical staff. A further cost containment project with far-ranging implications was the deletion of 13 training positions for medical staff.

In 1979 the state government announced that in future medical graduates could not be guaranteed intern positions. In effect the government was saying that not all Commonwealth-funded graduates could expect to become state-funded interns. In the interests of economic rationality the state government had abandoned a commitment to provide the first year obligatory for every graduate. A flurry of correspondence ensued between the medical students association, SASMOA, the university and government. SASMOA, adopting a low profile, proposed that junior doctors should not request a pay increase and should, perhaps, accept a reduction in salary. There were rumours that a salary increase might result in a reduced number of appointments at all levels. Other rumours suggested that the number of jobs was fixed and nothing in the way of salary claims would influence this. SASMOA now faced the full implications of industrial negotiation and bargaining. Despite the government's reluctance to guarantee appointments to all applicants, there was an informal suggestion that refraining from routine salary claims might elicit a more flexible response to employment. Routine industrial activity was withheld and full employment was achieved by those applying for the intern year.

SASMOA's decision pleased the members. As one of its representatives declared, "SASMOA had gone from the worst union to a responsible, thinking one that made the right decisions." The 'right decision' was a compromise, forced by a government balancing the cost of employing junior doctors against the number employed. By forsaking an increase in salary, SASMOA had gained the

appointment of all new graduates as interns and earned the gratitude of trainees, who perceived a 'responsible, thinking union' as one which did not threaten the progress of a professional career. The activities of SASMOA, as a union, had been undermined by the practical considerations of a medical career. Failure to achieve the hospital appointment meant not only no salary but also no registration as a medical practitioner. The strength of the government's position lay in the absolute necessity of hospital employment for the first post-graduate year.

The Strike Threat

The results of the 1979 decision to withhold pay claims did not emerge fully until 1983. In the previous year, changes in rostering by the medical administration appeared to threaten overtime payments and for the first time strike action became a consideration. SASMOA calculated that since 1977 the base salary of junior doctors had slipped by 35% and overtime had been some compensation for this. For months, negotiations for a pay increase had elicited no response from the Public Service Board (the controlling body of the public service) and the introduction of a Federal wage pause presented the board with the opportunity to procrastinate indefinitely. In reality, the wage pause guidelines allowed junior doctors to claim an increase of over 18% to equate with a claim by metal-workers, an ironic position in view of their reluctance to identify with other unions. Furthermore, it was probable that the doctors could prove exceptional circumstances because of their 'voluntary' wage pause and achieve an award above this level.

After continued unsuccessful negotiations with the Public Service Board, SASMOA put the problem to a general meeting of its members and, by a very narrow majority, it was agreed that industrial action would be pursued.

Until this point it seemed that the PSB had never really taken us seriously as an active union with strike potential. A strike was threatened to precipitate some sort of offer so that for once we wouldn't have to go to court - which was expensive - just to prove a point patently obvious to both parties and the government (SASMOA representative).

The important point made to the Public Service Board was that SASMOA was intent on employing all the tactics available to a trade union. Strike action was carefully planned with full awareness of its consequences. Nevertheless, this level of industrial action was not a palatable move and opposed by the visiting medical officers and expressed in terms of traditional medical charters.

I don't believe doctors should ever strike, simply because patient care has to be affected,

and

We can't afford to go on strike - we start killing people.

As significantly, the seniors could apply training sanctions which might influence a career.

Any junior on my unit who goes on strike can't expect any teaching from me (Visiting Surgeon).

Paradoxically, actions similar to those of the junior doctors had been undertaken at various times by the honorary staff but couched in different terms. During their drive for payment for hospital sessions described earlier in this chapter, pressure was brought to bear by the honorary staff in terms of not re-applying for appointment. The phraseology of industrial militancy had always been avoided.

In contrast to the visiting staff, full-time specialists were generally sympathetic to the cause of the junior doctors. Not only had the specialists been

part of the movement for the formation of SASMOA but they, too, were economically vulnerable depending for their major source of income on a hospital salary. They had vested interests in supporting SASMOA's activities, some of which were devoted to wage negotiations for staff specialists. It is doubtful whether a majority of the full-time specialists would have embarked upon strike activity, but a side-effect of the proposed action was the reinforcement of old prejudices. It appeared to visiting medical officers that the full-time specialists were embracing an industrial attitude which could be interpreted as unprofessional. In effect, the full-time specialists appeared to the visiting specialists to be substantiating the image of paid public servants.

Opinion amongst the trainees was not totally supportive of SASMOA which was indicated in excerpts of letters published by the association, such as:

The increasingly industrial orientation and the steady progression in militancy in the terms of the Newsletter is upsetting and at times offensive (SASMOA Newsletter, February, 1983)

A group at one teaching hospital refused to take any part in strike action and there were hints at other hospitals that juniors involved in such activities would receive a poor assessment of their clinical work, a threat which limited their enthusiasm for this industrial activity. In addition SASMOA suffered from its mixed and not totally representative membership. Perhaps 50% of medical staff across the board were members, but this was mainly constituted by juniors and full-time specialists. There was, however, a small but determined membership core which intended increasing medical and public awareness of the seriousness of the situation. Letters were to be sent to outpatients and elective admissions advising them not to attend hospital because of the proposed industrial action.

The message was that SASMOA was capable of behaving like a trade union and initiating strike action.

In the event, the strike did not take place. Immediately prior to the event, it was overshadowed by a State disaster. The government met to discuss not only the medical crisis but also the bushfires which had started throughout the State. Assurances were given to SASMOA that an offer of a 20% salary increase for trainees and 10% for full-time specialists would be guaranteed. That same evening, the SASMOA council decided that during a wage pause and a state emergency the public would perceive the offer as enormous and concluded that a strike was not politically feasible. The government was therefore assured that during the bushfire crisis no industrial action would be taken and the hospitals would be fully staffed.

Although SASMOA refrained from industrial action, the offer of 20% and 10% was considered unacceptable. Further claims were pursued in the industrial court which alarmed some members who thought that enough had been achieved. The court appearance resulted in an award of 35% to juniors and an interim award of 14.5% to specialists. To defuse comment on the size of the award SASMOA published in its March Newsletter part of the judgement of the Full Industrial Commission. The decision rested essentially on the fact that none of the junior medical officers had received an increase in salary since 1977. Consequently, they were by far the lowest paid in Australia and if a wage pause were to operate in relation to them it must be on a just and equitable basis. The Commission judged it totally unfair for the doctors to continue to endure the disadvantage in salary. SASMOA had, in its terms, pursued and achieved the principle of 'comparative wage justice' despite wavering in its members' resolve.

The 1983 controversy, however, illustrates a number of SASMOA's continuing problems. First, the union's representative status was limited. It is difficult to obtain accurate figures for the number of medical officers who were eligible for membership at the time but, when numbers are at a high level they probably comprise only 50% of potential members. The association could never be said to represent a large majority. Second, SASMOA is composed of different groups with the greatest proportional membership from the full-time staff (approximately 60%). These categories are defined by employment as full-time, visiting, junior and other medical staff, categories which disagreed over industrial questions such as overtime payments and strike action.

The problem for SASMOA lay in the contradictions and ambiguities of the employment modes of the medical staff. The full-time medical staff, in Weber's words 'secure in a bureaucratic position', were more willing to adopt routine industrial tactics in an employer/ employee relationship. The junior staff, whilst willing to use such tactics at an economic level, were partially constrained by influences applied at a professional level. It should be recalled that careers of junior doctors could be influenced by the opinions of the seniors. Apart from the reluctance of seniors to support industrial activity and awards, the certification of adequate training by medical administrators discouraged militant action. According to a medical administrator, prior to 1974 interns received at least 100 hours a week practical experience (Heath 1979). From 1977 this was reduced by industrial awards to 68 hours, and later to 48 hours per week. As Heath interpreted the result,

this is posing a problem for the medical administrators who must certify that the interns in their charge have had adequate practical experience to warrant full registration (1979:12).

The potential strike of 1983 provoked more than a salary increase. A reassessment of the implications of unionism was forced upon all levels of hospital staff. By their industrial tactics in 1979 and 1983 the leaders of SASMOA increased their awareness of and expertise in the area of industrial negotiation and their members began to accept a new relationship with the state as employer. Attempts to control their conditions of employment, however, were problematic. Industrial efforts to achieve a pay rise focused attention on the legitimacy of strike action which conflicted with accepted medical charters and contradicted fundamentally the traditional and medical construction of 'being a doctor'. Although pay increases were legitimately awarded in the industrial court, the new *modus vivendi* required adjustments. Full-time specialists had to endure the criticism of their visiting colleagues and regrets were expressed by some juniors.

It's a pity that every fine detail is covered by an award somewhere. There are a lot of things spelled out in an award that I think we would have been happier if they had been left as a gentlemen's agreement (Registrar).

At the time of SASMOA's inception, the arguments had been based upon the premise that doctors were different. Now, approximately 10 years later, it was argued, "we're saying we're the same as everybody else" (Registrar).

The Senior Full-time Staff and Private Practice

Despite the enthusiasm of full-time specialists for the formation of SASMOA, membership of the union produced little immediate change in their conditions of employment. Salary increases were negotiated on their behalf as part of combined claims in the industrial court and the results flowed on to the visiting staff. The initial increases though of the same order (12% over two

years), slightly favoured the junior staff. In 1979, two events transformed the employment conditions of the full-time specialist staff.

First, the Medical Officers Award, to take effect from 1st June 1979, included a provision for 'on-call' payments to full-time senior medical staff. This meant the payment of a fixed sum of nearly \$40 for a week-day night and \$70 at the week-end for the inconvenience of being available whether called or not into the hospital. The question of overwork for juniors had been settled in favour of overtime payments but this was the first time that senior doctors had established a need for payment over and above their salary. Notably there was no question of hourly overtime payments as such. The charter of patient care conflicted with any concept of regular working hours but on-call payments were a recognition of out-of-hours responsibility, a somewhat different concept. For the first time attendances were set down on a fortnightly time sheet so that absences from duty, on-call periods and so forth were recorded. This provision was an unforeseen consequence of the award. The concern of some staff specialists was the increased monitoring of hours worked by medical administrators. Their unease was accentuated by a second event in 1979 which eventually led to administrative control of the private practice of full-time senior medical staff.

Full-time specialists had the option of private practice up to a maximum income of 25% of a senior director's salary in addition to a full-time hospital salary. Private practice could be conducted inside and outside the institution but the total income was used for calculations. Service fees were paid to the hospital by the specialist and excess earnings over the allowable 25% were to be donated to the Commissioner of Charitable Funds (the trustees of donations to government institutions), such donations to be used for non-budget equipment,

research fellowships, library acquisitions, and so forth. For some time this combination of public employment and private practice had been regarded by the public service administrators as an idiosyncrasy, since there were few, if any, other full-time government employees with such an arrangement. A common complaint was that a salary was already being received for work at the hospital and hence additional fees from private patients constituted a 'double' payment. The visiting staff were unhappy about double payment and competitive excursions into private practice outside the hospital continually provoked a particularly vigorous opposition, which is examined with reference to anaesthetists in chapter six.

The state administration was also concerned about the extent of private practice conducted by full-time specialists because they saw a potential source of untapped revenue. First, the full-time specialist received the benefits of excellent facilities provided by the state which were only partially recompensed by service fees. Second, certain groups of specialists within the hospital used funds from their private practice for their own departmental purposes when they might have been used by administrators to reduce the hospital budget in other ways. The third point, one of particular irritation, was the fact that the total income from private practice was difficult to assess. The donation of excess earnings to the Commissioner of Charitable Funds relied heavily on individual honesty. Mechanisms to increase monitoring of private practice, such as requesting statements of income, were considered less than effective by the administrators. The Public Accounts Committee (PAC) revealed that for the financial years ending June 1976, 1977 and 1978 only about six specialists had donated to the Commissioners of Charitable Funds. The committee concluded that,

Present arrangements are not being enforced and do not provide for control over the extent of such practice and could result in the provision of

additional resources above needs (Public Accounts Committee Report 1979: 184).

Apart from lost revenue, the Public Accounts Committee pointed to a defect in the principle of private practice. A random check of privately treated patients (July 1977) revealed that only 35% were referred to a named specialist. In a sense, the remaining patients were patients of the hospital who happened to have private insurance. Fees should be paid to the hospital rather than to individual practitioners. The committee recommended that,

all accounts for specialist fees charged to private patients be rendered and collected by the hospital with the specialist being paid a percentage of such fees, if necessary on a sliding scale.....This would also obviate the need to raise charges against specialists for the use of hospital facilities. Additional funds from these earnings should be identified and made available to the hospital for research and equipment (Public Accounts Committee Report 1979:193).

As the PAC was motivated by what it perceived to be "serious inadequacies" in the control over private practice in government hospitals, it was determined to deal with private patients, in the same way as public patients, as if they 'belonged' to the hospital. All accounts would be rendered by the hospital and the full-time specialist would receive a proportion of the income.

There was another attempt in the same year (1979) to claim excess private practice funds. All full-time specialists were requested to donate all excess earnings from private practice as per their conditions of employment. SASMOA intervened to imply that bureaucratic inefficiency was the major problem and dissociated itself and its members from 'past inconsistencies and maladministration'. It also cited legal opinion that the recovery of past excess earnings could not be enforced. As the PAC realised, the only certain means of access to the private practice earnings of full-time specialists was control over the entire process.

At the end of July 1979, there was a special general meeting of the full-time specialists belonging to SASMOA, and the single item on the agenda was "Private Practice Rights for Full-Time Specialists". Discussion revolved around details of a new scheme which had been proposed in a letter from the South Australian Health Commission, consisting essentially of a detailed scheme based on the PAC conclusions previously cited. The meeting accepted these proposals by a small majority with the proviso that modifications should and would be made later. The proposals, however, were soon found to be non-negotiable. The acceptance of what were to be radical changes in the organisation of full-time private practice was influenced by rumours of the possibility of private practice being withdrawn altogether if the proposals were rejected. At the time, as part of the Federal government's efficiency campaign, the arrangements which allowed private practice in public hospitals were being examined by the Jamison Commission. The Jamison report later concluded that,

in the light of all circumstances and the evidence, the commission believes that steps should be taken to phase out this system (1980:77).

Aware of this general feeling, the majority at the meeting did not want to precipitate the loss of the limited private practice available, and, thus, voted for its control by the administrators in each hospital.

The management of private practice accounts gave control of the total salary earned by staff specialists to the state. The administrative apparatus of the hospital took over the billing of patients in the name of the doctor concerned. Payments were received by the hospital, contributions to expenses, equipment fund and so forth deducted and the remainder paid monthly to the medical officer. Surplus funds were paid into a trust fund, administered by specialist staff for the reason given bluntly by the Public Accounts Committee, that,

It is a fair bet that if the doctors themselves administer the trust fund then they will keep an eye on each other and ensure that it is administered honestly (Public Accounts Committee Report, 1979: 191).

Of equal importance for the hospital, capital expenses could be defrayed, at least partially, from private practice resources deployed for such purposes from the newly-created equipment fund which became important in the fibre-optic dispute (chapter four).

Whilst the income from private practice was a welcome addition to salary, opposition to the scheme was not expressed in economic terms. Given the attitude of visiting specialists, health administrators and the Jamison report, this would have been a difficult argument when private practice was still permitted. Ironically, the government now saw the benefits of retaining private practice. The medical protest which did occur was not only muted but also articulated in charter terms - in this case the doctor-patient relationship. The complaint was that the hospital administration had inserted itself in the economic arrangements between doctor and patient. The previous system of direct financial exchange was held to reflect the special nature of the doctor's relationship with the private patient. This relationship would be adversely affected by the new arrangements. The private patient, it was argued, in contrast to the public patient, had a specific relationship with the doctor rather than with the hospital.

There are three points worth emphasizing about this protest. First, following the argument of Willis noted earlier in this chapter, the medical discourse of professionalism expands to incorporate the economic. The medical view of the personal relationship between doctor and patient was that it should be expressed at all levels including both medical and financial. In this way, not only was the relationship individuated but both doctor and patient were freed from

their respective restraints. The doctor could be seen to be employed by the patient not the government and the patient could choose the doctor rather than have one allocated by the government. The autonomy of each was reflected and consolidated in the economic relationship. This flew in the face of the evidence from the Public Accounts Committee that 65% of privately insured patients were not referred to a specified doctor.

The second point follows from the first and underlines the special nature of private patients. The purpose of payment was that the patient might gain the best medical care. Indeed, it was often expressed that they were entitled to the best in medical care. By implication the best in medical care was defined by the demands of private patients within the hospital as much as outside. The access to private patients by the full-time staff reflected the definition of status embodied in a visiting appointment. Both were measured by private rather than public practice.

Thirdly, the access to private practice, separated the full-time staff from other state employees and, thus, preserved for them a special place in the hospital order. It distinguished them as not completely public servants, as, at least partially, outside the bureaucracy. As Fielding and Portwood (1980) argue the nature of the clientele is a significant feature of the analysis of 'bureaucratic professions'. This serves as a benchmark for determining the degree of bureaucratisation. More specifically, the critical variable is,

the extent to which a profession has negotiated and maintained the privilege of handling private clients in normal working hours (1980:49).

The complex intra-professional differences at the Adelaide Hospital gave rise to an internal gradation of 'bureaucratisation'. The junior full-time staff had no rights to private practice, the senior full-time staff had rights to 25% of a director's salary and visiting staff had unlimited rights. Unfortunately, Fielding

and Portwood fail to take account adequately of the collective political processes which secure these positions on the continuum. SASMOA had maintained the privilege of a limited private practice for senior full-time staff by accepting new conditions. The cost to the full-time specialists was a loss of control over the financial process. In effect, SASMOA had agreed to a more documented surveillance, by the finance department, of this portion of the income of full-time specialists.

It is important, therefore, to recognise not only the economic significance of private practice but also its symbolic role in the issue of medical autonomy. For full-time specialists, the larger part of their practice depended upon a clientele provided by the state. They were likewise dependent for the greater part of their income upon the state. Thus, limited private practice permitted a degree of freedom from state control over both patients and income. Nevertheless, as the Public Accounts Committee pointed out, a significant proportion of private patients were referred to the hospital, not to the doctor. In this way the state provided most of the private practice clientele as well as all of the facilities. The concern expressed by the Public Accounts Committee was not only that revenue was being lost to the state but also that the loss was attributable to a 'complete lack of control' of private practice in government hospitals. The result of the SASMOA vote was that a mechanism for control was written into a formal industrial agreement. The doctors in one small department but so highly specialised that the State depended upon its services were so incensed that they all changed to visiting status to avoid these restrictions. The remainder, less confident of arousing public emotion, fell into line. The days of agreements amongst gentlemen were gone.

SASMOA as a White Collar Union

From the formation of SASMOA, its organisers had to attend to two major problems common to white-collar unions. First, the division of the hospital medical staff into three levels of employment - junior, full-time and visiting specialist - presented problems of unity. Throughout this chapter I have analysed these groups as separate categories to continue my treatment of the hospital medical staff as a loose federation of segments. This was justified by the different conditions of employment of each category of staff. The difference resulted in varying grades of financial dependence upon the hospital. In economic terms there was also a gradation of medical dominance among the three groups. This was compounded by the training hierarchy. In the final analysis, status was inversely related to the degree of dependence upon the state for income. The problem of unity always weakened any resolve of SASMOA. Most of the industrial agreements gave ground to an increasing intrusion by the state. Increased monitoring of hours, private practice and so forth resulted from the limited tactics of SASMOA. The reason for this lay in the second problem faced by the association.

SASMOA had never been truly representative of all the hospital medical staff. In addition to weakening a possible unified approach to any industrial problem, the reluctance of doctors to join SASMOA highlighted a fundamental conflict. Many were concerned that the tactics of industrial negotiation would contradict the traditional ideas of professional behaviour. There was a reluctance to accept a commitment to an organisation whose activities might compromise patient care, teaching and the doctor-patient relationship. The tactics of an

industrial strategy were incompatible with the charters of professionalism. Because of this hesitation to embrace totally an industrial philosophy, the potential of medical unionisation remained unfulfilled.

Sociological interest in the problematic of white-collar unionisation was provoked by the work of Lockwood (1958) and Blackburn and Prandy (1965) following that of Wright Mills (1956). Lockwood examined the changing situation of the bank clerk and identified three important elements for unionisation - the market situation, the work situation and the status situation. The market situation comprised the source and size of income, degree of job security and opportunity for upward occupational mobility; the work situation - the position occupied in the division of labour; the status situation - the degree of prestige attributed by society. He argued that because the clerk was more privileged than the manual worker in all three areas, there was thus no similarity of perceived class position, and offered this differential of social perception as an explanation for the low level of unionisation amongst various white-collar workers. He concluded that variations in the degree of unionisation were related to variations in the work situation, and that variations in the character of unionisation were related to variations in the market situation.

It is appropriate to compare SASMOA's early history and Lockwood's criteria. Certainly, the junior doctors in the lowest strata of medical labour keenly sought SASMOA's formation. However, SASMOA was equally supported by their full-time seniors who were secure in permanent posts without the need for occupational advancement. The opportunity for salary increases clearly influenced many doctors in the move towards unionisation, but conditions of work were the important motivation for the industrial activity of others. Conditions of

work were related to the degree of control by the state as employer. Many doctors sought in SASMOA an organised counter to state intrusion, and therefore a means of preserving professional autonomy. The immediate difficulty was that medical charters of patient care contradicted any union call for strike action. Without overt industrial action however it was difficult for medical staff to press for changes in conditions or salary with any force and to maintain their autonomy.

The tension between medical notions of professional behaviour and union activity remained problematic for SASMOA. The degree to which this tension was resolved in favour of unionism could be estimated by a scheme contrived by Blackburn and Prandy (1965). This work is a refinement of the early pioneering work in this field by Wright Mills (1956) and Lockwood (1958), particularly insofar as they avoid the tendency to an individualistic perspective and lay some stress on representative organisations. They summarised the attachment of an organisation to union activity in the neologistic term - unionateness - which they defined as,

a measure of the commitment of a body to the general principles and ideology of trade unionism (Blackburn and Prandy 1965:112).

The degree of unionateness could be gauged by examining its commitment to seven important elements which I apply in turn to the medical union. SASMOA, like its original competitor, the PSA, did not call itself a union. It was distinguished from manual unions by its title of 'association'. However, together with other unions, it was registered in the industrial court as the recognised negotiating body for salaried medical officers. In maintaining an identity separate from those of clerical and manual workers the Association has still not become affiliated to the combined union body in South Australia. The disadvantages of a separate identity were pointed out in the presidential address of 1985. It was

emphasised that affiliation might present opportunities to bring influence to bear on other groups and unions, and the move to affiliate was therefore recommended - a significant change in attitude.

Blackburn and Prandy's fourth criterion was whether or not the association had links with a political organisation. The orthodox position was expressed in the SASMOA report of 1985:

We have always in past years attempted to remain 'apolitical' except in those instances where we felt obliged in the interests of our members and the practice of good medicine to make comment. Our ability to maintain a non-political stance has been largely due to our *raison d'être*, i.e. to be responsible for the conditions of employment of our members, in this rather well defined and less expansive role we have perhaps been more fortunate than the A.M.A. (SASMOA Newsletter 1985: 3).

There had always been a careful relationship between SASMOA and the AMA. The fledgling organisation had originally shared both the premises and industrial advocate of the older association. Indeed, it has been argued by the PSA that AMA support of SASMOA was an inspired effort to win salaried medical officers back into the ranks of the AMA to present a united front in medical politics. The AMA was the political voice of doctors in Australia and, it is fair to say, formed a lobby representing the establishment 'right wing'. Its role could also be interpreted as industrial in a limited sense. It argued the case for increases in fees for private practitioners with the government. Thus, it helped to determine their income. However, because its members were mainly private practitioners, it never had a sufficiently representative presence within state hospitals. SASMOA, on the other hand, offered an alternative to the conservative position of the AMA and could be seen as 'radical' in its adoption of union activities but 'centrist' in its politics; that is, it could be 'apolitical' and take the moral high ground. Indeed, SASMOA only adopted a political attitude within the stated charter of 'the

practice of good medicine' which, in itself, could be viewed as a responsibly professional stance.

SASMOA's independence from employers for purposes of negotiation was another factor which presented difficulties for unionateness. The association was composed of categories of medical staff who not only had opposing interests, but the jobs of one segment could also depend upon the opinions held by another segment. The immediate employer of full-time juniors and seniors was the Adelaide Hospital. The crucial figure in employment was the medical director who, as a member of the full-time salaried medical staff, was eligible to join the same industrial association as the juniors. The other important figures determining the fate of junior staff were the senior members of the full-time and visiting clinical staff who, whilst not involved in payment of wages, were empowered to make recommendations on the appointment of trainee specialists. Full-time senior staff and later in its history visiting staff were entitled to join SASMOA. By achieving sessional payments, visiting specialists could be classified as salaried employees, as some had feared in 1970. This mixed composition constrained the association in its protection of members' interests and in collective bargaining. Indeed, in 1989, when industrial activity was considered by full-time specialists, it was thought possible that visiting specialists might take over their work. Collective bargaining became progressively more necessary but, paradoxically, more difficult to achieve.

Fragmentation of the medical staff reflected within SASMOA threatened the degree of militancy it could exercise which, according to Blackburn and Prandy, is,

the extent to which an organisation will go in asserting the interests of its members against employers - in fulfilling its function as a trade union (1965:114).

SASMOA as an organisation was prepared for strike action but only formally fulfilled this criterion. The real issue was whether or not its members were prepared to strike. The ever-present medical charter of patient care allowed rapid resolution of the events of 1983. The criterion of militancy addresses the position of the leaders whereas the crucial point was less readily defined - the willingness of members to follow militant leaders. The degree of support for SASMOA's strategies, in general, reflected the differing aims of the association's varied membership and their different conditions of employment. The aims of the association's officers were not necessarily in accord with those of all its members and the members' commitment to the more radical implications of unionisation was, at best, unreliable.

The Problematic of White-Collar Unionisation

The aims of white collar unions have been problematic for decades. Wright Mills (1956) argued that, for white collar unions, economic struggle was no different from that of wage workers. He remarked that,

to most members, the union is an impersonal economic instrument rather than a springboard to new personal social or political ways of life (1956:309).

Blackburn and Prandy (1965) drew the same conclusion. Bain (1970), however, takes a different perspective, and writes that,

white-collar workers value trade unions and join them not so much to obtain economic benefits as to be able to control more effectively their work situation (1970:188).

The need for an organisation to represent medical officers in industrial matters had apparently been provoked by a deteriorating economic position. However, this was not merely an economic protest but was also a response to changes occurring in the traditional medical way of life.

Part of the original scenario of being a junior doctor was to be resident in the hospital. Indeed, until late in the 1980s, the first year pre-registration jobs were compulsorily resident, with resident medical officers being continually available for the needs of patients and seniors, a situation with important social implications. Resident staff led an almost monastic life centred upon their seniors, the hospital and its patients. The historian of the hospital, writing of former times, suggested that the plunge into matrimony should be deferred until this important first year was over (see Hughes 1982:107). From the 1960s, the increasing number of junior doctors marrying at an earlier stage in their careers led to increasing pressure to define acceptable non-working hours away from the hospital. Thus, social factors reinforced the economic argument of inadequate compensation for long work hours.

Prandy, Stewart and Blackburn (1983) argue, in their study of the growth of white collar unions, that analytical attempts to divorce economic from social factors are unsound and my evidence supports this conclusion. Social factors were of fundamental importance in SASMOA's formation both in the changing social demands of the medical staff and their adherence to traditional medical culture. A special and separate union (an association) was self-consciously formed to present the medical viewpoint because of the 'special' nature of the professional commitment. No common ground was seen in terms of solidarity with the trade union movement. On the contrary, the aim was neither to be a small but active

part of a large union, nor to support other unions in their struggles but rather to produce a singular association expressing singular medical needs. As Rosemary Crompton (1976) argues, white-collar unions

represent, and are certainly perceived by their members as, a very different approach to collective bargaining than that of trade unions (1976:423).

The rhetoric of professionalism modified SASMOA's union activities and created an ambivalence which was problematic for the pursuit of industrial gains. There was limited agreement regarding the methods to be adopted in pursuing industrial claims. Any identification with the wage-worker, whatever the reality of medical employment, was unpalatable.

Oppenheimer (1973) in his analysis of the changing economic position of professionals in general, adopted the idea of proletarianisation as an explanatory framework. By proletarianisation he meant the tendency towards an ideal-type, characterised by a form of work where there was an extensive division of labour, the conditions of work were not determined by the worker, the primary source of income was a wage and the worker moved toward collective bargaining to address deteriorating standards. This occurred, according to Oppenheimer, with the growing incidence of employment within bureaucracies.

In short, bureaucratic organisational structures lead to proletarian conditions of work and, in turn, defensive reactions which can be considered the beginnings of a working-class consciousness (Oppenheimer, 1973:213).

McKinlay (1976) takes up this argument of proletarianisation through bureaucratisation. Both writers seek to ground their Marxist categories of analysis more firmly by an explicit reliance on concepts developed by Max Weber. However, despite the increasing bureaucratic and employee status of all grades of medical staff, there was no evidence of the development of a working-class

consciousness within their ranks. SASMOA was formed to achieve and maintain social and economic advantages rather than to serve as an agent of political change. Indeed, preservation of status and prevention of change were the aims.

Lockwood (1958) makes the point that,

it is important to realize from the beginning that action in concert, while obviously an expression of group consciousness, is not necessarily an expression of class consciousness. There is no inevitable connection between unionization and class consciousness (1958:137).

Rosemary Crompton (1976) claims that one of the problems of white-collar workers is that they carry out the functions of both labour and capital, and her approach to the analysis of white-collar unions reveals considerable ambiguities in the class situation of white-collar workers. This claim was reflected by the membership of SASMOA which had no intention of redefining their class situation vis-a-vis other workers. Empathy with manual unions, the union movement or the Labor Party was distasteful to the majority of doctors. Despite the medical staff experiencing an increasing 'industrial' control, their behaviour was based upon a perceived elitism rather than subordination.

Notwithstanding the inadequacies of any thesis which argues that the medical staff are moving towards proletarianisation, the employment situation of the medical staff had altered and an industrial association had been formed. The medical staff had imposed upon them conditions by which they could be increasingly defined as employees and, therefore, proletarianised in economic relationships with their employer. Their actions and reactions were, however, essentially conservative, aiming to maintain distinctions and status of even within the profession. The formation of an industrial association perpetuated external and internal differences. SASMOA's response was fragmentary, reflecting its inherent obstacle to the solidarity required by unionism. The main activity of

SASMOA was the pursuit of narrow sectional interests related to each of its constituent categories. The heterogeneity of its increasing membership meant that there was often contradiction or opposition within the overall objective of collective bargaining. The proposed strike by juniors in 1983, for example, was opposed by senior visiting staff.

SASMOA accepted and formalised the status differences among categories of medical staff by means of different industrial awards. The association treated each of three groups - visiting medical officers, full-time staff and junior doctors - as a separate category, as a separate sub-culture, each marked by status and economic indicators which signalled their relationship with each other and with the state via the hospital. For example, the subordinate status of junior doctors was expressed both by their position in a hierarchy of knowledge and experience, and by their total dependence upon the hospital for a salary. This dependence was compulsory for the first pre-registration year. In the normal course of events, according to the traditional model, professional advancement would be reflected in decreasing economic dependence upon the hospital and increasing involvement in private practice. Changes in both economic and social circumstances modified this integrated pattern and impelled each group to argue its individual position in industrial terms and to resist new conditions of work which were seen as adverse. The difficulty for SASMOA lay in putting the case for one group without seriously antagonising other groups, inevitably, these weaknesses were reproduced throughout its organisation. The challenge was to represent the interests of all as a collective union entity.

The Legacy of SASMOA

This chapter has sought to demonstrate that unionism as a strategy for the medical staff to control conditions of work was problematic both in its concept and in its execution. Antagonism between heterogeneous medical groups in SASMOA had to be defused and unified activity encouraged by appeal to a common purpose. Moral unity could always be achieved by restating the charters of 'patient care' and 'teaching'. The irony for medical unionism was that these concepts conflicted with industrial action. In this sense, unionism failed as an attempt to secure control over conditions of work because the basis of union power, the refusal to work, contradicted the special nature of that work as was claimed during the formation of SASMOA. Professional charters and unionism were mutually exclusive. Certainly, its approaches to industrial bargaining redefined the working conditions of the medical staff, and obtained recompense for overtime and on-call work which had been regarded as major successes. However, again ironically, the change in conditions had increased the employee status of all hospital medical staff, making the need for an industrial organisation even more pressing.

The industrial awards resulting from the negotiations of SASMOA were achieved at the expense of a loss in professional autonomy. State intrusion and control were endorsed rather than opposed by SASMOA. Both the amount of private practice and the hours on-call of the full-time specialists were reckoned in financial terms by administrative staff. Similarly, the hours worked by juniors and the overtime claimed was documented. Not only did the state increase its monitoring of the amount and type of work performed by the hospital medical

staff, but also the salary of the medical officer depended upon this documentation and surveillance. For the juniors, documentation was essential and was checked by senior medical staff who were part of the scrutiny of overtime claims and, therefore, of income. On behalf of the seniors, the clerical staff monitored and apportioned the income from private practice as appropriate. The work practices of both groups were thus continually documented and extra salary determined accordingly by the hospital managers.

The disadvantages to the medical staff which were apparent were made more palatable by appeals to the managerial charter of economic rationality. Accountability for public resources and the reduction of expenses was a permanently available source of legitimation for increase in state control. As a result, the medical staff have now to demonstrate an increased efficiency to earn productivity awards. The fiscal advantage for the administrators lay in the possibility of reducing hospital costs by means of controlling overtime or private practice. There was, therefore, a move towards increased control of the medical staff.

Conclusion

I have described the growing structure of documentation and monitoring in the hospital as a total system whereby the work activities of various categories of staff were documented by a central 'bureau' of administrators who allocated essential goods, in this case, salaries. The hospital functioned, thus, not only as a co-operative institution but also as both a co-ordinating and controlling enterprise. The means of control of the medical staff lay partly in the control of the salary of

all the categories of the hospital medical staff. It was in the interests of the state and the hospital managers in their control of the Adelaide Hospital that the separate identities of the medical sub-cultures were retained. This was assisted by the activities of SASMOA in maintaining the definition of different groups because of their separate and particular needs. The adoption of a strategy of unionism emphasized the fundamental difficulties presented by medical charters and disparate groupings, the one collective, the other divisive.

Another aim of this chapter, therefore, has been to analyse the effects of internal differences within the medical staff on unionism, and by so doing to re-emphasise the utility of discarding the conventional concept of the medical profession as a distinctively united group. Whilst internal differences are implicit in the organisation of relations between medical segments, they are almost always explicitly denied except in academic and professional terms. Indeed, medical charters are strategically used to control and defuse conflict and to refuse to admit to significant divisions - 'really, we all want the same thing'. The legitimating use of collective charters is illustrated in the next chapter which analyses conflict between different categories within the same specialty. It addresses the power relationships exposed when an over-production of specialist anaesthetists appeared imminent.

CHAPTER 6

THE TRAINING SCHEME AND THE SATURDAY ROSTER DISPUTE

Introduction

In previous chapters I have analysed the social order of the hospital medical staff and its relationship to the state in terms of 'ideal-typical' models which include professionalism, bureaucracy, unionism and managerialism, each with its companion rhetoric. The problem repeatedly confronted is the consequences for the medical staff of specialist fragmentation, of its effect on professional unity and of the methods of organisation adopted in attempts to retrieve this unity - methods of organisation which reproduce mechanisms of state control. This chapter extends my analysis of the segmented order of the medical profession by attending to the balance of unity and disunity within a single specialty - anaesthesia. Additionally, I expand upon the economic structure of the medical staff, discussed in the previous chapter, by detailing the influence of market forces on the relationships between anaesthetic specialists. Finally, I address the role of professional associations in contributing to these relationships.

A common approach to analysis of the professions has been to treat the rise of professional associations as a unifying strategy to assist in the process of occupational control (see Johnson 1972). By using such a framework and emphasising the inclusive nature of associations, their exclusive characteristics have been somewhat neglected. In Weberian terms, social closure has been underemphasised. Professional associations were formed to exclude competitors as much as to present a united voice. Specialist associations were formed with the same end in view and this occurred in the face of opposition from other

practitioners. The antagonism provoked by the formation of specialist associations to argue the cause of an exclusive group was a feature of specialist development. As much as forging links between colleagues, associations could serve to support and legitimate breakaway groups, and thus paradoxically contribute to fragmentation and conflict within the medical profession. Against this potentially conflictual background, two problems demanded the attention of any developing specialty such as anaesthesia. These were the monopolisation of a specific area of medical practice and sufficient financial reward to practice solely in this limited field.

The historical part of this chapter details the development of anaesthesia as a recognised specialist area of medical practice. The main basis for this recognition was the construction of a body of theoretical knowledge and a course of practical instruction in a teaching hospital leading eventually to an examination. The successful completion of both was recognised by the award of a specialist diploma indicating the attainment of an accepted standard of expertise. The definition of a specialist, therefore, was partly constituted by undertaking a recognised hospital training scheme. The institutionalisation of training programmes provided not only a mechanism for producing specialists but also a further justification for junior staff to do the less attractive work. These two functions of training eventually came into opposition because the inevitable difficulty was to balance supply and demand. The public hospital required junior staff but the production of too many specialists would create unwelcome competition for private practice.

The ethnography of this chapter details the problems arising when the success of a specialised training scheme seemed destined to produce an excess of

anaesthetists. The central feature of the ethnography is the control of the anaesthetic training scheme in South Australia as a mechanism to control competition for private patients.

The effects of the manoeuvres to control the training scheme were felt most acutely by the full-time hospital specialists. The vulnerability of their structural position, foreshadowed in the previous chapter, was exploited. Any defence of their conditions of work had limited success because these had to be expressed in the particular terms of the industrial position of staff specialists. Arguments about justice on their behalf were couched in terms of hours and salary which did not address the perceived threat to their status. The pragmatic basis of this status was continually contradicted by medical rhetoric. The positions adopted by the main actors in this dispute were expressed in terms of the charters of teaching, patient care, economic rationality and so forth. Indeed, this chapter presents an almost complete catalogue of medical and managerial charters which were compiled to pre-empt argument and defuse conflict whilst furthering the cause of particular medical subcultures. In effect, appeals to a moral principle of unity concealed the extension of vested interests and disarmed opposition.

The relationships among medical sub-cultures and between them and the state have been addressed in previous chapters in terms of a pattern of cleavage and conflict continually arising but continually subsumed within the rhetoric of the various charters. In addition, these charters were not merely rhetoric but could be operationalised to produce concrete ties of co-operation and dependence between specialists. Similar networks of divisions and linkages have been addressed by Max Gluckman. His work is useful as a framework of and for interpretation. Gluckman developed his theory of social systems in terms of both change and

cohesion. He emphasised the centrality of conflict in social life but, at the same time, pointed to cross-cutting ties as the uniting threads of the social fabric:

In any social system there tends to be co-operation across all lines of cleavage (1958:70).

Following Gluckman, I treat the division between public and private practice as a medical cleavage fundamental to the structure of the whole profession.

The social system of hospital medicine in intra-professional terms, is constituted by both the separation of private from public practice and their inter-relationship. Ties uniting the two fields were expressed originally as a 'natural progression' of medical development. An apprenticeship with public patients reduced the tension of competition and was an acceptable entree into the lucrative market of private practice. One of the aims of specialisation was to increase the success of this process and, to this end, formal documentation of practical experience and examination of theoretical knowledge was required and such distinctions advertised. The first part of this chapter chronicles the development of anaesthesia as a specialty.

History of Specialisation

The enduring professional association in South Australia, the local branch of the British Medical Association (BMA) was founded in 1879. This was a direct predecessor of the present Australian Medical Association founded in 1962. One of the early fears of the infant BMA in South Australia was the threat posed to its new found unity by the potential development of specialist organisations in Australia. Ironically, at approximately the same time as the formation of the local

association, the first specialist in Adelaide was establishing himself in private practice (see Hughes, 1982:129).

One solution to the anticipated problem of specialisation was the establishment of sections of the BMA to represent specialist groups, especially at the important Intercolonial Medical Congresses (after 1901, the Australasian Medical Congress). These congresses were inaugurated by the South Australian Branch in 1887 and represented a conscious effort to demonstrate a unified profession. Specialist sections of surgery and medicine were included under the umbrella of the BMA. The development of a surgical association in Victoria in 1920, however, foreshadowed the end of this amicable arrangement. The objectives of the Victorian organisation were plainly stated. The creation of an alternative body would raise the status of surgery and deter unwanted practices by controlling hospital appointments and by determining a proper level of training. Accordingly, in 1926, a meeting of delegates was held in Sydney to form an Australia-wide organisation beyond the purview of the BMA - a College of Surgeons. The College held its first annual meeting in 1928.

The formation of a specialist body outside the BMA provoked a predictable opposition from the association in general and from general practitioners in particular. First, the BMA was alarmed at the potential erosion of authority in medical politico-economic pronouncements and activities, an authority based on its claimed wide representation. Second, general practitioners were fearful of any threat to their private practice because of competition from better qualified specialists. Specialists were eager to establish themselves as a group with extra qualifications and to exclude non-specialists. This separatist trend accelerated in the 1930s following the impetus provided by the surgeons. First the

physicians and then the anaesthetists formed separate organisations thus laying down the foundations of a professionally segmented order.

Until the late 1920s, the administration of anaesthetics had presented neither a practical nor an academic problem. Gwen Wilson, the main historian of anaesthesia in Australia, described the then prevailing attitude toward anaesthesia:

Unlike a number of other specialities, such as ophthalmology and pathology, there was resistance for many years to the idea that the administration of anaesthetics required any specialist knowledge or training. This resistance was reinforced by the fact that the giving of anaesthetics was a lucrative part of medical practice; lucrative not only for the general practitioner, but for specialist physicians and surgeons. In general, the referring practitioner gave the anaesthetic for the subsequent operation and in a large number of instances this, in the early stages, created a barrier to the employment of an independent specialist anaesthetist (1987:13).

At the medical congresses professional discussion of matters pertaining to anaesthesia had been included in the sections of surgery or medicine, depending, according to Wilson, on

whether the Executive Committee of Congress regarded anaesthetics as an adjunct to surgery or as the prerogative of physicians (1987:16).

However, in 1929, a Section of Anaesthesia was accepted within an Australasian Medical Congress for the first time.

It was unusual, at that time, for anaesthesia to support a full-time practice. Whilst honorary anaesthetists had been appointed at the Adelaide Hospital since 1922, they were mainly general practitioners. No opportunity existed for specialist training and payment for private anaesthetic services was precarious. The surgeons included the anaesthetic fee in their account and reimbursed the anaesthetist as appropriate. A specialist anaesthetist, therefore, would be dependent upon the surgeon for both work and payment, virtually a de facto employer/employee relationship. General practitioners who might give

anaesthetics, on the other hand, were less vulnerable since the surgeon depended upon them for referral of patients.

This state of affairs created a heterogeneous group of anaesthetists which was reflected in the office bearers of the new section. One vice-president was an honorary surgeon to the Royal Perth Hospital; another was both honorary anaesthetist and honorary physician to the Royal Prince Alfred Hospital. Significantly, the academic contributions were also from mixed sources. One of the papers at the 1929 meeting was presented by a Dr. Rollinson of South Australia, initially a physician and then an administrator. The paper was entitled, "Deaths under Anaesthesia at the Adelaide Hospital during 1928". 'Anaesthetic deaths' were already a repeated concern at academic meetings and eventually became a significant influence in the development of anaesthetic training as a specialised undertaking.

After the 1929 congress, enthusiasm for a separate anaesthetic forum grew and local state branches were encouraged. In South Australia, a letter to 15 honorary anaesthetists led to the inaugural meeting of a local branch of the Section of Anaesthesia in September, 1930. This first meeting took place at the Adelaide Hospital in the lowly surroundings of the Students' Laboratory. This venue and those of subsequent meetings appeared to reflect the increasing status of anaesthesia as a specialty. The early meetings, established a pattern of assessing anaesthetic deaths and medico-legal items in general continued on most agenda.

By May, 1933, the venue for meetings was in the slightly more congenial Students' Common Room. At about the same time, anaesthetic opinion had begun to coalesce around the notion of a society of anaesthetists separate from

the BMA section in order to improve the status of anaesthetists. Taking the opportunity of meeting at the Australasian Medical Congress in 1934, seven anaesthetists formed the nucleus of the future Australian Society of Anaesthetists (ASA). A letter sent to all state branches of the section of anaesthesia outlined conditions for membership which would be acceptable to the Executive of the ASA. Membership was limited to,

members of the BMA holding the post of Honorary Anaesthetist in a recognised public hospital, or to such other members of the BMA as may be approved by the Executive (Wilson, 1987:58).

The South Australian branch of the Section of Anaesthesia unanimously supported the formation of the new society.

The problem arising was the limitation of membership and, by inference, the definition of a specialist anaesthetist. A public hospital appointment was tantamount to a de facto legitimation as a specialist. Concerned over its general members, BMA in 1935 began to discuss the definition of a specialist. At the same time, the new specialist society began to refine its own policy on the matter.

In September, 1935, the ASA held its first Annual General Meeting in Melbourne. Once again anaesthetic deaths were a feature of the programme. At this meeting moves were proposed to affiliate the new association with its long-established counterpart in Great Britain. The significance of this recommendation lay in the British association's accreditation examination, the Diploma of Anaesthesia. The hope was that not only might training in Australia be recognised as acceptable for the examination but also such a diploma would define a specialist anaesthetist in Australia. The status of anaesthesia as a specialty was a more respectable subject for discussion amongst anaesthetists because of the huge area of expansion vis- a-vis general practitioner anaesthetists.

The venues for the meetings of the South Australian Section also became more respectable. In 1936 the meeting was held in the staff room of the Adelaide Hospital and in the following year, acting as hosts to the association, the General Meeting of the South Australian Branch was held in the Board Room - a significant move from the early days of the Students' Laboratory. The Presidential Address of 1937, reflecting the concerns of the time, was entitled "The Present Status of Anaesthesia and Anaesthetists in Australia". However, irrespective of the increasing prestige attached to anaesthetists, their remuneration remained limited. In 1939, a small survey revealed that the average gross income of an anaesthetist was 800 pounds (equivalent approximately to \$33,000 in today's terms) from about 300 cases per year. It is interesting to compare these figures with those in the second part of this chapter.

During World War II the specialist cause was promoted by a special training in anaesthesia within the armed forces. Anaesthetic training was soon embraced by the universities. In 1944, the University of Sydney followed the example of Britain and introduced a Diploma in Anaesthesia. A Melbourne University course for a Diploma in Anaesthesia soon followed. This crystallised the fears of many in the society who had predicted undesirable status differences in qualifications, especially when these qualifications were organised by universities outside the umbrella of the federal BMA. The need remained, therefore, of a single post-graduate qualification in anaesthesia, recognised throughout Australia. By 1950, following a similar development in England, it became known in communications between surgical and anaesthetic officials that a proposal for an Anaesthetic Faculty within the College of Surgeons would receive a sympathetic hearing. In 1952, the Faculty of Anaesthetists was formally

inaugurated and became the academic voice of anaesthesia throughout Australia. Four years later, in 1956, the first Fellowship examination was held.

The political voice of anaesthetists, however, was divided between the BMA and the ASA and relationships between the two continued on an uneasy course. The development of anaesthesia as a speciality created problems for the BMA and its non-specialist members in a number of ways. First, a hierarchy of expertise was constructed and legitimated by examination to separate those with a specialist diploma from those without. This echoed the experience of surgeons and physicians. Second, the competition for hospital appointments became progressively limited to specialists with a diploma, and they alone would reap the associated rewards of status and influence. Third, a grading of recognised expertise provided the potential for differential payments for anaesthetic services. The role of the BMA in resolving these issues became problematic. The claim to represent all Australian doctors in political negotiation became at best equivocal given that some of its constituent groups had conflicting aims. The problem was highlighted after 1953 when minimum benefits for medical services were guaranteed by the government. The National Health Service Act of that year introduced a table of subsidies now known as the 'Medical Benefits Schedule'. Criticism from anaesthetists was immediate. Apart from the fact that government subsidies did not approach 90% of the usual anaesthetic fees, as agreed with the BMA, the principle of anaesthetic recompense was to relate the anaesthetic fee to the operation. There was no recognition of patient assessment, of the difficulty or of the duration of anaesthesia as issues independent of the surgery. It was argued that, in effect, the scheme failed to recognise the anaesthetist as a separate specialist. The difficulty for the BMA was to argue for the rights of its anaesthetic

members as specialists whilst, at the same time, protecting the anaesthetic practice of its general practitioners which would be threatened by specialist recognition. Resolution of this conflict was eventually achieved outside the BMA.

In 1961, representatives of the state medical boards and of the Royal Colleges met in Canberra to agree upon an Australia-wide definition of a specialist. It was decided simply that an anaesthetic specialist was defined as the holder of a specialised qualification awarded by the Faculty of Anaesthesia with due allowances for already established anaesthetists. The consequences were twofold. First, all hospital appointments were limited to recognised specialists and, second, specialist training schemes were formalised in state teaching hospitals.

Throughout the 1960s, the consolidation of the Faculty examination as a specialist qualification and the establishment of training programmes in major hospitals meant that increasing numbers of specialist anaesthetists were produced. Non-specialist anaesthetists were concerned that this competition would threaten their income but concurrently there had also been an increase in the state employment of specialists because of an expansion in hospitals and services which softened much of the competition by absorbing about 30% of specialists. The threat to the income of non-specialists, therefore, was less real than imagined until 1970, when a new Health Benefits Plan was introduced.

One of the plan's provisions, which provoked immediate reaction, was a standardised common fee which was interpreted as a step along the road to nationalisation. The concept of the state fixing medical fees and, thus, controlling private practice income was not welcome. The second point of contention was that the fee schedule was differentiated according to whether the service was

supplied by a general practitioner or by a specialist, specialists being reimbursed more than general practitioners for the same service. This was a significant incentive towards a specialist service. Furthermore, the 1970 plan made provision for a National Specialist Recognition Advisory Committee which was to verify the specialist status of practitioners claiming the higher fee. South Australia had already established a specialist register in 1966. The practice and financial rewards of general practitioners had become limited in what was now defined academically, legally and financially as a specialised area of medicine.

The main tactic of the specialist associations to achieve a monopoly over anaesthetic practice was the creation of a distinguishing mark to indicate that the holder had obtained an acceptable standard of trained expertise. This qualification, additional to the basic medical degree, facilitated the control of the market. Both the idea and the reality of doctors certified as specialists were necessary to support the claims by a segment of the medical profession to special status and exclusive rights. The monopoly of an area of medical practice was legitimated by appeal to the charter of patient care. It was argued that specialist training would improve the quality of anaesthetic care. At one level, therefore, the public motives of specialist associations were the improvement of standards of practice. It is fair to say that these aims were sincerely meant and, indeed, mainly successful.

Anaesthetists possessed, in the terms of Bucher and Strauss (1961), 'a sense of mission', that is, the claim of a specialty to the unique contribution it can make in the grand design of patient care. The particular asset which was offered by anaesthesia as a specialty was increased anaesthetic safety and a potential reduction in deaths. From the early days, the discussion of deaths under

anaesthesia had signalled the gravity of administering an anaesthetic, the need for specialist care, and the developing mechanism of enquiry into events leading to each disaster. This internal surveillance included appraisal of the experience, expertise and training of the anaesthetist. Professional self-criticism received support from external sources in the findings of many coronial inquiries, which added further legal and social legitimacy to the quest for specialist status in anaesthetics. The argument, in brief, was that anaesthesia was safer if given by a trained specialist.

Success in gaining a monopoly for specialist anaesthetists had financial as well as professional implications. Restrictions on the practice of non-specialists was pursued in conjunction with adequate remuneration for specialists who had to develop a private practice sufficient to pay for time spent in a limited field. The market was not only limited but also could not be expanded by anaesthetic enterprise: patients requiring anaesthesia 'belonged' to other doctors. As Bucher and Strauss point out, the central problem was that,

we are likely to think of pathologists, anaesthesiologists, and radiologists as doctors without patients ... (1961: 329).

All of these specialties were secondary and subsidiary in the structure of medical treatment, which did not allow them to secure their own clientele and, therefore, made them dependent upon other doctors for their work. Anaesthetists, for example, were in a highly vulnerable position relying entirely upon surgeons for private practice. As one visiting specialist described it, "I never disagree with surgeons. They're my bread and butter." This dependency made competitive access to the market a sensitive issue.

By the 1970s, specialist anaesthetists had established their claim to a realm of expertise and its corresponding rewards. These rewards, in summary, were the

success in achieving a higher fee than non-specialists for their work and the eventual exclusion of non-specialists from that work. Private anaesthetic practice outside the Adelaide Hospital had been mainly removed from the sphere of most general practitioners and, therefore, an adequate income seemed assured.

The relationship among specialist anaesthetists in South Australia remained amicable until the late 1970s when an over-supply of specialists appeared likely. Anaesthetists established in private practice foresaw a threat to their income from the continual production of newly-qualified specialists. Even the limited access of staff specialists to private practice assumed important proportions. The problems generated within the anaesthetic department by this conflict constitute the ethnographic material in the second part of this chapter.

The Medical Expansion in Adelaide

In chapter two of this thesis, I drew attention to the demographic changes in South Australia following the second world war. The population of Adelaide itself increased at a steady rate of over ten percent every five years until 1960. From 1960 to 1965 the population leaped by almost 25% (Australian Bureau of Statistics). Consequently, a predicted shortage of both hospital beds and doctors in the late 1960s led to a rapid expansion of medical services. In 1965, a newly elected state Labor Government announced plans for two major hospitals - one general and one teaching. The report of a Commonwealth government committee the following year recommended that the establishment of a second medical school in Adelaide should be hastened in view of,

the urgent need for more hospital beds and the need for more doctors to qualify by 1975 (A.M.A. in South Australia: A Centenary History 1979:54).

The report noted that there was a shortage of doctors, especially in general practice, and drew attention to the tendency for doctors to seek full-time salaried positions. Because of delays in financing the new teaching hospital, the AMA, in 1967, repeated the call for more doctors,

It was very necessary that the number of medical graduates in South Australia, be increased from 110 to 140 a year (ibid.:55).

This was an increase of 27%.

Five years later, in 1972, work began on the new teaching hospital which was opened in 1976. However, by this time, misgivings had arisen over the accuracy of the projected need for doctors and hospitals. Some of the original estimates were based on figures from 1969 and supported by the report from the Karmel Committee on the Expansion of Medical Education (1973), but changes in the birth-rate and immigration had weakened the validity of these projections. The population increases for 1965-70 and 1970-75 were barely ten percent. In the same year that the second teaching hospital was opened, the Dean of the Faculty of Medicine at the University of Adelaide claimed in the Medical Journal of Australia that,

with the planned increase in the output of doctors, the state may soon be saturated and some adjustments may have to be made in the number of students accepted (Rhodes 1976:911).

He also pointed out that if the 'ideal' ratio of doctors per head of population, given in a Federal government study published in 1975, was accepted,

then there is no immediate need for orthopaedic surgeons, anaesthetists, obstetricians and gynaecologists or pathologists in South Australia (ibid:912).

The 'ideal' ratio for anaesthetists was 1 per 20,000 of population; the actual ratio in 1975 was 1:12,026. Suddenly, and quite contrary to previous predictions, there

appeared to be a threat of over-production of doctors in general and of some specialists in particular in South Australia.

In 1979, a report to the South Australia AMA on medical manpower provoked a resolution

requesting the faculties of medicine at both universities to give consideration to an immediate reduction by 10 per cent in the number of medical undergraduates (AMA History: 59).

Simultaneously, concern was expressed about the immigration of overseas doctors who were said to be limiting the job opportunities of local graduates. By the late 1970s an oversupply of doctors which could result in overcrowding in the profession was feared. These variations in estimated needs were reflected in the staffing of the anaesthetic department of the Adelaide Hospital. A rapid increase in trainees (registrars) and full-time specialists (staff anaesthetists) had occurred in the late 1960s. The increased production of specialists had been absorbed initially by the full-time positions created at the Adelaide Hospital and by the expansion of government hospitals. By the late 1970s, this avenue had been closed and the future placement of anaesthetic trainees was causing anxiety, particularly to specialists working in private practice. The result was a reassessment of the appropriate number of trainees and a change in the work pattern of full-time specialists.

The Saturday Roster Dispute

In 1977, the general hospital, which was built as a result of the 1965 government plan, acquired its own anaesthetic department and dispensed with the anaesthetic service which had been supplied by the Adelaide Hospital since 1973.

In March, 1977, the senior director of the anaesthetic department at the Adelaide Hospital circulated a notice prior to a departmental staff meeting which suggested that, since the department was reducing its commitments, it was an appropriate time to review staffing. The specific proposal was that a predicted reduction in trainees (registrars) could be met by modifying the emergency anaesthetic roster, so that on Saturdays, one of the two anaesthetic registrars normally 'on-call' would be replaced by a staff anaesthetist. This notice confirmed rumours of a change in the working conditions of staff anaesthetists which had been circulating throughout the department.

The senior anaesthetic staff responded immediately, angry that specialists were being asked to undertake the duties of trainees. Their perception of this reduction in status was expressed in the resentment shown at the April staff meeting. The situation was made worse by a coincidental proposal that the intensive care staff should be increased. Intensive care, part of the combined department and staffed by intensivists who were anaesthetists, was often perceived as the more privileged 'high-tech' area of the hospital. It seemed to anaesthetists that whilst their duties were to become more onerous, intensive care was to be favoured. Following the meeting, a circular was issued which noted the reaction of members of the department but pointed out that all staff were obliged to be continually available for whatever duties were rostered. Some account was taken of staff anxiety for the future by stating that there were no detailed plans for longer-term staff restructuring. Nevertheless, continuing changes were anticipated in the departmental circular which repeated the original statement of the senior director that,

pressures are arising from a number of sources calling for a reduction in the number of anaesthetic trainees and that if this reduction is valid,

service needs will need to be met in other ways, most obviously by fully trained staff (Department circular).

The responsibility for the potential changes to the work of full-time anaesthetists was attributed, therefore, to sources other than the senior director.

One source of pressure for a reduction in trainees was the South Australian government, which had commissioned an enquiry into medical manpower in general. This eventually became the Hassam Report (1978) which dealt with the current and projected supply of medical specialists. It proposed ideal numbers for each specialty and for anaesthetics, the suggested ratio of specialist per head of population was 1:10,000. This was compared with the Commonwealth Department of Health ratio of 1:20,000. The Report calculated that the actual ratio would exceed its own figure in 1980 if the training scheme were to be maintained with its total of 48 registrars. Even a reduction to 36 trainees would not completely solve the problem. It was made apparent, that the anaesthetic training scheme was producing an inevitable surplus of specialists. Whilst the figures indicated that only an unacceptably huge reduction in numbers would contain the problem, the Hassam report demonstrated to the satisfaction of interested groups that some reduction was essential.

The interested groups represented both professional and administrative concerns and whilst their aims were identical their motives were very different. The gain for the administrators lay in a reduction in hospital staff. From the mid 1970s, the hospital had experienced a tightening of its budget and a corresponding pressure to reduce costs. Any opportunity to reduce the salary bill by reducing numbers was, therefore, welcomed. There was an additional financial benefit for the hospital in the proposed re-arrangement of the Saturday roster. Since 1975, junior doctors had received overtime payments which included a loading for

weekend work. On-call payments for specialists were not achieved until 1979 (see chapter four) and then only as a fixed sum, not as an hourly payment. Briefly, it was cheaper to roster staff specialists for out-of-hours work than registrars.

The professional associations had different motives and I discuss the strategy of the Australian Society of Anaesthetists (ASA) later. The Faculty of Anaesthesia had academic reasons for welcoming proposals for a new roster. One aim of its continuing attempts to further the status of anaesthesia as a speciality, was that every anaesthetic should be given by a specialist or a trainee supervised by a specialist. The replacement on the Saturday roster of an unsupervised registrar by a staff specialist who could provide advice and supervision to the second registrar furthered this aim. Furthermore, by supplying specialist services to more patients and by better supervision of the remaining trainees, the charters of patient care and teaching were unarguably fulfilled. This point was not lost on the senior director of anaesthesia. The morality of the proposed changes and their concurrence with Faculty policy was continually emphasised.

There were also pragmatic reasons which influenced the Faculty's response. The Faculty was eager to reduce the emergency work performed by registrars. At the Adelaide Hospital, emergency work comprised a significant proportion of the registrar roster but was the least supervised. A training scheme made obligatory an appropriate degree of supervision and this was less than ideal at the Adelaide Hospital. The Faculty therefore supported any move which would increase specialist involvement and thence registrar supervision.

The registrars themselves were mainly peripheral to the argument because of their limited influence but they did not object to a reduction in emergency work. Furthermore, they supported a belief long-held by many members of the

department that all trainees should be guaranteed a job opportunity at the end of their training. At this time, the construction of public hospitals had ceased and the appointments of staff anaesthetists had slowed. New specialists increasingly looked for places in private practice and recognised that any reduction in the training scheme would provide less competition in their future.

Thus, the anxiety of the staff anaesthetists at the Adelaide Hospital was built upon an awareness that sympathetic support might be difficult to obtain. They felt isolated and vulnerable and this was vocalised. In a sense, they were victims of the original drive for the recognition of anaesthesia as a specialty. Having established that anaesthesia was safer in the hands of specialists, it was difficult to argue that some anaesthetic tasks were more appropriate for junior trainees. Furthermore, support could not be anticipated from colleagues in other specialties, particularly from their closest colleagues, the surgeons. The senior surgical staff were disinterested in the conditions of work of the anaesthetists. In practice, the emergency work performed by senior specialist anaesthetists was often at the behest of junior trainee surgeons, a working arrangement which could be justified under the rubric of anaesthetic patient care, but which emphasised the subordinate status of anaesthetists.

The problem of status was recognised by the senior director who circulated within the department his belief that, contrary to popular opinion in the department, considerable prestige would be gained by undertaking the proposed roster. The prestige to be gained was based upon the recognition of the anaesthetic department as possibly the first in Australia to offer a totally specialist service. Not only did this fulfill and extend the ideals in Faculty policy documents, it also epitomised ideal patient care, in effect, an ideal of specialisation.

The potential recognition of this prestige was, however, always limited to acclaim within the specialty and perhaps within the department. Claims to prestige should normally have been signalled by marks of deference and recognition of a privileged status. This status was not acknowledged by medical colleagues. In fact, the majority of their surgical colleagues were unaware of the sacrifice to be made by the anaesthetists. Prestige received no confirmation outside the department and this was illustrated by correspondence with a surgical department which, three years after these events, expressed dismay that only one registrar anaesthetist was available on a Saturday. The surgical department was obviously unaware that the second registrar had been replaced by a specialist anaesthetist who supplied part of the on-call service.

Despite the absence of widely-based support for their cause, staff anaesthetists sent protests about the Saturday roster to the senior director on both an individual and a group basis. Individual protests expressed fears of a downgrading of working conditions and status. A particular anxiety for anaesthetists in a technological specialty was the risk of being considered as technicians. They feared that surgeons were only aware of their status by not being resident when on call. As expressed by an anaesthetist, "On tap technicians are easily taken for granted". Two further concerns surfaced in the group submissions. The first was a fear that the proposed changes were a preparatory step towards a rumoured 24-hour residential specialist service. This is discussed later in this chapter. The second concern was that because anaesthetic cover of the other hospital was no longer required, each staff anaesthetist at the Adelaide Hospital would be on call less often. This was one of the bases of the argument of the senior director and the significance of this was that prior to industrial

awards, compensation for anaesthetic on-call, negotiated by the senior director, took the form of two sessions of time off-duty. One session was for reading and research; the other could be used to give anaesthetics at a private hospital. Less on-call work could make this arrangement harder to justify and, therefore, present a threat to off-duty time and income. On the other hand, anaesthetists in private practice welcomed the potential exclusion of staff anaesthetists from private practice outside the hospital.

The attitudes of the staff anaesthetists to the Saturday roster proposals were mixed but eventually consolidated in a letter to the senior director, signed by all staff anaesthetists, objecting to the proposals. Apart from provoking surprise and anger, the letter had little effect. An appeal to higher levels of authority, for example the hospital board, was thought inappropriate by a majority of staff anaesthetists. Two weeks later, in June 1977, a departmental circular gave details of the new Saturday roster and its commencement date. The staff anaesthetists accepted this with reluctance but without revolt. The specialist anaesthetists were caught in conflicting arguments. By trying to avoid the less pleasant demands of anaesthetic practice, the 'dirty work' carried out by trainees, they contradicted the basis for establishing anaesthesia as a specialised field of practice. The argument was that anaesthesia was a potentially dangerous business best undertaken by a specialist. By implication, anaesthesia not given by a specialist, albeit a trainee specialist, was less than best for the patient.

The Strategy of the Australian Society of Anaesthetists

The new departmental roster was issued three days before a meeting of the South Australian Section of the Australian Society of Anaesthetists (ASA). At this meeting, on 20th June 1977, a motion was put forward by the senior director of anaesthesia at the Adelaide Hospital, seconded by a former associate from a private practice, proposing the formation of a committee to examine anaesthetic practice and services in general. Amongst other things, it was to enquire into

the number of anaesthetists in training and its influence on anaesthetic practice, to include estimations of 'man-power' requirements and the availability of teaching material for trainees (Notice of Meeting, 1:6:77).

The 'availability of teaching material' for training purposes was a new feature of the argument and implied a mismatch of trainees and experience. It rose to prominence later, as the Faculty became increasingly concerned with the clinical exposure of its trainees and questioned the adequacy of that exposure in some hospitals, that is, the number of anaesthetics given per trainee. Decreasing the number of trainees would help solve this problem. The list of other areas suggested for consideration by the Committee included,

the advantages and disadvantages of private practice granted to full-time hospital anaesthetists and the impact on the organisation of private practice outside the teaching hospitals (ibid.)

Clearly, the continuing irritation caused to private practitioners by the option available to full-time state employees of a private list outside the hospital, had not been resolved. The fear of an oversupply of trained specialists increased the relevance of this concession to full-time specialists.

The regional branch of the ASA combined with its Faculty equivalent to form a committee which represented all shades of anaesthetic opinion from

general practitioner to professor. In 1978 the committee's preliminary report echoed a widely-held feeling:

Many specialist groups have recently reviewed and revised their training programmes. An assessment of the demand for anaesthetists and the number of trainees that will be required is essential for forward planning of teaching and training programmes (A.S.A./Faculty Report, 1978:1).

The assessment of demand for anaesthetists was based on the current and predicted future population of the state and the number of specialist anaesthetists, despite a notorious inaccuracy in previous predictions. The significant figures in the report were the 'ideal' ratios of anaesthetists per head of population. The Commonwealth Department of Health recommended 1:20,000; information from Canada and America suggested 1:15,000; and the Hassam Report concluded that 1:10,000 was ideal. The basis of such widely divergent figures was not explained. From the number of anaesthetics given in the urban area, the committee calculated that the current ratio was 1:9774 and concluded that the density of anaesthetists in Adelaide had already exceeded even the most liberal of the suggested limits (the Hassam figure). The rationale for adopting this figure as the 'bottom line', together with the calculations, occurred later in the ASA/Faculty report.

The argument was that the average workload of a specialist anaesthetist in private practice was calculated to be 1,022 anaesthetics per year. In 1977 the average fee for an anaesthetic was \$55 which provided a gross annual income of \$56,000. It was argued, therefore, that the minimum reasonable workload should remain at approximately 1,000 cases a year. Continued production of specialists at the current rate was unacceptable because,

It would appear that any increase in the numbers in private practice would reduce the average workload below 1,000 cases (A.S.A./Faculty Report 1978:5).

The inference to be drawn from the calculations of the ASA/Faculty committee was, therefore, that the minimum reasonable workload was based on a minimum reasonable income for a specialist in private practice.

The conclusions of the committee were, predictably, that saturation point had been reached, particularly in the private sector. The committee's report argued that the existing number of anaesthetists sharing the anaesthetic work available represented a minimum acceptable level of income for those in private practice. Any increase in competition would threaten this level of income. Therefore, the number of vocational trainees should be reduced to a level consistent with local private practice needs. The committee recommended strict control of the training programme, essentially to preserve the financial status of private practitioners.

One of the original arguments put by the ASA was about the problem of workload appropriate for a specialist. One of the early definitional features of a specialist was the proportion of time spent in anaesthetic practice in order to gain expertise. The notion of a minimum annual number of anaesthetists required to maintain expertise had often been discussed among specialists. This, however, might be well below the economic minimum of 1,000. A professor of anaesthesia in New Zealand, in his discussion of adequate staffing of anaesthetic departments in teaching hospitals (Baker 1979), recommended that full-time specialists should have a workload of 600 patients per year. Presumably this was sufficient to maintain the skills of specialist staff in a teaching department. The ASA suggestion that an increase in entrants to private practice would reduce the workload so that expertise would suffer, disguised a minimum income proposal.

The rhetoric of specialist expertise constructed here as the continuing practice of a skill, and intertwined with financial reward, focused specifically on the numbers. However, the figures which I have given point to the quite arbitrary character of much of the argument. The size of the 'problem', the degree of overproduction of anaesthetists, was defined by whichever figure was chosen. The suggestion of overproduction itself should be viewed as part of a political rhetoric rather than a matter of possible fact. Without considering the measurement of the rather nebulous concept of expertise, there was very little evidence available to show that there had been a decline in anaesthetic income because of 'overproduction' of specialists. Nevertheless, predictors of such a decline continued.

From 1979, the teaching hospitals effected a relative reduction in trainees by appointing those not intending to stay in South Australia and reappointing those who had completed their training. There was also a reduction in the absolute number of training positions available. Continuing pressure to reduce trainee numbers further provoked the next crisis in the anaesthetic department at the Adelaide Hospital.

A Residential Specialist Service

The staff anaesthetists at the Adelaide Hospital had grudgingly accepted replacement of a registrar by a full-time specialist on Saturdays. Over the next two years the Saturday roster was accepted as a way of life. Concerns about an extension of this scheme arose when, prior to a staff meeting in July 1980, a

departmental circular drew attention to the significance of the second item on the agenda:

To discuss the implications of the reduction in the number of vocational trainees and replacement by specialists (Department circular).

Although trainee numbers had been reduced, all the directors of anaesthesia had agreed to a further small reduction, provided that specialist positions were created instead. The demand for the reduction was seen to originate from the Health Commission, on the advice of the ASA/Faculty committee. Despite reassurances that the directors had agreed to implement these changes slowly, the proposed changes to the anaesthetic roster at the Adelaide Hospital were revolutionary and worth quoting in full.

It is anticipated in the first instance, the exchange of one 'trainee' position for one Staff Anaesthetist position will involve each full time specialist in one, 8-hour, after hours shift per month. It is expected that 1/2 of these shifts will fall in the period of time before midnight; i.e. each full time specialist will be required to live in the hospital once every 2 months (ibid.).

With the loss of some junior posts and the conversion of others, the redistribution of the "service commitments" to the specialist staff, including out of hours residence, seemed inevitable.

This was not a localised difficulty. Baker (1979) had anticipated the problem in his assessment of staffing in Australia and New Zealand teaching hospitals. He writes that a reduction in the number of registrar posts would,

ensure that clinical service cover for departments does not depend on registrars. Such action will increase the need for more senior staff, and their on-call commitment will increase (1979:374).

In fact, this had been planned by the senior director of the anaesthetic department at the Adelaide Hospital since 1975. He had informed the medical superintendent that,

it is one of our objectives to move gradually to a 24-hour residential specialist service.

Indeed, this objective formed part of the argument for the increase in staff anaesthetists at that time. Despite the director's comment that no staff specialist would be rostered on duty after midnight until 'acceptable accommodation' was available in the hospital, the agenda of the staff meeting of July 1980 realised the worst fears of staff anaesthetists. The question of residential staff specialists had finally emerged.

The July staff meeting was conducted in a tense atmosphere. Various objections to the residential proposals were explored. These included questioning the assumption of over- supply of specialists and canvassing the responses to the problem of other teaching hospitals in Adelaide. A new factor brought into the argument was the emerging authority of industrial awards. In particular, it was argued that radical changes to working conditions, as proposed by the senior director, should receive an opinion from the industrial court. Conflict between industrial and department perspectives was avoided by the senior director's appeal to the essential service element of an anaesthetic department:

My brief is to provide an anaesthetic service, if in doing this certain things are done which some of you may feel is contrary to the Award, then you should prepare your material and put this to S.A.S.M.O.A., hopefully to achieve reasonable recompense rather than challenging whether you should or should not work the roster, because the service has to be provided.

This defence not only implied the charter of patient care but was also pragmatic - a service to both patients and surgeons had to be provided.

After much argument and discussion a disarming question, in view of past trends and current arguments, was put by the senior director.

Do you see a need for reduction of the input of trainees to anaesthesia? If we agree trainees should be reduced, what do you see are the avenues open to this Department to cope with this proposition?

A formal response was avoided by a proposal to form a working party of five anaesthetists who would receive submissions and report back to the whole of the staff. Nevertheless, the message was unequivocally stated by the senior director in his final comment. The department was faced with a reduction in the number of trainees, changes were necessary and 'certain inevitabilities' had to be recognised.

Less than three weeks after the staff meeting a joint submission signed by three quarters of the staff anaesthetists was presented to the convenor of the working party. An extensive document of twelve pages, it offered solutions which were acceptable to a majority of the staff. The underlying feeling was antagonism to the perceived change in status.

We believe we have been employed at consultant rank and we see no reason to change that role (Working Party Submission 1980).

The intent was to point out the threat to both the practical and symbolic aspects of their senior status. Reversion to registrar duties meant more uninteresting work at unsocial hours which had previously been considered part of an apprenticeship en route to more rewarding work conditions. The senior director's proposals meant that the status of the anaesthetist would be diminished by a return to registrar work in association with registrars from other specialties. This would not only undermine the senior status but also demonstrate quite clearly and publicly the lack of choice, the limited autonomy of staff specialists.

Whilst resistance to this stage of the departmental grand plan was no more vigorous than that to the Saturday roster, the proposals were never put into effect. Throughout the remainder of 1980 the plan resurfaced occasionally, but never with the singularity of purpose which had characterised its original presentation. It

may have been that a residential specialist service was too radical to institute without a broad-based support in all the teaching hospitals. Another likely factor was the decline in health of the senior director. In addition, the industrial implications were enormous. A departmental circular, in January 1981, detailing the basis of the working week for staff anaesthetists, mentioned only the Saturday roster with no reference to a residential scheme. A specialist anaesthetist residential service was not commenced at the Adelaide Hospital and has not been mentioned officially for some years.

Formal Knowledge and Dirty Work

Previously in this chapter I have referred to the important separation of public and private practice. Originally, this was spatial - public patients were 'inside' the Adelaide Hospital, and private patients were 'outside'. Indeed, in the early history of the hospital, repeated moves were made specifically to exclude patients who could pay. This led to a temporal separation of the medical staff so that public practice was an internal and brief novitiate en route to establishing an external private practice. From an early stage efforts were made to limit the private practice of the small number of government medical employees, a limitation which became more pressing when full-time hospital employment became more popular as a permanent career. The agreement to allow each staff anaesthetist the option of one list in a private hospital was a later concession of the 1960s in order to attract specialist anaesthetists and retain them within the public hospital system.

Outside the hospital a private practice was achieved by competition and the establishment of an area of practice was assisted by a claim of special expertise. The special nature of the expertise required for administering anaesthetics was continually emphasised by pointing to the increased possibility of fatal consequences should the task be undertaken by the inexperienced. Coronial and medical enquiries into anaesthetic deaths supported this view. The academic basis for the specialist claim was that anaesthesia presented a distinct field of learning - in the terms of Freidson (1986), a higher or 'formal knowledge' - a concept I have used in an earlier chapter.

Similarly to Simmel's treatment of secret knowledge, which I discuss in the next chapter, Freidson makes the point that prestige and respect tend to be given to formal knowledge and to those who possess it by those who lack it. This social status is converted into economic advantage by a credentialling system which not only establishes a claim to special status but also encourages political patronage in the form of protection from non-credentialled competition. Freidson identifies the professions as,

typically credentialed on the basis of higher education and a relying for their living on labor-market shelters built around those credentials (1986:109).

There are two distinct methods of credentialling, occupational licensure and institutional credentialling. The institutions usually offer the courses on which licensure is based and the two are inter-meshed. This strategy is refined further in the process of specialisation.

Specialisation is legitimated by examination and diploma at the conclusion of a period of training. The credentialling process, however, is institutionalised by training schemes located within public hospitals and trainees who are financed by

the state. The claim, therefore, to formal knowledge and to a 'labor-market shelter' in competition with others, is grounded in the state hospital. There is an inter-dependence as well as a separation of private and public practice and access to the former is based upon success in the latter. The anaesthetic training scheme supported a claim to formal knowledge and a credentialling process which, ultimately, led to access to the private market. Unfortunately, the training scheme produced a continuing supply of specialist anaesthetists which appeared to threaten this market. This was a market where the prices were more-or-less fixed by the government's determination of a 'common fee' for each service. This was also a market where, because of population movements, the demand appeared unlikely to increase. The supply of anaesthetists, therefore, the training scheme still had to be controlled.

The original aim of the qualifying examination, the control of unqualified competitors, had been enveloped in the rhetoric of the best interests of the patient. Control of the training scheme also necessitated legitimization of this move beyond the narrow self-interests of private specialists. This was achieved in two ways. First, the actions taken formed part of the policies of the official institutions - the Health Commission, the Australian Society of Anaesthetists and the Faculty of Anaesthetists. This unusual harmony was fortuitous and resulted from the arithmetic of the calculated need for anaesthetists. The correct match between trainee numbers and job vacancies was a concern of both the professional bodies. The Australian Society of Anaesthetists was concerned over the future income and experience of anaesthetists in practice. As I noted in a previous chapter drawing upon the comments of Willis (1978), economic arguments spilled over into the professional arena. Specialist expertise could only be maintained by controlling

pressure on the market to guarantee a calculated minimum experience in private practice. Similarly, the Faculty of Anaesthetists was concerned about the amount of experience of trainees in the public hospitals. The government, for its part, was eager to reduce costs by reducing numbers but providing the same service. Whilst, in general, the state's strict participation in the affairs of the medical profession is resisted, its active co-operation has always been sought to control competition. The significant feature of the common purpose of the official bodies here was its ostensible rationality. Previously, I drew attention to the arbitrary choice of ratios, number of anaesthetists and so forth and the continuation of a political rhetoric based upon the concept of overproduction. The point made now is that whatever the number chosen, the rhetoric was legitimated in the view of everyone by the inescapable rationality of arithmetic. As a member of the ASA/Faculty Committee said, "The numbers spoke for themselves".

The attention to numbers was neither new nor local. As Pensabene (1980) notes for Victoria, this reaction had been a traditional response of the medical profession for many years. He writes, for example, that,

the rapid increase in supply of doctors in the 1880s and 1900s brought deep concern to the profession. It was believed that the competitive position of the doctor had been seriously eroded (1980:78).

I have noted previously the volte-face of the South Australian AMA in the 1970s when it was realised that the suggested increase in medical graduates was inappropriate to its members' market interests and that a reduction was required. The AMA also pressed for a restriction in the immigration of overseas doctors which, again, was not a new position (for example, see Kunz 1975). The issue, however, was presented as a problem of employment for new graduates rather

than a problem of competition for the established. Nevertheless, this was repeated at the specialist level.

The opportunity for each trainee to find employment locally became more valued and contested as employment opportunities decreased with the slowing of both population and hospital building. In addition, this option was increasingly viewed as an obligation for the organisers of training. A new charter was thus created in terms of guaranteed employment opportunities at the successful conclusion of a specialist training in anaesthesia. This was repeatedly articulated in the drive for a reduction in the anaesthetic training scheme. Each trainee, it was argued, should be able to anticipate local employment.

The second source of legitimacy, therefore, was the appeal to various medical charters. Staff anaesthetists could accommodate more readily the adverse working conditions of the Saturday roster when these were couched in terms of better patient care. The financial implication of increased competition could be submerged in moral rectitude and transcended by higher motives. Indeed, when the argument over financial competition was more overt, or not overlaid with the charter of patient care, as in the attempt to deprive staff anaesthetists of their private list, the outcome was less successful. This specific attack did, however, form part of a general criticism of the private practice of staff specialists which I discussed in chapter five. The arguments addressed to oversupply of trainees, were better received by all groups, including staff specialists, when they were expressed in professional charters rather than in financial terms. The number of anaesthetics given by trainees became a feature of the teaching charter. A growing concern of Faculty educators was the amount of experience and teaching gained en route to a specialist qualification. This had been decreasing over the

years for reasons which included the number of available teaching cases as well as the limitation of working hours by industrial awards. The eventual result would be the addition of another year to the period of training. Immediate effects could be achieved by reducing the number in the training scheme and thereby increasing the variety and amount of clinical exposure for each remaining trainee. As importantly, at the Adelaide Hospital a major contention was a purported lack of supervision of each trainee, which led to a Faculty inspection. The ideal aim of Faculty remained that of total specialist cover of anaesthesia either in fact or via an adequately supervised trainee. Unarguably this policy would be in the best interests of the patient and undermined the resistance of staff anaesthetists to the Saturday roster. It was impossible to propose that trainees should be giving anaesthetics in place of specialists. In brief, the senior director's argument was unassailable.

A repeated objection from the staff anaesthetists was that they would have to do the less interesting work at less socially acceptable hours - the 'dirty work' (see Hughes 1958) - would again be their lot. In effect, their status would be reduced. The senior director argued to the contrary. In simple terms it was absurd to argue that anaesthetists would lose status by doing the job for which they were trained. Additionally, it was argued that the Saturday roster should be seen as a public good rather than a debate on private status. Finally, he argued "concern with status was inappropriate for professionals".

This view received support from a politically authoritative source. At the annual general meeting of the ASA in 1974, the past president drew attention to what he saw as an inappropriate search for status.

In the first place, it might be worthwhile giving a little less emphasis to the question of status, and for each section of the profession to see itself as

merely a contribution to a good health service which, in turn, along with other essential services, e.g. education, is only a contribution to the running of the community (Maplestone 1975:92).

He went on to argue that the status of anaesthesia was largely in the minds of anaesthetists. This notion was echoed in a number of comments made by the senior director who argued that the emphasis should be on providing a service for the patient and for the hospital. Personal prestige would be acquired by serving the public interest.

The public interest would also be served by the financial saving from the new roster. Maplestone had summarised the contributions that anaesthetists could make to containing the expenses of health care.

In the field of anaesthesia itself, there are two broad areas of cost regulation, i.e. efficient use of trained personnel and economical use of resources (1975:93).

The director's plan for the anaesthetic department conflated these areas of cost regulation. Efficient use of trained staff was an economic use of resources. The salaries and overtime costs of trainees could be reduced by rostering in their stead staff anaesthetists who, by virtue of their employment conditions, were available as required. The plan fell comfortably within the managerial charter of economic rationality. The strategy could be presented in terms of fiscal efficiency for the state rather than protection of the market for private practitioners. Fulfilling the requirements of various charters then, the reduction in the training scheme was justified by its proponents at multiple levels.

The problem for the staff anaesthetists was both pragmatic and ideological. They had no control over the number of specialist trainees and they were allowed only a limited contribution in suggesting resolutions to the problem of over-production. They also had very little power to resist the decisions made by the

senior director. The 'dirty work' could be transferred to staff specialists despite their protests. Their position in a bureaucratic hierarchy, subordinate to the directors and senior director, thwarted any substantial opposition. Furthermore, in practice, there was very few options of appeal against unwelcome decisions to higher authorities who were, essentially, the members of the hospital board. In chapter four it was noted that the thoracic physicians created antagonism by appealing to the board. Indeed, the higher levels of the hospital administration had a tacit if not open sympathy with the proposals. Apart from high-level appeals, therefore, options for resistance without jeopardising a career were very limited indeed. The weaknesses of the structural position of full-time hospital specialists were exposed by the proposed scheme and because of their employment by the state, the limits of their autonomy were clearly demonstrated.

Employment as a Mechanism of Control

Willis and Freidson both identify the conditions of employment as the significant factors for analysis rather than the simple fact of employment itself.

Willis agrees that doctors can be located as new middle class,

irrespective of their nominal status as self-employed or salaried. Political and ideological factors 'over-determine' economic factors in locating them as an occupational group (1989:17).

Freidson doubts the significance of employment status, the critical issue lying in the characteristics of the employment position itself:

Therefore the serious issue for theorising and descriptive analysis is not some trend toward the loss of independence through entrance into employment but rather the conditions for employment themselves and whether they are changing sufficiently to be worth comment (1986:34).

The conditions of employment are the issue for enquiry and I have analysed some of the changing conditions in the previous chapter.

I argue here that the distinctive employment characteristics of the visiting and full-time staff were critical not only to their market position but also to their relationship with each other and the power which they could exercise over their conditions of work. Private practitioners, because of their vulnerability could, paradoxically, more easily co-opt support for their attempts to control the market. The economics of oversupply were readily appreciated by everyone and, indeed, sympathy for their growing difficulties was evident even amongst the staff specialists. They could, therefore, draw upon wide cultural values of financial independence and entrepreneurship which staff specialists could not.

The general economic attitude of a state eager for stringency in public expenditure supported the protection of the market position of private practitioners. Staff anaesthetists, on the other hand, were vulnerable to the different market relationships controlled by the state. Dependent upon a state salary, they were obliged to accept unwelcome changes in their conditions of work. In this sense staff anaesthetists were subordinated to the concerns of other groups and their mode of employment was the necessary condition for this subordination. Because there was no immediately available alternative income their mode of employment could be exploited. This is not to argue that their position was identical to that of a 'blue-collar' worker. It is to argue that there was an increasing analogy, however. This is made clear by the differential power available to groups with different employment characteristics. The powerlessness of staff anaesthetists was clearly shown in their limited influence over the events affecting them. Their conditions of work were changed as a result of the actions

of the senior director, private practitioners and professional anaesthetic organisations, against a background of financial restrictions. Both employers and colleagues exerted control over the staff anaesthetists. Colleague control was expressed not within a company of professed equals as described by Parsons, but rather because of a 'company of unequals' (Lorber and Satow 1977). Indeed, the differential status of categories of anaesthetists created a mechanism for the control of subordinate groups such as state employees.

The unequal relationship between different medical subcultures remains inadequately addressed in most analyses of the medical profession. The implication often is that medical segments are equal in status. The first part of this chapter showed the dependence of anaesthetists upon surgeons for patients and, therefore, income. This was expressed even in the academic field by the dependency of the Faculty of Anaesthetists on the College of Surgeons, that is, a Faculty within a College; almost a symbolic recognition of anaesthesia as a dependent specialty. The financial dependency of anaesthetists upon surgeons was, however, less relevant where the state provided both patients and salary. Within the Adelaide Hospital, relationships could be signalled in other ways. In terms of professionalism, medical relationships would depend upon the ability of an individual or the success of a department in its practice. The route to approval chosen by the anaesthetic directors, however, was bureaucratic. Anaesthesia as a specialty, occupied, of necessity, a secondary place in patient care. In a sense it was a derivative specialty stemming from the demands of other specialists for an anaesthetic service. The senior director was intent on using this structured relationship to gain prestige for the department by improving its efficiency and expertise in the provision of an anaesthetic service. No request for service would

be denied, however inappropriate or ill-timed. Presented thus, individual anaesthetists saw themselves as a sacrifice to the will and whim of other specialists, most particularly surgeons. The more the service charter was pursued, the more the full-time anaesthetists felt disadvantaged but incapable of reacting against any service obligation to patients or surgeons.

The inability of staff anaesthetists to control their conditions of work and the disillusion arising from their efforts to do so was a result of the conflicts arising from their structural position within the hospital staff. On the one hand they were independent qualified specialists, identical to the directors and the senior director. Subordinate to them in obvious professional terms were the trainees. On the other hand, the staff specialists were themselves subordinate to the less obvious requirements of a bureaucratic system. Superior to them were directors and a senior director who possessed authority by virtue of their managerial positions. The position of staff anaesthetist, therefore, was located between professional and bureaucratic hierarchies, between two different but legitimate systems of control.

The situation was compounded by factors more relevant to the market, by subtle differences in status between full-time and visiting anaesthetists, between public and private practice. The result was a complexity of relationships with both horizontal and vertical components. Furthermore, within the anaesthetic department, professional equality between senior medical staff was transformed into a bureaucratic hierarchy. The senior director was, after all, only another specialist anaesthetist. Thus, horizontal relationships in professional terms could simultaneously be vertical relationships in bureaucratic terms. To maintain the inequalities created and to accommodate the tensions in the system it was

essential to refer continually to common professional values. The mechanism of harmony which produced a workable solution to conflict was the appeal to an appropriate charter. This high moral ground devalued the basis for protest and disguised the hierarchy of prestige and power. It also cemented differences between professional bureaucratic and market systems of organisation.

Johnson (1972) as pointed out by Willis (1978) has argued that, "elements of the bureaucratic role become inter-weaved with the occupational role in service organisations" (1972:79). and the bureaucratization of the occupation stratifies and formalises incipient cleavages between practitioners. He writes that,

Such differentiation may destroy colleague relationships and neutralise the controls which our autonomous profession imposes on its members (1972:80).

State mediation, Johnson argues, threatens the formation of the 'complete community' of professionalism. The position taken here is that the state facilitates relationships rather than always mediating them directly. In reducing the training scheme, the role played by the state was to provide conditions for the profession to control itself. These conditions include official reports supporting the notion of over-supply, the bureaucratic employment structure of a hospital department and an over-riding rationality for organising health services in terms of supply, demand and, particularly, cost. In this way the state encourages professional control, a true collegiate control open to review. The potential disunity of the activities of collegiate control described in my ethnography were subsumed within bureaucratic, market and professional values.

Conclusion

My approach differs from that of Willis (1989) who discusses vertical power relationships of the medical profession in relation to the hierarchical control of other health workers (see 1989:32). This has occurred in other work such as that by Lorber and Satow (1977) whose phrase 'company of unequals' I borrowed earlier. This chapter addresses the hierarchical control of specialists and trainee specialists by their specialist colleagues. An important feature of this subordination was that it occurred within a hospital structure responding to pressures arising in the medical and general community. The locus of activity and the focus of control of the medical staff was the public hospital organised by the state. Because hospital appointments were crucial to graduates, trainees and specialists, rules which directed their behaviour and limited their autonomy could be formulated. In brief, the hospital became the geographic context of control.

The characteristics of employment assisted this process and bureaucratic mechanisms further supported the internal control of full-time specialists. Whilst this was to the benefit of external groups, it occurred significantly in accordance with the broader economic strategies of the state and its continuing control of hospital organisation.

My argument is that a ladder of prestige was continually produced and reproduced within the medical profession. Underlying this hierarchicalisation was a self-conscious strategy aimed at securing status and controlling potential competitors to protect or create a market of patients. The process of specialisation as an extension of professionalisation was aimed at controlling access to markets by means of qualifications and expertise, by 'formal knowledge'.

The status and influence of each specialist was located within a matrix of co-operation, opposition, dependence and conflict - a network of conjunctive and disjunctive processes characterised the medical profession. To combat disunity increasing mechanisms of control became a regular and accepted mechanism of its organisation. This was most clearly defined within the state hospital. At this locus state aims and professional motives coincided.

CHAPTER 7

THE PATIENT DECONSTRUCTED

Introduction

Thus far the structure of this thesis has been built upon an ethnographic enquiry into the idea of medical dominance. The methodology chosen has been to test this idea against the observation of the everyday activity of the medical staff at the Adelaide Hospital. The material to this point has enabled me to analyse medical relations in this context in terms of state-professional, administrative-clinical and intraprofessional coalitions and oppositions. The hospital and its medical staff have been progressively penetrated to focus on different layers of hospital structure in order to analyse medical power and its exercise. Finally, I arrive at a central feature of both medical activity and medical discourse, the doctor-patient relationship, which is the subject for analysis in this chapter.

The specific focus of the chapter is the development of the concepts of 'brain death' and 'natural death' in South Australia. Both concepts arose from the use of medical technology, essentially the mechanical ventilator, in the near-dead patient. Whilst many of the events later described occurred in Adelaide and directly involved the anaesthetic and intensive care specialists of the Adelaide Hospital, the material presented extends upon my previous ethnographic approach. Here, I want to locate the hospital and its problems in an appropriately international area of debate and opinion. This is a suitable finale to my

presentation of the particular locale of the Adelaide Hospital, considering that all its problems are of a global nature in a very real sense. Above all medical discourse is an international mode of talking, one which translates across the boundaries of nation state with consummate ease. Medical discourse is a cosmopolitan cultural capital and in this final ethnographic chapter will be treated as such.

Some of the important incidents described here took place in America and other events occurred in another state in Australia. The events which unfolded in Adelaide were participated in by this writer. Due to their very nature however some had to be reconstructed post hoc.

I have argued in previous chapters that a number of factors have contributed to an erosion of medical autonomy but that the refuge of the medical profession was an appeal to the charter of patient care. Whilst the 'good of the patient' was adopted as a legitimating rhetoric by many of the groups discussed, only the medical claim was based on clinical contact with the patient. The ultimate repository of medical power was the doctor-patient relationship. At this personal level, it was assumed that medical power was safe from challenge. This chapter will present evidence to the contrary. With reference to the notions of brain and natural death, I will show how this relationship was invaded by the state, initially on behalf of the medical professionals and then against their wishes.

I have also argued previously that the state was not simply an over-arching bureaucratic structure but partly a 'facilitator' of relationships so that decisions appropriate to a managerial discourse were encouraged. At other times the state via its local agents played a more explicit role. In the events detailed here the state mediated between doctor and patient directly in a relationship which hitherto

had been sacrosanct. The doctor-patient relationship had been preserved from scrutiny by a professional code of ethics which as both Willis (1989) and Freidson (1986) have pointed out was a mechanism of internal control assumed by the medical profession. Because of a code of ethics, external influences on the doctor-patient could be restricted. In this way, the code of medical ethics both created and protected this relationship. A social space was constructed which was inhabited by doctors and patients but sealed from outside scrutiny by the rules of confidentiality. Within this space, the safeguard of the patient was the integrity of the individual doctor and, thus, medical autonomy was firmly grounded.

An important part of medical autonomy was, therefore, secrecy legitimated by a code of ethics. As George Agich (1980) points out, most sociological analysis focus on a too-narrow definition of autonomy:

Autonomy in health care is restricted to mostly economic and political considerations instead of incorporating the ethical (1980:192).

To this point, the same criticism might be levelled at my approach but in this chapter I 'incorporate the ethical'. Agich argues that the production of medical knowledge is central to analysing the affiliation between ethics and professionalisation, because all medical knowledge implies responsibilities towards the patient. The second part of this chapter analyses the effects of new knowledge on state involvement in the doctor-patient relationship. Firstly, however, I describe the creation of a social space wherein both doctor and patient could be insulated from state involvement in the doctor-patient relationship.

The Hippocratic Corpus

The popular ancient authority for medical secrecy is the Hippocratic Corpus of some 2,000 years ago. The most well-known section is the Hippocratic Oath which, until recently, was sworn at many medical schools. Margaret Stacey (1985), in her discussion of medical ethics, makes the important point that the oath contains two particular duties of confidence. First, there is the expected guarantee concerning the patient:

And whatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets (translation by W.H.S. Jones in Reiser et al. 1977:5).

Second, there is a medical safeguard, an exhortation to secrecy within the profession,

to impart, precept, oral instruction and all other instruction to my own sons, the sons of my teachers, and to individual pupils who have taken the oath, but to nobody else (ibid.).

Confidentiality thus operates simultaneously as a mechanism of exclusiveness and inclusiveness. "Outsiders" are defined in opposition to "insiders" by access to information. Secrecy therefore works on two levels, defining the client relationship and the professional group. The Physician's Oath urges professional solidarity as much as patient confidentiality. Stacey suggests that there may be a tension between "the role of ethics in protecting the patient and maintaining the solidarity of the profession" (1985:14). It is to this tension and its resolution that much of this chapter is addressed.

The doctor was also permitted to criticise the correctness of the patient's behaviour for sound medical reasons. Medical decisions could only be made if the intimate behaviour of the patient was revealed. Illness was perceived as individual

and individualising. Behavioural transgressions which disrupted an internal balance or external harmony were critical features of diagnosis and, importantly, were revealed privately. As Pellegrino and Thomasma write,

Greek medicine therefore defined for itself a moral framework which made the patient-physician relationship a private affair (1981:158).

The moral framework was based upon rules of behaviour which created a special form of confidentiality. In effect, a medical charter was constructed which informed the practice of medicine; a charter which required the exposure of the patient. Within the doctor-patient relationship secrets were revealed by the patient, but access to this personal knowledge was denied to outsiders. The obligation of the doctor lay in respecting this confidential information, by maintaining confidentiality. The medical obligation was immediately qualified, however, by the sharing of information with other doctors. They also guaranteed patient secrecy and secrecy characterised the medical profession as much as the doctor-patient relationship. By creating a secret society the rules guiding medical behaviour were as important for the doctor as they were for the patient.

Secrecy as a subject for sociological enquiry was first addressed at length by Simmel and, opening his chapter on the secret society, he writes,

The secret is a sociological determination characteristic of the reciprocal relations between group elements; or, rather, together with other relational forms, it constitutes their relationship as a whole (Wolff 1950:345).

It may characterise a group in its totality. The other important aspect of the secret noted by Simmel is the feeling of possession of something of value. By virtue of the exclusion of outsiders, the thing possessed increases its value. The increased value may be reflected in an increased social status of the possessor. The possession of knowledge about the patient, for example, combined with the esoteric knowledge of medical practice created a position of superiority for the

doctor, "a position of exception" in the words of Simmel (Wolff 1950:332). The secret produced a degree of inequality because those excluded from knowledge were subordinated both by ignorance and, according to Simmel, by a sense of the mysterious.

For, the average man, all superior persons, and all superior achievements have something mysterious (ibid.:333).

The essential mechanism of continuing the mystery and maintaining the position of exception was, therefore, the restriction of information within the boundaries of the chosen group.

Here, secrecy is its own sociological purpose: certain insights must not penetrate into the masses; those who know form a community in order to guarantee mutual secrecy to one another (ibid:355).

Thus, control of information was the basis for preserving a special status. The special status of the doctor was based upon the particular information given within the confidential relationship with the patient.

Else Øyen (1982) has described some of the social functions of confidentiality and points out that the benefits to the doctor in terms of power may outweigh those to the patient in terms of privacy.

Secrecy may hide unfair decisions and shrewd distribution of privileges, and measures to correct irregularities cannot be put into effect. The importance of professional secrecy reaches far beyond the interests of the single client (1982:6).

Øyen argues that in codes of ethics, professional secrecy is mentioned without being problematised. The point is, argues Øyen, that secrecy is not a neutral instrument but rather, a means to handle the flow of information in society in very particular ways. Furthermore, this information was the essential requirement for formal autonomous action. The process whereby certain occupations could isolate

their critical decisions from social scrutiny was the door to autonomy and secrecy was the key.

The two possible constraints on medical autonomy within the doctor-patient relationship were the influence of the patient and the scrutiny of medical colleagues. The patient could exercise a variable degree of internal control. When the essence of diagnosis was a personal history, the patient had multiple choices as to which personal historical events should be presented to the physician. The patient's compliance was important in the interpretation of illness and the diagnosis could be influenced by the revelation or concealment of facts which might be medically relevant. Information from the patient was the critical basis for interaction. This was less important as the investigative technology of medicine grew. As Henderson (1935), a physician himself, points out, communication was, however, rather one-sided. His advice to doctors is that,

When you talk with the patient, you should listen, first, for what he wants to tell, secondly for what he does not want to tell, thirdly for what he cannot tell (Henderson, 1935:822).

The implication was that information could and should be obtained despite the ignorance or reluctance of the patient. The role of informant became more passive as the patient's participation became less vital to the diagnostic process.

Henderson applied the notion of a 'social system' to the doctor-patient relationship and this idea received substantial treatment later by Talcott Parsons in his book, The Social System (1951). In this major work Parsons discusses the doctor-patient relationship mainly in terms of the part to be played by the patient - the sick role. I do not intend to explore the well-known rights and obligations attributed by Parsons to the structure of this role. For my present purposes it is sufficient to point to the relatively passive role of the patient. The Parsonian

paradigm has received much criticism (for a brief review, see Gerhardt, 1987), in part that the formulation is too medico-centric (see Gallagher, 1976).

As the patient was subdued within the doctor-patient relationship, relationships with colleagues became the more important restriction on medical autonomy. Whilst any constraint was accepted with reluctance, negotiation with colleagues in the name of professionalism was more acceptable than 'outside' control. As Øyen writes, "To the extent that they are subject to control at all, this is preferably performed by their own colleagues" (1982:15). The importance of relationships amongst medical colleagues led to rewritten codes of ethics.

The Hippocratic Corpus, as a tradition of medical ethics, was, according to Thompson (1987), more honoured in the breach than in the observance until the social standing of doctors became an issue.

Only in the nineteenth century, with the development of modern scientific medicine and the struggle among doctors, surgeons, and apothecaries for professional dominance, did the oath re-emerge as the basis of the doctor's code of practice (1987:1461).

He argues that the Hippocratic Oath was reborn as a tactical ploy to invest medicine with a respectable image based on a scientific and ethical tradition stretching back to the Greeks. As important, was a list of ground rules for dealing with relationships with medical colleagues. The main ethical code formulated in the nineteenth century was that of Percival and it was directed towards the hospital medical staff.

Thomas Percival (1740-1804) was a leading physician of the fever hospital in Manchester and, after a medical dispute in 1789 which led to a number of resignations (see Pickstone 1987), he was asked to devise a scheme "of professional conduct relative to hospitals and other medical charities" (see Reiser et al. 1977:18). Percival's code was written as much to guide professional relations

with other doctors as with patients. Waddington (1975) points out that only a few of the 48 pages are devoted to a consideration of ethical problems in the doctor-patient relationship. He argues that,

The everyday problems facing medical practitioners, it is clear, arose not in their relationships with their patients, but in their relationships with their professional colleagues, relationships which all too frequently were characterised by tensions, by hostilities, by accusations and counter-accusations (1975:41).

There was vigorous competition for the wealthier patients and Percival's aim was to defuse this competition by regulating relationships and allowing to every doctor his place in the process. Percival's solution in fact was to emphasise the existing divisions within medicine but, at the same time, cement them into a workable unity by means of rules of conduct. Not only did these rules apply to the inter-relationships between doctor and doctor, and doctor and patient, but also were directed towards a specific arena and to a new category of patient - the hospital patient.

At about the same time as Percival wrote his code of ethics there was a change in attitude towards the patient which revolutionised the practice of medicine. Part of the revolution lay in the increasing importance of the hospital for medical practice. Doctors began to move away from the individual patronage system and to acquire legitimacy via measures which were more institutional. As Bellaby and Oribabor (1980) write,

They retained their upper-class patients, but established an independent base for their authority in the 'scientific' treatment of the poor in hospitals and infirmaries (1980:297).

An essential feature of this scientific approach was a new attitude to the captive body.

Where there once had been a divorce between theory and practice - between the speculative classification of disease and the various treatments

meted out to different social classes - there was now a unity, founded in clinical anatomy and the practice of the hospital-based clinic (ibid.).

This phase is described by Jewson (1976) as "hospital medicine" which is characterised by a structural nosology, a localised pathology, physical examination and statistical analysis. This radical change in the practice of medicine transformed the patient by reducing his contribution to the diagnostic process. The key to accurate diagnosis lay more in physical examination than in the individual confidential history, although this remained an important starting point. In Jewson's terms the "sick man" had disappeared. His place had been taken by his body as the problematic of medical enquiry.

The Body

According to Michel Foucault in The Birth of the Clinic (1973), the new attitude to the body began towards the end of the eighteenth century. He argues that the body was a product of a classification, similar to Jewson's structural nosology, which was characteristic of hospital medicine. The patient-as-subject became patient-as-object and the tool of objectification was pathological anatomy.

Pathological anatomy was given the curious privilege of bringing to knowledge, at its final stage, the first principles of its positivity (1973:124).

The essential way of looking at the patient was, for Foucault, "the gaze". Secrets withheld knowingly or unknowingly could be exposed by the piercing and piecing attention of pathological anatomy. Its systematic approach provided the basis for the scientific rationality of medical knowledge.

The difficulty lay not in the concept but in the practice. For such a development, sufficient bodies had to be collected in one place and for this the

"clinic", as a teaching hospital, was invaluable not only as a source of the diseased living but also as a potential supply of the dead. Dissection of the body was a method of learning both anatomy and pathology, but the examination of the dead body presented problems. Autopsy of the body was usually refused by relatives and dissection had criminal overtones.

Ruth Richardson (1987) argues that in France the bodies of the poor became available for dissection after the revolution. Notably, this was the same era that Foucault postulated for the birth of modern medicine. In England, a similar end was achieved by the Anatomy Act of 1832. Under the terms of the Act the bodies of "unclaimed dead" could be donated for dissection.

The masters of poorhouses and hospitals could cut expenditure on pauper funerals by donating the bodies of patients too poor to provide for their own burial. By creating a cheap, legal and institutionalised source of bodies, the Act led to the collapse of the body snatching trade (Richardson 1987:196).

According to Richardson, the Anatomy Act transferred the terror of dissection, previously a punishment inflicted on a criminal's body, to the voiceless and destitute poor. Poor and, in Foucaultian terms, 'docile' patients became clinical and pathological material; the view of the living bearing a close resemblance to the use of the dead. The clinical gaze saw systems and structures beneath the skin which were verifiable by dissection. Clinical detachment, which diminished the patient as a person, was proclaimed as a major advantage of medical interaction. The inevitable result, however, was that the living patient was perceived as anatomical pathology - as a metaphorical corpse - and this perspective laid the foundations for a fragmentation which was reproduced in specialisation.

A mechanical view of the body was also reflected in a utilitarian attitude. The body as a collection of organs could be re-cycled to correct the defects of the

bodies of others. This depended upon first, the availability of medical technology to separate in viable form the parts of the body; and second, the flexibility of medical ethics to redefine the meaning of the person at the boundary of life and death. The progression of medical technology rapidly achieved these two events provoked by a European tragedy.

Artificial Ventilation

In 1952, Copenhagen suffered the largest and most severe epidemic of poliomyelitis ever recorded in Denmark (see Lassen 1953:37). During the last five months of 1952 the Blegdam Hospital received almost 3,000 patients with polio, of whom an unusually high proportion had difficulty in breathing. Facilities for artificial ventilation - for keeping alive patients with respiratory paralysis - as at all hospitals were woefully inadequate. Blegdam Hospital had only seven mechanical ventilators. In the first month of the epidemic there was a mortality rate of 85-90%. Lassen writes,

I do not want to dramatise the state of affairs existing in the middle of August 1952, but it certainly was desperate: nearly all our patients with poliomyelitis had died (1953:68).

A new approach was considered essential for a disease which attacked the movement of muscles.

On August 25 we decided to call into consultation our anaesthetist colleague, Dr. Bjorn Ibsen, as we thought positive pressure breathing - as used in modern anaesthesia - might be of value (1953:68).

In the event it was, with 6-12 patients per day benefiting from an anaesthetic technique. For several weeks 40-70 patients required ventilation and to do this, in the absence of machines, up to 250 medical students were employed daily in

eight-hour shifts at 30 shillings per shift. The mortality rate fell to about 40% - half of the previous figure. The success of intermittent positive pressure ventilation was established and this gave a tremendous boost to the world-wide commercial production of mechanical ventilators. Whilst artificial ventilation was a technique familiar to anaesthetists in the operating theatre, the Denmark experience demonstrated, quite dramatically, that patients outside the operating theatre could be assisted by sophisticated machinery. The result was that ventilation support was used occasionally in inappropriate circumstances.

Brain Death

The concept of "brain death" first achieved respectability in 1959 when it was described by two French neurologists (see Jennett 1981). Brain death subsequently became widely accepted in medical practice and, for many years, ventilators were disconnected when it was evident that nothing further could be gained in a mortally brain-injured patient. The patients disconnected were a mixed group composed of all grades of prognostically hopeless pathology. There were no officially sanctioned guidelines surrounding the management of these patients and, whilst the medical practitioners might have good intentions in a particular situation, in general, the withdrawal of mechanical assistance left legal and sometimes ethical uncertainties. These uncertainties were brought into sharp relief in 1967, by the first successful heart transplant by Dr. Christiaan Barnard, when it was obvious that the donor heart must have been beating at the time of its removal. The transplant surgeons had placed their faith in a diagnosis of death which was outside the conventional cardio-respiratory parameters. In effect, it was

a public demonstration of the accepted medical attitude towards ventilator-dependent patients.

The first formal criteria defining brain death were published in 1968 by an Ad Hoc Committee of the Harvard Medical School (1968). Without detailing the medical items, it is fair to say that these criteria have withstood the test of time (see Jennett 1981, Pallis 1982 and 1983). With some modifications, they form the basis of most definitional codes. Australian doctors had, therefore, in the Harvard and in subsequent codes, a clinical basis for the diagnosis of brain death, yet the concept continued to present legal difficulties as illustrated by the following events.

In 1978, near a town in the Northern Territory, a middle-aged man stopped the car in which he was travelling to Darwin in order to relieve himself. He had been drinking and fell over but when reseated in the car, he appeared rational. Shortly afterwards however, he was noticed to be unconscious and not breathing. His companions turned the car around and headed for the nearest hospital giving mouth-to-mouth ventilation as best they could. On admission to hospital he was not breathing and had no pulse. After a brief period of cardiac massage, which restored a spontaneous pulse, the patient was intubated and ventilated. A consultant physician in a nearby town was contacted and he served as a continuing source of advice via telephone. Later in the day, after a period off the ventilator, it became evident that the patient would not breathe by himself and that reconnection to the machine was essential. Later still, a diagnosis was made of a massive subarachnoid haemorrhage (a bleed into the brain). Over this period of time, it became apparent that a diagnosis of brain death could be entertained. The consultant was again contacted and after conferral, it was decided that if

further tests confirmed the diagnosis, which they did, then the ventilator should be turned off. When returning to do so, the medical officer voiced his relief to a nursing sister that a diagnosis had already been made thus avoiding the need for an autopsy. She replied that she thought post-mortems were mandatory for all victims hospitalised for less than 24 hours. The machine was turned on again and the police contacted for their opinion. Whilst in the process of telephoning, it was realised that the patient had been admitted more than 24 hours previously. The discussion with the police was unhelpful and so the ventilator was finally switched off. Death was certified by absence of heartbeat. The drama, however, continued.

Over the next couple of hours, there were at least a dozen seemingly pointless telephone calls from suspicious police and identification of the body was requested. The medical officer was driven to the point of refusing to cooperate further with the police. Following this, the local Health Department telephoned and after hearing the sequence of events gave its support to the medical officer. He was informed, however, that the case had been drawn to the attention of the coroner and a murder investigation had been formally instigated. The medical officer was advised to cooperate within reason because the inquiry would have to be completed. The police mounted an armed guard for the night over the mortuary building. The next day police officers took a statement from the medical officer and interviewed other members of staff. The ventilator was photographed and it was rumoured that the machine would have been seized as a court exhibit but the police were persuaded not to do so.

At the inquest, a well-known neurosurgeon from Adelaide appeared on behalf of the medical officer. This expert testimony was of crucial importance to

the outcome. The point was made that whilst the public might have some difficulty in accepting the idea of a dead patient with a heartbeat, the application of technology had made the concept an inevitable feature of medical practice. The problem was that there was no legal basis for this position. Its legitimacy lay in widely accepted medical criteria and common practice. The coroner was satisfied that all the actions in the case had been carried out in accord with currently accepted medical practice and dismissed the charge.

The immediate result in South Australia was to remedy what was seen as a gap in information by advertising more widely the concept of brain death. The main vehicle for this was a film which was shown to a wide spectrum of interested groups and which remains generally relevant today. On a broader level, the legal position was being clarified. The Australian Law Reform Commission had been considering a number of contentious medical issues which included the legal doubt over brain death, illustrated in my previous account. The Commission expressed the feeling that,

the law should ensure that a doctor who determines, according to proper medical procedures, that death has taken place in terms of cessation of brain function should not be exposed to legal risk on the accusation of killing (by termination of support systems), any more than he could have been by employing the older, classical criteria (Editorial, Medical Journal of Australia, 1977:313).

As a result of such opinion, moves were made to protect the medical position on brain death. In 1983, in South Australia, one of the briefest Acts to receive assent passed into law. By this Act (No. 12 of 1983) entitled in short the "Death (Definition) Act, 1983", a legal definition of death was established. The Act states that,

For the purposes of the law of this state, a person has died when there has occurred - (a) irreversible cessation of all functions of the brain of the

person; or (b) irreversible cessation of circulation of blood in the body of the person.

Because of mechanical techniques absence of respiration had become a less relevant feature of death.

The success in achieving legal recognition of brain death had consequences some of which were not been previously apparent to some members of the hospital medical staff. First, the statute gave medical officers security in their actions but the criteria for action were left unstated. Death remained a medical diagnosis and, on this level, an esoteric process. The technicalities excluded the public which could possibly determine cessation of respiration but not death of the brain. Second, and less obviously, the idea of death as a process rather than an event, an idea which had been widely proclaimed in the medical journals, had achieved legal status. In 1968 the World Medical Assembly in Sydney had stated that,

Death is a gradual process at the cellular level, with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of the person. Here the point of death of the different cells and organs is not so important as the certainty that the process has become irreversible, whatever techniques of resuscitation may be employed (Gilder 1968:493).

The concept of process allowed the diagnosis of death despite a beating heart and led to a change in clinical practice at the Adelaide Hospital. The third consequence of legally defining brain death, therefore, was the practice of 'beating heart donors'. Previously, once the patient's prognosis had been determined as hopeless, the opportunity arose of transplantation of useful organs. In the operating theatre the ventilator was turned off and, at cessation of heartbeat, death was formally declared and the kidneys were removed. There was in effect a congruence of brain, respiratory and cardiac deaths. The new legislation meant

that organs could be removed whilst the ventilator was working and with the heart beating which improved the chances of a successful transplant.

The usefulness of the brain-dead patient or some of the parts presented a scientific rationality which coincided with the utilitarian face of hospital organisation. The kidneys of one patient, for example, could be used to help two recipients. The physical and fiscal expense of two people on dialysis could be saved by one donation. There were other costs which might be avoided. To ventilate a brain-dead patient was demanding on the emotions of relatives, nurses and doctors. It was also a waste of intensive care resources which were expensive and limited. Such resources were in demand and could be used more appropriately for potentially recoverable patients. The introduction of the legal definition of brain death decreased costs in a number of areas.

A few members of the anaesthetic department at the Adelaide Hospital displayed some reluctance to adopt the new practice. This led to a meeting of interested groups such as anaesthetists, intensivists, neurosurgeons and religious and community groups. Part of the protest was related to the role of the anaesthetist as a technician in the sequence of events, but, part echoed the argument of Sir Zelman Cowan who opposed,

a view which sees human beings, through the application of impeccable scientific skills, as ambulatory assemblages of spare parts (1982: 335).

On the whole, however, the revised process of 'beating heart donors' was accepted not only without resistance but also in the spirit of an advance in medical treatment. A biomechanical perspective had ultimately transformed the body into a useful physiological preparation. The establishment of brain death as a legal as well as a medical state added social legitimation to the medical gaze.

Irreversible Illness

The problem remained, however, of the irreversibly brain-damaged patient who was not brain dead but required ventilator support. At times, it seemed pointless to continue this support and the couplet written by Arthur Hugh Clough, as part of a satirical poem, was often quoted,

Thou shalt not kill, yet need not strive
Officiously to keep alive.

The approach was reflected in medical attitudes. Phillips, a South Australian intensive care specialist, wrote,

Given the advances made and the resources available, we must be prepared to 'pull out all stops', as it were, for the patient who can be returned to a full and useful life if recovered from a potentially fatal illness. But we must not be guilty of prolonging death in a patient whose time has come (1977:256).

The problem was, however, that without a diagnosis of brain death, intensive care specialists who withdrew ventilator support from dependent patients placed themselves in a difficult ethical and legal position. In America, the events of the Karen Quinlan case started to clarify the legal possibilities from the viewpoint of the relatives. Since this had implications for Australian practice the events are documented briefly.

On April 15th 1975 Karen Ann Quinlan, aged 22, stopped breathing, probably as a result of ingestion of both alcohol and drugs, and received less than successful resuscitation from friends. She was admitted to hospital deeply unconscious and requiring assisted ventilation. After assessment she was described as being in a chronic persistent vegetative state. All medical opinion agreed, however, that she was not brain dead. Karen had basic reactions to light, sound and pain, but her breathing had to be maintained by machine.

Her family became reconciled to the irreversibility of her state and, via her father, requested the withdrawal of life support systems. The medical staff and the hospital administration refused. Mechanical support of ventilation could only be withdrawn after the patient was declared brain dead. In the case of Karen, this had not occurred and therefore withdrawal of life support would, in effect, kill her. At this stage Joseph Quinlan sought a solution through the courts. He applied to be appointed guardian of his daughter and to be authorised to order the discontinuance of all extraordinary medical procedures. Having accepted the medical evidence, the Court, by a unanimous decision, agreed that there was a right of individual privacy to be executed through the father which might permit termination of treatment should everyone be agreed that the prognosis was hopeless. In the event, the ventilator was withdrawn in May 1976 but, ironically, Karen Quinlan continued to breathe until 1985 when she died.

The essential element of the court's argument of privacy was self-determination. Although this was located in a social relationship with a third person, her father, the court had established a legal degree of patient autonomy within the doctor-patient relationship. The court argued that the greater the degree of bodily invasion, the greater the right of the patient to oppose medical decisions. By this judgement, therefore, the extent of medical control over an incompetent patient had been successfully challenged. Essentially, the court was judging the social consequences of medical decisions. No commentary on the clinical decisions was given or implied.

However, even while the case was in progress, fears were expressed about legal intervention in the doctor-patient relationship. In the Journal of the American Medical Association, Richard McCormick, a leading Jesuit theologian,

wrote of the threat of invasion of the doctor-patient relationship, and of the doctor becoming "increasingly a tool of technology dictated by law" (1975:1057).

He argued that,

decision-making within health care, if it is to remain truly human and an expression of the cardinal rule of the physician, *primum non nocere*, must be controlled primarily within the patient-doctor-family relationship (ibid.).

The increasing accessibility of this relationship to legal control was shown by the Saikewicz decision three years later. Its salient point, summarised by Relman in the New England Journal of Medicine, was that,

when patients are terminally ill beyond care and are incapable of consent all decisions about the institution or termination of life-prolonging measures must be made by the courts, not the family or the physician or any hospital ethics committee (1978:508).

The editorial comment criticised the imposition of more constraints on the decisions of doctors.

The medical position common to both America and Australia was that the doctor-patient relationship should be free from outside interference. Restrictions imposed from outside the profession were viewed as a threat to the sanctity of a relationship which had been established by history and tradition as a medical domain. Despite increasing legal and social pressures, the medical profession continued its attempts to maintain total autonomy in decisions which affected the patient. The difficulty lay in the legal and social effects of medical decisions and were felt most acutely in the application of medical technology.

One response was to modify the effects of technology by incorporating social factors in medical decisions. The decision of Phillips and his colleagues not to admit patients to intensive care were made on,

an over-all assessment of the patient's likely prognosis based not on objective data points, but on such factors as disease process, physical and mental state before acute deterioration, and age (1980:426).

The medical community was eager to establish social guidelines for medical decisions but, as in America, only within the seclusion of the doctor-patient relationship and the medical profession. As Phillips et al write,

it would be far better to establish criteria for withdrawal of life support within the framework of the doctor-patient relationship than to have legislation introduced which would unnecessarily complicate the issue (1980:426).

The medical response to any 'unnecessary complication' was immediate resistance. Paradoxically, therefore, whilst the medical profession was beginning to consider social factors in medical decisions, legal enforcement of this process was vigorously opposed.

In South Australia, forewarned by the Quinlan case and the Saikewicz decision, the medical profession acted swiftly when the question arose of a legal modification of clinical decisions concerning life-support. The comments of Phillips et al. formed part of the sometimes heated discussion over the rights of patients with particular regard to potential technological extension of the dying process. Criticism focused on the legislation introduced to substantiate these rights, to achieve a so-called 'natural death'.

Natural Death

On 18th July 1978, Mr. Frank Blevins MP initiated a debate over 'natural death' by forewarning the Legislative Council of South Australia that he intended canvassing opinion and, if this was favourable, proposing a Natural Death Act. This was part of a more general movement throughout Australia. Blevins paid specific attention to the technical mechanisms of life- support:

The particular aspect of dying that concerns me today is the lack of legislation in South Australia, or any other state, that gives a terminally-ill patient the right to refuse life-sustaining mechanical procedures when they serve no purpose except to delay artificially the moment of death (Hansard 18/7/78, p.40).

He was careful to emphasize the distinction between natural death and euthanasia. The speech was reported in the local newspaper the following day and the report included criticism by the President of the South Australian branch of the Australian Medical Association (AMA), who said,

It is a very delicate matter and one I believe should be left in the hands of the professionals.

and

I do not think it is a matter that the legislators should get into unless there is any abuse - and there is no abuse in South Australia (The Advertiser, 19th July, 1978).

The intention was to retain decision-making and thus power within the profession. This initial anti-legislation response eventually became the official attitude of the AMA towards natural death legislation.

Blevins circularised all the people who might have a professional interest in his proposals. This stimulated a number of responses. The Australian Society of Critical Care Nurses (ASCCN) felt that legislation of this type was not needed in South Australia. They recognised that most situations covered by the proposals would occur in Intensive Care Units which already had policies on withdrawal of life support. Furthermore, patients already had the right of refusal of treatment. The society suggested,

making the public more aware of this right, rather than legislate for a natural death Act (Letter, 25/9/78).

The Society did put forward the view that legislation might help communication between patients and medical staff and it might also help to educate and reassure the general public over the use of life support machinery.

The AMA, immediately took a defensive position to political intervention. Preparatory to formulating a decision, a joint committee with the ASCCN was arranged to discuss the topic of natural death and to gather information. Towards the end of 1978 a brief statement of the committee's findings was drafted which articulated the current medical attitude, that the perceived need for natural death legislation was probably due to a misunderstanding in the community of the aims of medicine in terminal illness. The apparent solution lay in educating the public. This education theme became a feature of the medical argument and was pursued at meetings with Blevins and in communications between doctors.

The final report of the combined committee was a wide-ranging document of comment and argument. It expressed concern that the apparent communication gap between the public and doctors was damaging to patient confidence. It argued that legislation was not the answer but rather educating the public in their rights. By comparison, brain death required legislation as well as public education. In addition, the location of decision-making within the doctor-patient relationship was emphasised.

In summary, it was felt that the most desirable approach was that the traditional attitude of support of the patient in a terminal illness and the family by those with a direct relationship with them (medical officer and nurse in the first instance) should prevail and that decision making be contained within that group (report of AMA-ASCCN Committee, 15/2/79).

The AMA accepted the report with a view to preparing a course of future action.

In August, 1979, Mr. Blevins, contacted the chairperson of the combined committee. Blevins intended to introduce the proposed bill to parliament and

requested an official comment. Draft legislation had already been drawn up and circulated in May, 1979. Individual responses were sought from a number of doctors and administrators who might offer a representative opinion. In the main, these opinions were negative, criticism varying from the futility of the bill to the increased difficulties which new legislation would introduce into medical decision-making.

On March 5, 1980, Blevins introduced his natural death bill for a first reading in the Legislative Council. It was referred to a Parliamentary Select Committee and the Secretary of this committee wrote to the AMA in April 1980 asking for a presentation or written submission of its opinion of the draft bill. The AMA's submission was prepared in June and consisted of a refashioning of the substance of the report of the earlier combined committee. Emphasis was given to the primacy of the doctor in decision-making within the doctor-patient relationship.

Decision making on therapy has been the prime responsibility of the medical officer ... (AMA Submission to Select Committee, 18/6/80).

Once again, it was argued that public concern over the reluctance of medical officers to withdraw inappropriate life support was misplaced and could be countered by education. The submission included the significant comment that "withdrawal of these techniques occurs frequently", implying an accepted medical practice. It ended with the suggestion that the select committee might extend its terms to consider brain death, in order, it was admitted, to protect the interests of the medical officer rather than the patient. Essentially, the submission was framed in terms of medical discourse - the decisions of doctors were in the best interests of patients and, although some required legal protection from public criticism, others were better left without legal interference.

In the same month, a supportive religious opinion was expressed in the local press by Father John Fleming, a popular columnist, which repeated the medical position. Under the heading "A Right to Life" he clearly stated the basic principle of the argument, "a person's right to refuse medical treatment". In a later paragraph he questioned the demand for legislation to achieve this, adopting an unqualified medico-centric attitude.

As far as I have been able to find out doctors are coping well with the new medical technology ... (The Advertiser, 30/6/80).

Fleming added that the terminally ill were not having the death process unduly prolonged.

In August, 1980 there was a request from the Select Committee for a submission from the Adelaide Hospital. It described the draft bill as formalising common law. It also commented on the misfortune that no hospital opinion had previously been canvassed. The Medical Staff Society of the Adelaide Hospital, via its honorary secretary, expressed the opinion that the proposed bill lacked full understanding of the problem and its associated ethical considerations. Lack of understanding of the problem was a criticism repeatedly made of parliamentarians with whom discussions continued. In addition, opinions continued to be given to the local newspaper.

On 7 October, 1980, a letter to The Advertiser from an authoritative medical source argued that a legal discontinuance of life support measures amounted to homicide. The result of the act, it was argued, would be a licence to play God. The bill was condemned because it sought to leap ahead of current social and medical ideas. On the other hand, the writer proposed that a definition of brain death would give legal sanction for a concept which had been medical practice for 10 years or more and was,

a good example of the way the law is brought up to date from time to time with contemporary ideas and practices within society (The Advertiser, 7/10/80).

In the one instance, therefore, the law was ahead of medical practice and should be contained; in the other it was behind and should catch up. The determining feature was medical practice.

It was difficult to deny that withdrawal of life support in the irreversibly ill was also contemporary practice. The AMA submission to the Select Committee had made that clear. In addition, Phillips et al. quite explicitly detailed the clinical situation.

A study of patients' records showed that of the deaths in the unit, 28 followed withdrawal of life-support care. Of these, 13 had suffered brain death according to standard criteria and 15 **had not** (1980:425, emphasis added).

Withdrawal of life support in the terminally ill was indeed contemporary practice. Despite this the protests opposing its legalisation by decision of the patient continued.

In October, 1980, representatives of the teaching hospitals met to discuss the proposed Natural Death Act in the knowledge that many of their medical staff were unhappy about parts of the Act. It was considered that a combined approach was necessary to inform parliament of their opposition. The meeting concluded that the proposed Act merely emphasised existing patient rights and that an education programme on these rights should be initiated. However, the definition of brain death (originally part of the Bill) was an effective and important piece of legislation despite the fact that it merely enshrined current medical practice in law. By contrast, the hospital representatives considered the Natural Death Act as totally unnecessary legislation which should not be passed

by parliament. There was no evidence, it was argued, that the Act would produce care superior to current practice and therefore it was unnecessary.

The non-partisan Parliamentary Select Committee disagreed. It unanimously recommended a version of the draft bill to the Legislative Council. In his speech to parliament, Blevins proposed the draft bill as a,

small but significant step in asserting the rights of patients to control their own lives. It also raises questions about the whole medical industry. Whose benefit is it for? (Hansard, 22/10/80:1280).

This struck at the core of the issue. Blevins intended to modify medical decisions by making the wishes of an incompetent person, like Karen Quinlan, clear before the event causing the incompetency. The autonomy of the patient in advance was the intent of the legislation. The medical profession continued to debate this aim.

On 1st November, 1980 the Medical Journal of Australia, the official organ of the AMA, published a letter with the heading of "Natural Death Legislation" from Gilligan and Linn, a South Australian intensivist and a vice-president of the local AMA respectively. They criticised the legislation proposed for South Australia and repeated much of the AMA position. Outlining the existing legal rights of patients, they argued that,

the solution to the problem of public disquiet felt by the South Australian legislators may be not in the passing of legislation, but in emphasising to the public their rights in accepting or declining treatment, and what can be done to aid the terminally ill (1980:473).

They concluded that when medical treatment had nothing to offer, the patient should be allowed to die in "comfort and dignity". Legislation to achieve this should not be necessary.

Despite continuing medical opposition which remained as firm but became more subdued, the Natural Death Bill proceeded through the parliamentary

machinery. In 1983, by a majority of three to one on a conscience vote, the Natural Death Act became Law No. 121 of 1983.

An Act to provide for, and give legal effect to, directions against artificial prolongation of the dying process.

To date, it has had little effect on medical practice. By 1989, probably a few hundred people had signed the declaration resulting from this legislation which made clear the signatory's refusal to accept unwarranted life support. The intensive care unit at the Adelaide has been presented with a declaration on only a few occasions, but the impact on future intensive therapy remains to be seen.

Deconstructing the Patient and the Gaze

The development of legislation in South Australia to support the concepts of brain death and natural death, has been described in detail in order to analyse the different tactics of the medical profession toward these concepts. The active promotion of the idea of brain death stood in marked contrast to the vigorous opposition to legislation for natural death. Both concepts were the result of applying modern technology to the practice of medicine but, originating from different sources, they reflected different attitudes in the effects. The idea of brain death was a medical initiative to take account of technical developments whereas natural death legislation condensed the societal opposition to technical medicine. There were different interpretations of the appropriate place and control of the medical applications of technology. The eventual result was that legislation established two separate areas of control which reflected separate discourses; one scientific, the other social. Brain death was legalised on the basis of a scientific discourse employed by medical specialists to describe their activities.

Natural death formulated a social concept of the patient in opposition to the medical. State intervention in these critical and technical circumstances legitimated two different frameworks for the doctor/patient relationship. The social construction of the patient was emphasized without undermining the scientific basis claimed for medical practice. In this way, the state, in mediating the doctor/patient relationship, acknowledged the effects of medical technology whilst simultaneously empowering patients and their agents to monitor its use. Thus the state ordered relations between doctor and patient, on behalf of the good of the public, to support two positions - medical progress and patient's rights.

The important point is that the state was able to increase control of the medical profession without direct confrontation in medical matters by providing conditions for its monitoring. This is not to argue that the state represented interests hostile to the medical profession. On the contrary, the state encouraged the scientific approach as much as the social, encouraging the discourse of both doctor and patient. The advantages to the public in both fields legitimated state intervention.

In the case of brain death, an increasingly scientific perspective to medicine in general and the body in particular allowed a methodical deconstruction of the patient. The application of technology was part of a scientific rationality which allowed a separation of systems. Brain death could be safely diagnosed as an event separate from the heart and lung functions. Furthermore, this scientific rationality arose from an anatomical approach to the patient which facilitated the recycling of viable donor organs such as kidneys. The process appealed to a utilitarian economic rationality which could be based upon science. The concurrence of scientific and economic rationality led to a widening of the charter

of patient care. The diagnosis of brain death was made in the interests of others - other patients, relatives, hospital staff and resources.

Historically, these interests and the interest of the patient had been best served by a 'clinical' approach to the patient; according to Foucault, 'the gaze'. The gaze was penetrating and informative and based upon a new methodology - pathological anatomy. Bodily secrets withheld, knowingly or unknowingly, would be exposed. The relationship between doctor and patient was one of dispassionate observation. The result of the gaze was a clinical transparency which markedly reduced the need for patient participation in the diagnostic process.

The effect on the patient was subordination which in public hospitals was reinforced by a physical and financial dependence. With no available alternative, hospital patients, grateful for charity, formed a population which was not only docile but useful:

And in accordance with a structure of reciprocity, there emerges for the rich man the utility of offering help to the hospitalised poor; by paying for them to be treated, he is, by the same token, making possible a greater knowledge of the illnesses with which he himself may be affected; what is benevolence towards the poor is transformed into knowledge that is applicable to the rich (Foucault, 1973:84).

The "gaze" could be applied to the hospital patient without fear of rejection because these were the conditions of mutual benefit to the rich and the poor. There was, therefore, a moral obligation to accept subordination. Clinical medicine - the clinic - was,

the interest paid by the poor on the capital that the rich have consented to invest in the hospital (ibid.:85).

Public patients were scrutinised, investigated and dissected in the hospital. Richardson (1987) also emphasises the advantages which accrued to doctors by

gathering the sick poor in one institution and, hence, the increasing importance of the hospital.

Thus the intimate relationship between charitable hospital treatment and training, medical patronage and the lucrative market of private practice was predicated upon the availability of a relatively passive pool of humanity upon which surgeons could learn and develop their craft. This the charitable institution provided (1987:48).

As the hospital became more important to the practice of medicine, personal relationships between doctor and patient became less important and those between doctors more relevant. The doctor-patient relationship was transformed within the hospital as the patient was deconstructed under the influence of the gaze. The relationship was defined by the medical gaze.

The way to a medical definition of the situation and the abstraction of parts from the body was paved by abstraction of the patient from society. The hospital patient provided the source of knowledge of disease, dissection and donation. There was always, as previously noted, an implied obligation for the patient to contribute towards medical progress as repayment in kind for the charity of medical treatment. The obligation of utility of the body of the patient to other patients was accentuated by a medical construction of death which fragmented the body. The relationship between these fragments was reflected in medical culture. Hospital specialist groups were constructed progressively around organs and techniques. Relationships among colleagues reflected relationships between organs and between techniques. Disputes, for example, were less over patients and more over body territory - over fields of expertise (see chapter four). The result was that no particular specialist was responsible for the patient as a whole. The doctor-patient relationship was more appropriate to an organ or to a system than to a patient. The development of hospital medicine, the process

which transformed the doctor-patient relationship, denied any possibility of self-determination for the patient. Patient autonomy was subsumed within the perspectives of medical authority.

The medical definition of the situation took precedence over all others. Peter McHugh (1968) suggests that a definition of the situation is possible, "only when physical space and chronological time are transformed into social space and social time" (1968:3). He analyses the organisation of social meaning by using the concepts of emergence, the temporal dimension of activity, and relativity, his term for the spatial dimension. Events are characterised by the social interpretation of their relationship with other events over time and across space. In these terms, the anatomical gaze refined the temporal and spatial relationships of the body and produced a framework which allowed a medical definition of brain death. With almost prophetic insight, McHugh writes that,

the meaning of a death itself shifts regularly for those concerned, whatever its biological finality (1968:26).

The meaning of death was shifted by a medical perspective which accommodated the 'biological finality'. The essence of the definition of brain death lay in the argument that death was a process. The definition of brain death was dependent upon both the chronology of past history and future prognosis and also upon the separation of and the relationship between systems. The technology of resuscitation, by separating and supporting different physiological functions, highlighted the social problems, but for the medical definition the situation was clear. Medical technology could support bodily functions but death could still be determined. As Foucault writes,

Death is therefore multiple, and dispersed in time: it is not that absolute, privileged point at which time stops and moves back; like disease itself, it

has a turning presence that analysis may divide into time and space ... (Foucault, 1973:142).

and

To this chronological picture of successive death must be added the spatial picture of the interactions that trigger off chain deaths throughout the organism. These occur in three main relays: heart, lungs and brain (ibid.).

The technological separation of these 'relays' created possibilities for medical definitions of the situation beyond the knowledge of the public. The concept of brain death required the public to be educated in and to accommodate to accepted medical practice. The medical meaning of death was proposed in terms of a discursive reality which was, at the same time, scientific and social.

The decision was firmly medical and technical but it was important to convince the public that the traditional medical values were upheld. The medical profession needed to show that brain death was not only a technical decision but also a social decision with the interests of all best served. The ultimate success of the medical argument depended upon the co-operation of the state and legislation but it was helped by the education of the public. The aim was to establish the continuing propriety of medical decisions such as brain death. In the same way, it was essential to convince the public that medical decisions over treatment of the terminally ill did not require a legal definition of natural death. Again education was the proposed strategy. To refute outside interference, it was argued that decisions were always in the best interests of the patients and the safeguard of patients' rights was adherence to a code of medical ethics. Patients' rights, it was argued, were protected by,

the ethical system that has evolved and by the current laws governing medical practice" (AMA Submission, 18/6/80).

The propriety of medical practice was thereby guaranteed.

The main safeguard for the patient was the principle of informed consent. Reflecting the broader issue of public education, individual consent to personal treatment was based upon information. The assumption at both levels was that both the public and the patient would agree with medical decisions and that information was the key factor. I have drawn attention previously to the argument of Else Øyen that ethics serve as a means of information control. Ethical secrecy and the special relationship of the doctor-patient relationship were constructed both to elicit and to control information. Within the traditional doctor-patient relationship information was given by rather than to the patient. However, at the same moment that hospital medicine was established, and the patient subordinated in the 'clinic', the opportunity arose for increased scrutiny of the medical profession. Progressively, more information became accessible. Medical records, comparative statistics, clinical trials and publications provided a view of the medical profession which had previously been unavailable. Hospital doctors and their practice became more visible, public and accountable. The results of treatment were recorded and could be compared and analysed. Not only the practice of medicine but the process of medical decision-making itself could be scrutinised. The eventual result was a greater public awareness of the non-medical content of some medical decisions.

Ian Kennedy (1980) has pointed out that many of the decisions that doctors make are ethical rather than clinical. The position taken by Kennedy highlights the basic paradox. Whilst the code of ethics should protect the primacy of the patient's needs, these needs were defined in medical terms. The information necessary for decision-making was not only controlled but also abstruse so that the patient, informed or not, was unable to influence the medical behaviour affecting

his or her future. Decisions were made, in good faith, by the doctor on behalf of and for the claimed good of the patient. Privacy surrounding the doctor-patient relationship excluded the questioning of medical decisions or the judgement by others. Non-medical opinions were unwelcome and medical opinions were given only on request and again strictly controlled by ethics. The patient's opinion was usually solicited as a routine support for the medical process. However, when the immense social and financial consequences of some technological medical decisions such as those pertaining to chronic life support became apparent, the ethical basis of the decisions was examined by outsiders to the medical profession.

The new approach to medical ethics began to establish the primacy of the patient's wishes. The dilemma of Karen Quinlan was resolved by asserting her self-determination via her father. Ironically, from a medical ethics viewpoint, this was argued and established on the grounds of privacy. The perspective of the gaze and medical technology had conspired to achieve an extensive level of intrusion into the body and its subsequent fragmentation thereby destroying the construct of a patient-as- person. The ethic of personal privacy re-established the importance of individual integrity. To complement and to oppose or, rather, to balance medical autonomy, patient autonomy was proposed as a safeguard against medical infringement of patients' rights. The patient would have an active role in defining the situation and deciding treatment. The definition of the situation would thus become less medical.

The implications of this were not lost on the medical profession. This limitation of medical control underlay the arguments addressed to natural death legislation. As I have emphasised, in contrast to brain death, the concept of natural death was publicly and vigorously opposed by the medical profession

especially the intensivists. The crucial issue raised by this opposition to natural death was summarised in the Medical Journal of Australia by an academic lawyer,

The purpose of natural death legislation is to allocate decision-making authority between doctor and patient. The diagnosis of terminal condition and the imminence of death is for the doctor. The decision regarding refusal to consent to treatment in the form of a written direction, is for the patient (Thomson 1981:452).

The doctor's decision was to be confined to the purely medical. The patient would decide the course of action upon the doctor's information or, rather, would decide in advance in case the patient become incompetent. Legislation provided an opportunity for the will of the patient to be expressed. The important feature of natural death legislation was that the responsibility for decision-making was shifted perceptibly towards the patient. The implication of the Natural Death Act was the reappearance of the patient at centre stage with practical as well as symbolic significance of the doctor-patient relationship.

The revival of a patient-centred ethic has received growing attention from ethicists, particularly in America. Callahan (1980) had reservations to its morally superior value but Arras and Murray (1982) underlined the importance of the re-emergence of patient autonomy.

In response to an antiquated and narrowly professional Hippocratic ethic, contemporary bioethicists have enshrined the 'principle of autonomy' as the centrepiece of their emerging theory of how patients and physicians should relate to one another. A firm principle has gradually emerged from the convergence of various ethical traditions to the effect that medical decisions concerning the lives of patients properly belong to those patients, and not to physicians, no matter how knowledgeable or well-intentioned the latter might be (1982:123).

A recent review of ethical principles in critical care put autonomy as a principle "that has increasingly gained acceptance in the United States" (Luce 1990:696). The Natural Death Act in South Australia gave substance, although limited, to the autonomy of the patient in deciding a course of medical treatment in extremis.

Death could be required to be more 'natural' and treatment more non-interventional than might otherwise be determined by the medical profession.

In effect, the concept and legal establishment of natural death reconstructed a patient who had been divested of social relevance in the 'anatomisation' of the medical gaze. This deconstruction of the patient was opposed by a viewpoint which attended to the social relevance of the medical process - a social definition of the medical situation. Diana Crane (1975) predicted similar developments 15 years ago. On examining physicians' treatment of critically ill patients, she concluded that there was an increasing demand for patients to exert autonomy and an increasing unwillingness to accept unquestioningly the physician's judgement. The implications of the study were, she argued, that there was in process a cultural transformation in the definition of human life. She concludes that,

as the results which the physician can offer become more ambiguous in terms of their social value to the patient, one can expect that the physician's authority will increasingly be questioned (1975:212).

This was the crux of the matter in arguments leading to the introduction of the statute on natural death.

Conclusion

By comparing and contrasting the processes which led to two pieces of legislation, I have analysed an area where the clinical autonomy of the doctor could at last be questioned. The comparison was made between a medical and a social definition of death to analyse the extent of medical authority in the doctor-patient relationship. The definition of the situation in medical or social terms

produced agreement or opposition accordingly. On the one hand, the medical profession sought to establish a legal definition of brain death which would protect the doctor from the legal consequences of withdrawal of ventilator support. On the other hand, vocal opposition characterised the medical attitude to a legal definition of natural death which obliged doctors to withhold or withdraw ventilator support, even though this had been common medical practice. This response was due to what the profession perceived to be a fundamental threat to medical authority. The small increase in patient autonomy represented a shift in the balance of power in the doctor-patient relationship, a reduction in medical dominance in the clinical arena. Paradoxically, this followed from the deconstruction of the patient within the hospital which had been originally a powerful impetus for medical authority.

CHAPTER 8

CONCLUSION

This thesis has examined the historical development of the social structure of the medical profession within the context of a major public hospital. The methodology employed to achieve this has not only been historical but also ethnographic in a conscious attempt to avoid narrative history and ahistoric sociology. The context chosen was also deliberate, the aim being to analyse some of the changes in the relationship between the medical profession and the state. The hospital was the focus of analysis on account of its diagnostic value in identifying some of the elements of this relationship. The study analyses the continual attempts of the hospital medical staff to control their domain of work practice in the face of a simultaneous and determined increase in state penetration of health services in general. At one level, therefore, this thesis analyses change and conflict within a profession; at another level it is addressed to the problems of increasing state hegemony in the welfare order of contemporary Australian society. In a sense, the analysis of changes at both levels details a historical process from principles of charity to unabashed utilitarian concerns.

At a number of stages in my study, my analysis has developed points of contact with a Foucaultian perspective. In particular, I have addressed the exercise of power. Power, Foucault writes (see afterword in Dreyfus and Rabinow, 1983) exists only when it is put into action and this action modifies other actions. Thus, activity defines a relationship of power and these relations

are embedded in local level social networks. Social networks as a map of relationships at the local level form the basis of my Foucaultian perspective. As Foucault argues, power must be studied where it becomes 'capillary' at the extreme point of its exercise where its effects are produced. The organisation of micro-power arises from social interaction at this local level. Foucault suggests that power relations may be analysed by focusing on institutions which,

constitute a privileged point of observation, diversified, concentrated, put in order, and carried through to the highest point of their efficiency (ibid: 222).

The substantive material of this thesis presents the "privileged point of observation" of the Adelaide Hospital. The relations of power are the focus of the analysis, not the individual nor the exercise of personalised authority. The unit of analysis is the group, the occupational community and its subcultures.

At other points in my study, I have used explicit Weberian ideas, in particular his concept of rationality, to analyse power relationships within the medical profession and between it and the state. One focus of my analysis has been the penetration of the hospital by the state and the increasing adoption of processes of rationalisation as mechanisms of ordering hospital society. The state represents numerous powerful and not so powerful groups, some of which are hostile to the medical profession but direct confrontation is usually avoided. Rather, as I have argued, the state through its local agents creates the conditions for rational activity. Within the hospital, subject to state finance, this process most commonly takes the form of an economic rationality which becomes a charter for management replete with discursive strategies of efficiency and utilisation. The charter, as the explicit end of ideology, appears as an identifiable rhetoric of

ordered statements with their own sense of inviolability. Rationalisation driven by fiscal control becomes the only legitimate process for ordering this hospital.

The medical staff, formerly, the dominant force in hospital society are now exposed to a hospital environment radically penetrated by new ideas of production. To counter the process of rationalisation and to re-establish its dominance, the medical staff appeals to charters of its own. The legitimisation of medical authority and activity by claims of the good of the patient is a powerful appeal to the morality expressed by the professional model. This moral legitimacy, however, is co-opted by the state so that economic rationality may be pursued for the good of patients as a community, for the public good.

I have, therefore, throughout this thesis, been interested in the growth of power of various kinds and, particularly, with the effects on the hospital medical staff. Under the professional model, relationships were the result of transactional power. Collegiate negotiations might be unpleasant but were within accepted bounds. Indeed, similarity to the rules of conduct was learnt very early in the medical career. I have documented not only a breakdown of these rules but also the growth of different rules out of different power relationships. Whilst the medical staff remained organised as a 'professional' concern, the new order of 'managerialism' overtook it. The medical staff, distant from negotiation and manipulated by distant forces, discovered that they could react to but less successfully influence hospital decisions. In essence, the hospital social order was transformed as the traditional medical world was eroded.

The purpose of my extended case-studies is to supply an ethnographic basis for my arguments. The results of the analysis evidently run contrary to a widely accepted argument of medical dominance and by contrast demonstrate the ebbing

of power in the activities of the medical subcultures within the hospital. This decline has been pointed to in a few papers. For example, David Armstrong (1976) in reviewing government reports since the introduction of the British National Health Service, concludes that,

there is evidence of a gradual decline in the strength of the medical hegemony (1976:157).

Coburn, Torrance and Kaufert (1983) find similar evidence in Canada and argue that an important factor was the loss of control over the medical means of production to the state. They link this to large-scale processes in society and in a subsequent study of chiropractors, Coburn and Briggs (1986) conclude that,

the decline of medicine and the rise of chiropractic can both be related to the underlying influence of working class organisation and pressure and, more proximately, to increased state involvement in health care (1986:1045).

I have discussed previously aspects of working class organisation in chapter five.

Within a narrower field in Australia, Thelma Hunter (1984) sees the sources of a decline in the hegemony of the Australian Medical Association to lie in a wider critique of the medical profession and the realities of a changing political scene. Whilst Strong (1979), from a totally different perspective argues that sociologists have exaggerated the threat of medical imperialism by overlooking the factors which limit this threat. Her list includes financial constraints, restrictions on entry and a "bourgeois emphasis upon the liberty of the individual subject" (1979:210), all of which I have expanded in previous chapters.

A small number of sources, therefore, have provided some limited ethnographic evidence to support a general theory of a decline, or at least a limit to medical dominance. The points held in common by these approaches are that first, the decline in medical power has been associated with the rise in

interventionist policies by the state and second, the decline is an event of recent origin - variously, "the last twenty-five years" (Armstrong 1976: 157) or "the past twenty years" (Coburn et al. 1983: 425). With these two points in mind, I turn now to review my ethnographic material.

A Review of the Evidence

In chapter two, I documented how the issue of rebuilding the hospital in the 1960s was eventually resolved. The expectation of the medical staff was that its opinion would be the major influence. Whilst changes in the type of medical problems had provoked a reassessment of the hospital building, the final decisions were managerial and attached to the concept of planning. Parochial medical interests were ignored and, specifically, private medical beds excluded.

In the same way as control of the hospital by external authorities fell outside the area of influence of the medical staff, its internal divisions became less negotiable in purely medical terms. Increasingly, justification of the use of resources was demanded by the administration and computerised records formed the basis of judgement. Insufficient or inefficient use of such resources as available beds or operating theatres forced a modification of medical territory. Significantly, medical protest could be stifled by the rationality and neutrality of figures. An under-used ward or operating list could not be maintained as a proprietary right of any particular doctor. The computer functioned as a tool of managerial organisation of the medical staff.

This thesis emphasizes the ordering of hospital society in a particular form - a process of rationalisation. Computerised records represented a

technology of rationality and my purpose has been to analyse the effects of this, as a managerial technology on the medical staff. Initially, managerial perspectives of rationality were confronted by the totalising character of medical care, whereby all aspects of the hospital were claimed by the medical staff for the medical domain. Separation of non-medical areas, hospital building for example, from medical areas forced a redefinition of the boundaries of the medical world. By continual reclassification of hospital decisions as "non-medical", the state achieved a limit to the ambit of legitimate medical influence. Increased monitoring of an increasingly dependent medical staff achieved the same result in areas less easily defined as non-medical, such as theatre utilisation. The ultimate grounding of medical authority in the doctor-patient relationship preserved a residual area, more-or-less free from intervention but, even here, medical decisions were assessed and sometimes challenged (chapter seven). The shifting boundary between medical and non-medical decision-making territory is crucial to an analysis of medical dominance. Medical decision-making was limited progressively by an expansion of managerial power, here acting on behalf of the state.

The medical response to this limitation of influence was a continual attempt to redefine all decisions as clinical. To this end, throughout the history of the Adelaide Hospital, the rhetoric surrounding quality of patient care, together with concerns over the adequacy of teaching have been repeatedly linked with claims for greater authority over the running of the hospital. The effect of such rhetoric has been to elevate each dispute to the level of a moral crusade.

Patient care as a guiding principle surfaced during the fibre-optic dispute (chapter four). There were, however, other concerns expressed by the actors and these included the clinical privileges of a group of specialists - that is to say, their

control over the content of their work. The important aspect was that the exercise of control, the mechanism of discipline was attempted by one group of specialists over the activities of another not by an external agency. The department of thoracic medicine scrutinised the work realm of the anaesthetic department. In a sense, historical and continual conflict within the medical profession was reproduced at departmental and specialist level. Simultaneously, conflict was defused by advocating the cause of patient care - by appropriating a moral theme which transcended territorial disputes. The state, via the hospital managers, was not concerned as long as the activities of the hospital continued more-or-less undisturbed. The incorporation of the medical rhetoric of "patient care" signified that the staff on both sides of the conflict saw the fibre-optic dispute as medical. Despite this, resolution was only achieved when the threat of an external, non-medical judgement became real. The solution lay in increasing the fragmentation of the respective medical fields - in a finer job description. Conflict could be reduced by isolation and segmentation of medical practice. Segmentation of the medical staff, therefore, created a system of control which was exerted at a number of levels. Intra-professional and inter-specialist conflict made for a continual lack of unity - one of the continuing fears of the AMA. Furthermore, segmentation produced groups of unequal status - a further fear of the AMA. The AMA realised that there was always a potential for the creation of status differences between specialists, especially when one relied upon another for patients. This potentiality applied equally within the ranks of a single speciality.

Such trends were reproduced and magnified within the Adelaide Hospital. This was partly the result of increasing specialisation, legitimated by appointments

at the state hospital. But also, it was reflected in a separation of developing roles within the hospital which eventually produced a vertical hierarchy of medical staff in a progression from junior to senior. Originally conceived in terms of apprenticeship or preparation for private practice, the graduated scale became the training scheme for specialist practice. The result was that a significant proportion of the medical staff were exposed to the personalised dominance of senior colleagues. Vertical and horizontal divisions within the medical profession provided easily exploited mechanisms of control. The outcome of specialisation and a training hierarchy was an increase in surveillance of doctors by doctors.

The critical divisions within the medical profession were repeated within specialties such as anaesthesia. Horizontal divisions here were expressed in terms of employment as either full-time or visiting specialists. In other words, specialists were classified according to whether their practice was mainly public or private. The conflicting requirements of these two modes of practice were highlighted in the training scheme dispute (chapter six), where the necessity of providing a training scheme and a sufficient number of juniors to do mundane tasks such as caring for the simple needs of patients proved incompatible with limiting competition for private patients. Protection of the private market was expressed, however, in the terms of professional rationality. Each specialist required a minimum number of cases per year and every anaesthetic should be given by a specialist. Once again the argument was elevated above the conflict on the ground to a moral level - in this case the dispute incorporated all aspects of professionalism (see chapter six). The result was a subordination of a segment of full-time specialist staff. The staff anaesthetist was subordinated to the requirements of private practice. Not only was control lost over content of work

but also hours of work, the conditions of work were imposed on a reluctant group of medical staff. In addition, this control was exercised within the medical profession. Conflict between doctors was accommodated by an acceptable surveillance of one group by another.

The imposition of conditions of work by the departmental director was an explicit expression of power which had always been implicit in the medical hierarchy. The state remained uninvolved whilst senior anaesthetists reduced the number of junior employees whilst still fulfilling the departmental commitments to the hospital. Refusal to partake in the new conditions by the full-time staff was virtually impossible and would have provoked state intervention. Resistance to such expressions of power have always been problematic for the majority of medical staff.

The successive ethnographic case studies highlight the difficulties which the medical staff had in adopting a successful strategy to counter threats of territorial incursions and increasing control. One of the problems lay, and continues to lie, in creating a unified approach to perceived threats. Professionalism has been the incorporating ethos of resistance for doctors throughout most of the past century. Repeated claims to a higher morality of dedication to the care of the patient have underpinned the independence and power of the medical profession. Such appeals have been documented in each dispute here. Despite these tactics, the majority of medical staff felt an almost inexorable loss of power. Professionalism as a strategy seemed to have lost much of its strength as a "counter-power". More direct means to protect their threatened position have been resorted to by hospital medical staff in the form of a growing unionisation, a development which appears to support a proletarianisation theory which I discuss in the following section.

Proletarianisation

McKinlay and Stoeckle (1988) in continuing attempts to analyse major changes in the medical profession repeat one definition of this process.

The theory of proletarianisation seeks to explain the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism (1988: 200).

They specify seven prerogatives which are lost or curtailed through the process of proletarianisation, many of which I have addressed previously. Categories such as "autonomy regarding the terms and content of work", the "tools of labour", the "means of labour" and the "amount and rate of remuneration for labour" I have analysed in detail.

A more general definition was adopted in the work by Oppenheimer (1973). He used a concept of the "ideal-type" and argued that each example only tends towards this end model. By proletarianisation he meant the form of work where there is an extensive division of labour, the conditions of work are not determined by the worker, the primary source of income is a wage and to defend his deteriorating standards the worker moves toward collective bargaining.

In short, bureaucratic organisational structures lead to proletarian conditions of work and, in turn, defensive reactions which can be considered the beginnings of a working-class consciousness (Oppenheimer, 1973: 213).

Such different viewpoints have led to criticism that different authors might not be discussing the same thing (see Willis, 1989: 208). There is, however, a common foundation for all these approaches and it is based on the observed processes, in hospital medical staff for example, of an increased division of labour, loss of control over the workplace and the conditions of work and a loss of status.

The formation of an industrial association, SASMOA, did not, however, resolve these problems. Sectional interests were embodied in the structure of SASMOA and expressed in differing and sometimes opposing attitudes to its industrial activities as documented in the proposed strike (see chapter five). Furthermore, industrial action, overtime payments, and so forth, were at variance with the professional rhetoric of dedicated patient care and the individual doctor-patient relationship. In a sense, successful unionism contradicted the morality of professional discourse. Solidarity could only be achieved by adopting common values concerning patient care and teaching. The pragmatic issues of salaries, hours, overtime and so on exposed the fundamental fragmentation of the medical staff along lines of level of training and mode of employment. As a strategy for medical dominance, unionism was incomplete. The fact that some medical staff were willing to engage in union activities, however, would appear to mark a transformation in the nature of medical work as they saw it. Whether this marks a process of proletarianisation remains to be seen.

One conclusion, however, can be drawn. The hospital medical staff, particularly its senior members, felt distanced from the decisions which affected their daily work. Their current and future conditions of work depended upon the planning of distant authorities over whom the medical staff had little control. They were separated from the means of practising medicine which were controlled by the administrators. Moreover, because the medical staff had to compete for these reasons in a financially constrained and managerially organised environment, they were separated from each other. Feelings of powerlessness and isolation permeated a medical world whose rules had changed. The formation of a union might be seen as much a response to estrangement as to proletarianization. The

changing world was characterised by the rise of a new managerial class which included some doctors.

I have explored the relationships between doctors and the administration at the hospital at length in the previous chapters but one issue relating to the managers and the managed demands further attention. A critical determination, as Wolinsky writes, is that,

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? (1988: 43).

The operational distinction is whether or not,

physician-administrators as a class fully and permanently divest themselves of all actual medical practice (ibid).

The distinction became important in the historical development of the Adelaide Hospital and a shift in emphasis of the training of physician-administrators has been documented in chapter three. Put briefly, the status of the first medical superintendents, was buttressed by their clinical skill. Later superintendents and later still, medical directors, were sustained mainly by managerial expertise. The significance for the current argument is that whilst decisions over the organisation, content and context of work appear to be taken by colleagues, these colleagues are administrative rather than medical. This was reproduced at other levels in the hospital hierarchy so that the director of anaesthesia, although rising through the anaesthetic ranks, had little current experience of the conflicts of everyday anaesthesia but possessed the power to organise everyday anaesthetists. As Freidson (1970b) argues, it is not prior training but current practice setting which determines professional orientations and performance. Medical managers, therefore, become more managerial and less medical in a bureaucratic hierarchy

where the clinical task at hand is only one of the considerations influencing managerial decisions.

Hafferty, in a succinct discussion of evolving views of the professional dominance theory, and drawing from Freidson's own critiques of his opposition, suggests other avenues for exploration which are amenable to empirical investigation (see 1988: 209). These include the increase in competition among practitioners. This thesis has documented a continuous conflict within the medical profession based upon competition for hospital appointments, fields of expertise or private practice. This culminated in the training dispute (chapter six) and an explicit attempt to limit access to the private patient market. Whether there was an increase in competition amongst medical professionals is not the relevant point, the issue is that intra-professional competition continually made problematic the foundations for and of a united profession. Indeed, the consensual basis for the status of medical practitioners as a profession could never be totally assured. A surer footing was found in rhetoric, myth and ideology.

A second avenue directs analysis to another aspect of medical consensus. Freidson writes that,

of far more immediate importance to the solidarity of the profession is the second of two changes - the collapse of the norms governing the way colleagues evaluate and control each other (1985: 24).

In the fibre-optic dispute, the scrutiny of one department by the other was resolved internally to the medical staff concerned, only after open criticism and when the threat of an externally imposed solution became imminent. The future implications of the computer to the hospital medical staff are that aspects of medical practice in dispute can be assessed in managerial terms (i.e. occupancy, utilisation, turnover and so forth). The scrutiny of one department by another in

the competition for resources can be placed, therefore, in the terms of a managerial rather than a professional discourse. Computerised information and managerial assessments outdate professional ideas of who does what and when. This leads to an ordering of hospital activity which contradicts professional autonomy. Operating lists, for example, were altered and the distribution of beds arranged to satisfy requirements of efficiency and utilisation. Freidson argues that,

in the case of medicine, both supervision and control and the creation of 'production standards' are carried out by members of the same profession as those who perform the basic, productive work (1985: 27).

The supervisors and controllers at the Adelaide Hospital were medical but not clinical and more easily identified by the clinical staff as managerial. Indeed, the medical administrators articulated the needs of the state rather than the profession. These needs could be met by managerial measurements without challenging medical knowledge itself. Such a challenge, however, was foreseen by Marie Haug (1973) in her 'deprofessionalisation' thesis.

Deprofessionalisation

The computer as a mechanism to limit medical power has been addressed from a different perspective by Haug. Computer technology formed one of the bases of her ongoing discussion of deprofessionalisation. Her hypothesis has always been addressed to the relationship between provider and client - in the case of medicine, the doctor-patient relationship. She defines deprofessionalisation as,

loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over the client (1973:197).

Her most recent formulation of this perspective continues to view esoteric knowledge as a foundation of medical power and computer technology as the greatest threat to this knowledge monopoly. Computerised diagnosis and treatment should present a threat to medical judgement and authority by the review of easily accessible computerised information. However, as Haug admits, "that has not come to pass, at least not so far" (1988:55). The important point, surely, is that codification and accessibility of medical knowledge are not essential conditions for modifying the dominance of doctors. Haug misses this aspect of computerisation perhaps because it is somewhat lateral to her main thesis which focuses on the doctor-patient relationship. In distinction to Haug, I argue that the computerisation of medical activity not knowledge is the vital factor in surveying and controlling the medical profession. Assessment of the efficiency of this activity by the state's agents leads to potential changes in medical practice, voluntarily or imposed. The irony is that this mechanism of control of the medical profession can be achieved without understanding medical knowledge or intruding upon clinical practice. Indeed, to achieve this end without vigorous medical reaction, the state emphasizes that clinical knowledge is the sole preserve of the medical staff. My point of departure from Haug is that the content of medical knowledge does not require analysis by administrators or the state to achieve surveillance and control of members of the medical staff. It is their activity in using their knowledge which is the object of analysis, modification and standardisation.

On the other hand, the content of medical knowledge and its expression in clinical activity has become of increasing importance to consumers in terms of social norms. By this, I mean the growing concern with the mechanical conversion of person to patient and the social results of medical decisions within such a transformative context. This is more in line with Haug's approach but again, the question of an education gap is irrelevant. With no knowledge of medical theory but with an unease about certain aspects of medical practice in social terms, a small group provoked a parliamentary act and created the category of natural death in the face of medical opposition (see chapter seven). The motives for this action were social and cultural rather than medical. The challenge to the knowledge-based authority of medical staff arose not because of increased access to or increased understanding of this knowledge but rather because of the results of its application. The fragmentation of the patient occasioned by the specialisation of the medical staff eventually provoked opposition as the status of the person as a whole acquired increasing societal value. The maintenance of life-support in irretrievable patients who were not brain-dead became less acceptable as a medical strategy when social factors were taken into account. The creation of natural death as a social possibility contrasted sharply with brain death as a medical construction. Brain death could be diagnosed at the appropriate medical time only by a doctor. Natural death was defined in advance of the situation by the patient. Without acquiring medical knowledge, the patient regained a small participatory role in the medical decision-making process. Just as relevant is the fact that this role achieved a legal status. By signing a legal declaration, a person - a potential patient - could direct a medical practitioner in the future to withhold extraordinary measures to support life. Consequently, the

Natural Death Act marked a significant shift of power towards the patient in the doctor-patient relationship.

This was aided by the increased visibility of medical activity. The concealment of the patient within the hospital and an ethically inspired silence had protected medical behaviour from scrutiny by the public or state for many years. Paradoxically, however, the hospital also provided the structure for the patient eventually to exert some control over the doctor. As the activity of medical staff became more available for scrutiny and as the idea of patient autonomy grew, the patient, or his advocates, who are also potential patients, became observers of the activity of the medical staff. In this enterprise, the visible end results were questioned more than the unknown content of medical knowledge. Returning to the schema of Haug, therefore, the ethnography of this thesis lends some support to a modified deprofessionalisation thesis. She writes that,

clients want, on the one hand, expert opinion, but they no longer accept it unquestioningly, daring to ask if the experts are really right, and daring to complain if as clients they are not treated with proper understanding and respect (1973: 208).

The important point is that criticism was aimed at social results rather than medical process.

Medical Dominance Revised

Some of the previous discussion has been directed towards the aspects of my ethnography which appear to provide evidence for the proletarianisation and deprofessionalisation arguments. At this point, it should be clear that the thesis as a whole does not adopt either perspective in totality. My intention is rather to

indicate some ground in common between myself and proponents of these viewpoints and, indeed, other theorists such as Braverman (1974) whose concept of deskilling would find some support in the evidence I have presented. It is clear, however, that the evidence does not fall easily within these analytical frameworks. I have used these ideas partly because they identify the main constituents of an 'anti-dominance' approach to the medical profession and partly to distinguish my particular argument.

Throughout the discussion over 'medical dominance' one fact is generally accepted by proponents and opponents alike - the medical game has changed. Willis, for example, acknowledges that conditions have changed in Australia but he is reluctant to concede much ground in his argument that,

medical dominance continues. What decline there may have been has not been sufficient to suggest that either deprofessionalisation or proletarianisation has or is occurring (1989:213).

Within his analytical categories of autonomy, authority and sovereignty, he concludes instead that

medical dominance has changed its form and become more subtle and indirect than previously (ibid).

Willis is less sure of the shape of things to come and accepts that the future of medical dominance may be uncertain.

Freidson, for his part, accepts that conditions have altered but rejects their significance. He contends that changes in the medical profession are cosmetic and superficial rather than transformative and fundamental. He argues that changes will continue to occur at the periphery of medicine's jurisdictional boundaries,

But there is no reason to believe that medicine's basic position of dominance, its key position in the health care system, will change (1985:32).

He does agree, however, that as a result of lack of cohesion in political organisation, medical control over the economy, policy and organisation of health care may become problematic.

My contention is that medical control of these and other areas in the Adelaide Hospital have become problematic because of a key player in the game - the interventionist state. As Yeatman argues, the complex, interventionist state is,

a central site of social, political, cultural and economic struggles over the distribution of social, political, cultural and economic resources (1990:x).

Much of my ethnography illustrates these struggles. This is not to argue that the interventionist state is necessarily a confrontationist state. On the contrary, the state supplies the arena for conflict without taking part in the struggle directly. It does however, determine the rules of the game. In this way, state intervention in the Adelaide Hospital did not challenge medical authority directly but supplied a legal-rational framework for confining medical activity. Arguing within the rules, therefore, the medical staff were forced to examine their own position. The contest was not necessarily with the state but with the hospital administrators, other doctors, even the patient. The estrangement experienced by medical staff was solved not by a rejection of the new managerial order but by an adaptation to it. Within the hospital society organised by frameworks initiated by the state, the medical staff carried on the practice of medicine. Medical dominance, however, was limited and autonomy supervised.

Future Perspectives

One aim of this thesis has been to contribute to the growing volume of Australian literature analysing other professions in terms of limitation of power.

By so doing, two results are achieved. First, this thesis presents an alternative approach to analyses which, of late, have been too dominated by a preoccupation with professionalisation as a concept or a process. In assessing the rhetoric of occupational claims, the supposedly desirable transformation from occupation to profession has attained a spurious mystique. Second, the thesis may not only be of interest to analysts of the limited sphere of medicine but may also reflect fundamental socio-cultural trends. An interesting possibility for future theoretical research would be comparative analysis of the legal and teaching professions and their relationships with the state and its institutions.

The Adelaide Hospital has been the location of my fieldwork and the focus of this thesis which has revealed a progressive limitation of medical authority - a supervised autonomy. The hospital as an institution has been central to my analysis presenting a socio-cultural stage for the changing roles of doctor, patient and state. The important implication is that other transformations of hospital practice will provoke further changes in medical activity with continuing challenges to its status as a profession. The indications are that such transformations have begun.

I have repeatedly made the point that transformations in the medical staff of the hospital are not an isolated result of intra-group conflict but rather, reflect changes in the medical profession in general, occurring as a consequence of wider socio-cultural forces. The trend of these movements is likely to continue in the foreseeable future. In general, the practice of medicine may be subject to more legal judgements, more ethical constraints and more surveillance under the guise of peer reviews. The effects of these movements may be to restrict further the domain of the medical professional.

In one sense the medical profession has become deprofessionalised in partly losing its way with patients and colleagues. In another sense it has become proletarianised as a result of changes in its status, work and market conditions. Whether the medical profession can ever be alienated from its labour to the extent of the working class is, however, problematic. This is why I have used the word 'estrangement' in order to convey a sense of disenchantment with a world which has changed for the medical profession in general and the hospital medical staff in particular. It is difficult to see, however, how the medical profession, faced with an increasing rationalisation which obscures and displaces a commitment to a long-term ethic, can itself change from within.

The problem for the future is to encourage the best of professionalism whilst curbing its excesses. The problem is to save professionalism from itself (Freidson 1990:443). Freidson argues that this is best achieved by strengthening the spirit of professionalism, encouraging professional review and supporting professional goals. In brief, the solution is to make the professional model more of a reality than an ideal:

The goal should be to strengthen collective commitment to the quality of work for the benefit of patients... (1990:445).

This has always been the goal claimed by the medical profession. The essential problem is to control group self-interest openly so that a patient commitment is easily visible. It may be that the growing respect for an ethic of patient autonomy may achieve the appropriate modification of medical autonomy in the individual doctor-patient relationship. In the absence of empirical evidence, however, it is more difficult to predict the result of accommodating professional, bureaucratic and market models within the hospital environment. This remains for further research.

From its origins in charity and philanthropy through its transformation to motives of efficiency and utility, changes in the hospital have reflected, refracted and reacted upon a medical culture. In addition to its local characteristics, wider cultural attitudes are reproduced in the organisation of the hospital. It can be anticipated that this will continue. Future changes in the Adelaide Hospital will condense the rhetoric and the reality of South Australian culture and the hospital will continue to provide a fertile ground for, in Foucaultian phraseology, the archaeology and genealogy of the medical profession.

APPENDIX

THE PROFESSIONAL ME AND THE CRITICAL SELF

In a collection of articles related to the theme of 'anthropology at home', Angela Cheater (1987) discussed the problematic of the 'citizen anthropologist'. Although addressed specifically to Third World anthropologists working in their own society, she seeks answers from us all. Why, she asks, has social anthropology persisted in its self-image of studying other cultures and found anthropology at home so unattractive? Why do citizen anthropologists have so little of interest to communicate? "In short", she asks, "are we afraid to face the problems of conducting fieldwork among our equals?" (1987:176).

The problem Cheater addresses is the "Malinowskian separation of anthropological professionalism from citizenship" (1987:164). For Malinowski, the final goal of ethnographic fieldwork was, "to grasp the native's point of view, his relation to life, to realise his vision of his world" (1961:25, original emphasis). In this way is the professional distinguished from the amateur. The professional anthropologist also is easily distinguished from the citizen in the Trobriands but this 'Malinowskian separation' becomes problematic in the study of our own societies. Cheater clarifies the idea of citizenship by focusing on the notion of 'constructive engagement'. Indisputably, I was constructively engaged within my own medical society and the tension, and its resolution, between the roles of anthropologist and citizen is the real subject of this methodological appendix. The obvious starting-point of such a discussion, according to Cheater, "is to understand our own constructions of 'self' and 'other' in a system to which both are committed" (1987:167). Accordingly, I begin with the professional me.

The fieldwork for the preceding thesis was undertaken from an unusual and possibly unique position. This special situation arose *sui generis* from my location in the hospital's medical world. My position as a senior specialist in anaesthesia at the Adelaide Hospital, first as a full-time member of the Department of Anaesthesia and Intensive Care and later as a part-time visiting specialist, provided me with a distinctive knowledge of hospital events. In addition, my involvement in the formal teaching and supervision of the training of anaesthetic registrars allowed access to the courts and forums of the policy-makers whose motives might otherwise have been a less easy topic for revelatory discussion. Furthermore, the commonly accounted methodological problem of communication with the 'others', particularly those in specialised realms, did not, in the main, arise. Although occasional administrative/managerial tropes had to be learnt, I was 'at home' in the medical province of meaning.

This role of a full-fledged professional 'other' is not usually available for development by anthropologists. As members of a professional discipline themselves, they have had neither the time nor opportunity to explore another discipline as an accepted member. The penetration of the medical world presents the dual difficulties of training and a confidentiality shared only with 'colleagues'. Therein lay my privileged position and my advantage for anthropological analysis. Paradoxically, this was also my greatest hazard in analysis. My position was full of ambiguity and frustration in the struggle for insight into the processes to which I had privileged access.

From the outset I had to confront the problem of how, in any co-operation with my colleagues, I could generate a sense of anthropological 'strangeness'. How could a career anaesthetist in his forties, working and writing from the

'authority' of a traditional profession - maintain a social distance from his colleagues who were the main object of study? Self-evidently, situations like this are problematic for the critical anthropologist. Continually aware of my difficulties I have self-consciously attempted to overcome my own 'medical perspective'. This has been relieved in one way by the sheer size of the Adelaide Hospital which, with its structural cleavages, maintains a sense of distance between practitioners. Documentation and opinions from a wide variety of informants supplied views of the hospital previously hidden from me. There were, however, more important mechanisms of distancing which were available to me.

First, there is a temporal dimension. All anthropologists have need of history to distance themselves from the flow of current events. Indeed, in many anthropological studies current events rapidly become historical because of the unavoidable delay and distancing necessitated by the eventual withdrawal of the anthropologist from the society under observation. There is a temporal problematic in all anthropology such that whilst retrospective analysis might be construed as more 'objective', this temporal distance presents further difficulties. Temporal restrictions circumscribe traditional ethnography so that slices of time are taken of the society under study. Because of the practicalities of fieldwork, this synchronic approach, routinely glossed as the 'ethnographic present', presents a static picture of the society as it was in the past. In contrast my study is diachronic in presenting a view from within over ten years. It presents the unfolding of events within a bureaucratic institution. On the one hand it presents a retrospective analysis. The case histories were chosen, not only because 'I was there' - many other cases were available - but also because they were bounded by a conclusion, resolution or decision. This allowed me to record the reflections by

the participants on the events in which they participated. This supplemented not only my fieldwork notes taken at the time but also the documentation to which I had access. This retrospective analysis hovered, therefore, between the two worlds of archival and oral history, both of which could, in many cases, be compared with the record of my participant observation. Thus, the anthropological analysis was carried out at different temporal levels. Writing field notes was one level of anthropology, recording informants' retrospective accounts another, and analysing both at a much later date a third level. The fact that my fieldwork was carried out in a hospital which forms not only my object of study but also my place of work, provided me with continuing opportunities for reviewing past conclusions in the light of current events. The resultant text is woven from multi-temporal threads to present a continually emergent field whose essential pattern I have analysed.

To some degree, as for all anthropologists, those aspects of my material which allowed a temporal distance helped to construct a critical self. This was further aided by my position of marginality deriving from both my training, and my career position. First, I was an English migrant trained in a different medical school and health service and lacking the ties of school and family connections so prominent in the Adelaide medical profession. Second, I was an anaesthetist, a technical specialty without its own patients and of lowly status. In these ways I was marginal but firmly attached to the centre.

These two features facilitated a mental distance, an analytical distinction, between the professional me and the critical self. On the one hand there was the full-time anaesthetist at work interacting with surgeons, nurses, administrators, other anaesthetists and so forth. On the other hand, and sometimes

simultaneously, some of these same interactions and discourses were subjected to a critical anthropology continually reinforced by my own discourse with my academic supervisors, their departments and the relevant literature. This is not to argue that the schizophrenic existence was easy to live with or completely satisfactory as a methodological strategy. On the contrary, the Janiform act was difficult to maintain. My point is, rather, that this problematic dimension of my position was recognised and self-consciously attended to. Furthermore, as a consequence of my attention to creating a critical self, the 'other' - because of my difficulty, a category which was not an obvious given - was simultaneously and inevitably constructed. In brief, construction of self also defined other.

A significant point for analysis is whether the other, so defined, perceived me as critical anthropologist. To this there was a mixed response and I take as my example the introduction of the computer to the hospital. During my participant observation, the clerical staff quite obviously viewed me as a spy for 'the administration'. Occasionally this was expressed with hostility as when after an unusually revealing conversation one clerk said, "If any of this gets into your report, look out mate!" The medical administrators had partly seen me in this role but also saw me as adding a rather exotic anthropological legitimacy to the project. In addition, as directors, they had cast me in a minor role as intermediary, as far as the project was concerned, between them and the medical staff, an equivocal role. My immediate colleagues, on the other hand, wondered why I was not working, that is giving anaesthetics, and assumed I was their spy "finding out what was going on in the hospital" vis-a-vis the administration. These mixed perceptions were repeated throughout my fieldwork and in this way and quite serendipitously I discovered the 'multiple native' strategy described by

Mascarenhas-Keyes (1987). Whilst not always accepted I was at least distinguished by the other.

However, there is a fruitful tension here. The analysis depended upon a successful distinction or separation of critical self from professional me and the other. The successful acquisition of information depended upon professional me being subsumed within the other, both suspending and maintaining the marginality of critical self. In a sense the gathering of information and its analysis were undertaken by different personae, the other often agreeing with the recording persona and disagreeing with the analysing persona typically as, after a reading of a chapter, in terms of "Well, I know that is what happened but I don't agree with your conclusions and why didn't you write about (x, y or z) events?" To some extent such comments validated my distancing of critical self from the other but simultaneously pointed to further problems of the ethnographer. How can the analysis faithfully share a commonality with the participants and how can the information convey an honest picture?

I have mentioned the historical dimension of my approach and drawn the distinction between archival and oral history. I had intended for the problems addressed in each case study to arise from an historical background so that the ethnographic present could be seen as a continuity and emergent rather than episodic and static. In the writing of the text this became impossible not only because of the exigencies of length of thesis but also because of the inevitabilities of time. Ethnographic present became 'lived history' for the participants. Rather than detailing how the past created the present, the less-often asked question, according to Chapman, McDonald and Tonkin (1989) is how the present created the past. They point out that the past is selectively appropriated to account for

the present. On this criterion the participants' commentary was less well- founded than mine. I, at least, had documented the 'lived history'. But, then again, my documentation was also selective. Instead of recording and analysing "the imponderabilia of actual life" (Malinowski, 1961:18) I have chosen a series of disputes and conflicts to reveal what I believe to be the underlying structure of events. This personal element is the very point at issue and currently the source of much debate in anthropology.

James Clifford writing of post-colonial ethnography addresses the problem of authority in the representation of a culture.

Some authorising fiction of "authentic encounter", in Geertz's phrase, seems a prerequisite for intensive research. But initiatory claims to speak as a knowledgeable insider revealing essential cultural truths are no longer credible. Fieldwork cannot appear primarily as a cumulative process of gathering "experience", or of cultural "learning" by an autonomous subject. It must rather be seen as an historically contingent, unruly, dialogical encounter involving, to some degree, both conflict and collaboration in the production of texts (1983:152).

The production of texts became the increasing focus of interest of anthropologists (see Marcus and Cushman 1982) and, in particular, the involvement of the informants/participants in this production. There was, according to Clifford Geertz in his earlier work, an "anthropological irony" between ethnographer and informant which was the basis of authenticity in ethnography.

To recognise the moral tension, the ethical ambiguity, implicit in the encounter of anthropologist and informant, and to still be able to dissipate it through one's actions and one's attitudes, is what encounter demands of both parties if it is to be authentic (quoted in Webster 1982:92).

The point was that the 'niceness' and 'neatness' of the ethnographic enterprise was questioned and, more specifically, its translation into text examined (Marcus and Cushman 1982). This anthropological self-examination and critique reached its apotheosis in the book Writing Culture (1986), a collection of 'essays' edited by

Clifford and Marcus which has become one pillar of post-modern reflexive anthropology. Another force is the symbolic anthropology most commonly associated with Geertz particularly in his more recent and rhetorical works (see, for example, Geertz 1988). The main thrust of the post-modern argument in anthropology is deconstruction of the traditional ethnographic stance of the fieldworker confident in his/her monographic representation of the other.

For Marilyn Strathern, the key word which summarises the post-modern mood in anthropology is irony. She writes that, "irony involves not a scrambling but a deliberate juxtaposition of contexts, pastiche perhaps but not jumble" (1987:266). She points out that Geertz referred originally to participant observation and the moral tension between anthropologist and informant. The recognition of this,

gives post-modernist anthropology its special flavour - if the relationships involved between writer and subjects are to be negotiated, even fashioned as reciprocity, their cultural contexts after all cannot be scrambled" (1987:267).

If the contexts of writer and subject are permanently ironic then the production of text should be a mutual endeavour. Clifford (1988) argues for a collaborative production of ethnographic knowledge which may be achieved by dialogue. But as Strathern points out, paraphrasing Clifford,

The ethnographic text could conceivably move beyond dialogic (the staged reproduction of an interchange between subjects) to heteroglossia (a utopia of plural endeavour that gives all collaborators the status of authors) (1987:267).

Thus, the notion of participant observation is inverted when the observed become participants in the authorship. Clifford writes that,

Anthropologists will increasingly have to share their texts, and sometimes their title pages, with those indigenous collaborators for whom the term informants is no longer adequate, if it ever was (1988:51, original emphasis).

In a sense, the question is who owns the information given and acquired? Perhaps, this is the essential post-modern irony.

Multiple authorship of and proprietary rights over the information presented, created special problems to my 'ethnographic authority'. As I drew nearer to completing the writing of my text, increasingly I became aware that the material might be read by the actors taking part in the series of events described. Some of them had expressed their eagerness to do so. I was forced to admit to myself a feeling of unease since I was engaged in a continuous and inescapable dialogue with my 'collaborators'. Apart from potentially incessant arguments over the accuracy of my representation of events experienced in common, there were the additional and inevitable influences of publicity and confidentiality, the latter occupying a special place in medical ideology. Indeed, upon expressing my concerns to a colleague, I was advised to get legal advice. The dilemma, however, was ethical rather than legal. The problem was to weigh the needs of my textual analysis against the rancour of colleagues who might feel betrayed.

An 'outsider', whilst perhaps gaining less access to the inner councils would be at ease with a more graphic expose of social structure. This luxury was not afforded by the career position I occupy. I had considered using a pseudonym for the hospital but I concluded that it would serve no purpose and perhaps weaken my argument. In the light of post-modernism this would surely add fiction to ethnography whose facticity is, at least, arguable. The events within the hospital were detailed without intentional criticism of any of the actors. Indeed, my relationship to the actors, whose names and identities have often been disguised, has remained unexplicated in an attempt to conceal my sources and, thereby,

avoid offence. This provision does not, I believe, detract from the evidence presented.

This is not to argue that my text is what Marcus and Cushman (1982) term, rather deprecatingly, 'ethnographic realism'. Despite the problems which I have detailed, I believe my ethnography and its analysis accommodates any critique in the mode of post-modernism. A problem was set and a series of case studies served as an examination of the relevant material, an attempted pastiche and certainly full of irony. Inevitably, as Clifford argues in his introduction to Writing Culture, "Ethnographic truths are thus inherently partial - committed and incomplete" (1986:7, original emphasis). The whole truth cannot be known, let alone told. Partial truths limit the compass of both writer and subject.

There are no easy answers to the epistemic concerns raised by post-modernism. I do not claim that this thesis purports to tell the whole truth. Its analysis does not synecdochically 'explain' the hospital, let alone the medical profession. It does, however, offer an analysis of power in the relationships and disputes observed. In brief, it offers a critical anthropology of the medical staff in an Australian hospital going beyond the textual angst of the post-moderns to address history and politics as part of ethnographic present. Pat Caplan (1988) asks if anthropology is

inevitably split between a symbolic wing on the one hand, interested in culture, meaning and epistemology, and a critical wing on the other, interested in politics and ideology? (1988:10).

Whilst being only too aware of the epistemic problematic, my text falls definitively under the critical wing.

Furthermore, by its analysis of power relationships, ideology and the wider politico-economic context of medicine, it also offers a critical medical

anthropology. By this I mean to distinguish it from a clinical medical anthropology, an anthropology from within, co-opted by the medical profession. In a footnote to his paper in a special issue of Social Science and Medicine, Stein (1990) contrasts the etic to the emic view in terms of a critical anthropology of medicine and a clinical anthropology in medicine. He also describes the opposition he experienced from his administration when he tried to synthesize the two. Nevertheless, as Nancy Scheper-Hughes argues, from a position of 'voluntary marginality' a critical discourse should be pursued.

Our work as critical anthropologists should be active and committed. Medical anthropology should exist for us as a discipline and as a field of struggle. Our work should be at the margins, questioning premises, and subjecting epistemologies that represent powerful, political interests to oppositional thinking. It is, in short, the work of anthropology turned in upon ourselves, our own society (1990:196).

I should like to emphasize a particular feature of her plea which I take to be its essential point and that is the sense of commitment.

To a degree, the self-examination in medical anthropology echoes the turmoil created by the post-modernist critique of anthropology in general. A counter-critique of post-modernism, however, is its lack of commitment. Bruce Kapferer, in a review article headed the "anthropologist as hero", a description originally applied to Levi-Strauss, expressed his concern over the new ethnography.

Most of all, I think it is symptomatic of the growing lack of commitment in anthropological circles which the new ethnography often expresses, a lack of the very commitment which, despite all the faults, was integral to the vital and often radical understanding that an earlier anthropology did bring (1988:104).

Whilst no claim to heroic status is intended, there is a personal ideology at work here in my text. The thesis represents the commitment of one ethnographer to

attempt, perhaps not fearlessly (pace Cheater) but certainly with conviction, an analysis of his own medical society.

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