

THE BRITISH MEDICAL MONOPOLY:

HOW IT WAS CREATED, THE HARM IT
CAUSES AND WHAT TO DO ABOUT IT

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The B.M.A.: "I want it all, and I want to carve it myself."

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**Libertarian
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FOR LIFE, LIBERTY AND PROPERTY

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DAVID GLADSTONE

All professions are conspiracies against the laity.¹

That aphorism is from Bernard Shaw's *The Doctor's Dilemma*. Interestingly Shaw, a Fabian socialist, was echoing Adam Smith's assessment a century before:

People of the same trade seldom meet together for merriment and diversion, but the conversation ends in a conspiracy against the public.²

And here, much more contemporaneously, is Jeremy Paxman writing of much the same practice in *Friends in High Places*.

Because of the professionals specialised area of knowledge, the layman was unlikely to know what was best for himself. He depended on the integrity of the professional. Codes of practice were supposed to protect the customer by dangling the threat of expulsion and consequent loss of income over the practitioners. The professions therefore became midwife to the 'we know best' philosophy on which later the Establishment was to rest.³

Between them those three quotations, spanning some 200 years, reflect different political viewpoints; and, I suppose, of no occupational group are they more true than the medical profession.

It is interesting to note, in passing, that some of the earliest and most effective criticism of professional power came from the political Left. In his Fabian Society lecture *The Irresponsible Society*, delivered in the early 1960s, Richard Titmuss was critical of welfare professionals who seemed to put their own convenience and rewards before their patients and clients.⁴ Thereafter, among ideologues of the Left, it became increasingly common to vent their frustration about the apparent inadequacies of the Welfare state at the door of the purveyors of state services. Welfare professionals, to use the title of a book published in the late 1970s, were not only living "in worlds apart"⁵ from their clients; they were also guilty of creating a dependence on professional intervention. These were the "disabling professions" of whom Illich wrote, by whose actions people lost their capacity for independent self-reliant action.

While initially people become dependent on the professionals for specialist skills gradually they become dependent on them for services which, in the past, people provided for themselves or each other.⁶

Medicine, he suggested specifically, 'expropriates' health management from the people to the doctors and 'medicalises' life — in the sense that it claims that many of the decisions about how we should run our affairs should be resolved only by medical experts. What that has meant in

practice is that health care has been turned from a broad social concern with the whole life style, conditions of work and the environment of the population into a narrow concern with the sick individual.

If the Left laid the foundations, there can be little doubt that a concatenation of circumstances over the past 10 to 15 years has put the issue of professional power firmly onto the public and political agenda. Threats of strikes and work-to-rule among public sector workers, health and welfare staff among them; the increasing voice of the articulate consumer, whether expressing a concern with ineffective or even harmful drugs (such as thalidomide) or as a dissatisfied patient complaining about the quality of medical care; the challenge to cosy corporatism mounted by the governments of the 1980s as an integral part of their plan to roll back the frontiers of the state; the resurgence of the ideology of free market competition; and public choice theory which called into question the disinterested 'service ethic' of white collar professionals: each of these have contributed to a new world for professionals. A world which has introduced opt-outs, internal markets with their separation of purchasing and provider functions, Citizens Charters, quality assurance, and greater managerial efficiency and accountability into professional practice with increasing surveillance of activity, assessment of spending and measures of outcome expressed in indicators such as league tables, medical audit and indicative drugs budgets.

If that is the nature of the contemporary challenge to the producer interest in health care and welfare, why, when and how did occupational groups such as medical practitioners acquire and retain professional monopoly control for their services? And with what effect? These are the issues I wish to address later. For the moment, however, let me offer an historian's perspective on professionalisation.

I

It is not without significance that Harold Perkin has given the title *The Rise of Professional Society* to his recent study of English society since 1880. Its significance is especially obvious when set against the entrepreneurial ideal which dominated Perkin's earlier study of the century from 1780. The contrast between these two predominant types of social organisation is immense, as Perkin himself illustrates.

The entrepreneurial ideal

was based on capital as the engine of the economy, setting in motion the production of goods and services and calling forth the other factors of production, land and labour.⁷

But the professional ideal

was based on trained expertise and selection by merit, a selection made not by the open market but by the judgement of similarly educated experts.⁸

If there was a difference between these two types of social organisation, so too was there a distinction between the ideal citizen of each society. The ideal citizen of the former

was the self made man, the entrepreneur who has made his way to success and fortune by his own unaided efforts.⁹

While in the professional society

the ideal citizen was also a self made man of sorts, who had risen by native ability (with a little help from his educational institutions) to mastery of a skilled service vital to his fellow citizens.¹⁰

The crucial difference, of course, was that

the entrepreneur proved himself by competition in the market, the professional by persuading the rest of society and ultimately the state that his service was vitally important and therefore worthy of guaranteed reward.¹¹

In a nutshell, while the entrepreneurial ideal

called for as little state interference as possible, the [other] looked to the state as the ultimate guarantor of professional status.¹²

So far, by implication, I have been defining a professional as someone who has mastery of a skilled service which is practiced on the basis of accumulated expertise acquired by means of specialist training. Those characteristics by themselves, however, do not explain the phenomenon of professional power. That is based upon the strategy of occupational closure. Since most professional's expertise does not enjoy a natural scarcity

its value has to be protected and raised first by persuading the public of the vital importance of the service, and then by controlling the market for it.¹³

On this analysis, expensive or selective training, long periods of education and successive stages in the process of accreditation become means to the end of transforming human capital into property with a scarcity value yielding a financial return. In the case of the medical profession, not only do all these factors apply; but they are given legitimacy by Act of Parliament, specifically by the Medical Act of 1858.

II

The power of the medical profession lies in its success in having secured by political means a legal monopoly over the practice of healing in contemporary society. This made the doctor *the* official expert on health and illness in modern society, a title enshrined in written law. This is the legal-rational basis of medical power. It consists of a monopoly given by the state, giving the profession exclusive occupational rights, freedom to control the process of recruitment, training and practice, and control over the conduct of individual members who each enjoy the rights of clinical autonomy.¹⁴

That quotation from Nicky Hart neatly spells out what the medical profession achieved by the Medical Act of 1858. Its significance can best be understood both by reference to what had gone before and in terms of the particular legal position it accorded to the medical profession — 'the legal rational basis of medical power' that Hart refers to. Roy Porter encapsulates both these dimensions succinctly. What the 1858 Act did, he suggests, was to unite — symbolically at least — the much divided medical profession. This it did by giving a legitimacy to practice to some and assigning others to the practice of 'fringe' medicine.¹⁵

That process has to be set in the context of its time.¹⁶ Medical care grew rapidly in the 18th century. The doctors of Georgian England operated in a medical market place based on rapidly expanding consumer demand. And, increasingly, they hoped not just to relieve, but to cure: a change in values that led to a major expansion in the founding of hospitals after 1720. Whereas traditionally hospitals had been 'hospices' — places of hospitality for the needy — increasingly they became centres of healing for the sick poor offering opportunities for practice to trainee physicians and surgeons. Specialist hospitals such as the Foundling Hospital for abandoned babies, lying-in hospitals and hospitals for venereal disease began in this period and the dispensary movement — diagnosing and providing drugs for outpatients — significantly extended its activities.

Against the background of all these changes, the traditional hierarchical divisions within the medical profession were becoming increasingly blurred in the competition for fee-paying patients. Apothecaries, as well as prescribing and dispensing drugs, also performed minor surgical operations. Surgeons prescribed drugs as well as operating, and so on. Medical organisations and societies cutting across traditional structures were established and it was the reform movement led by one of these societies — the Association of Apothecaries and Surgeon Apothecaries — which brought about the passage of the Apothecaries Act of 1815. After it, no one could legally enter on a career as an apothecary without a licence. The Act, therefore, was a direct challenge to the rise of the dispensing druggist in the 1780s and 1790s who offered cheaper medical care.

Licensing was also one of the key elements in the more comprehensive legislation of 1858. That Act created the single medical register of approved practitioners and established the General Medical Council to oversee the related activities of education and licensing. To quote Roy Porter again:

The significance of the Register lay, of course, in those it excluded. For all ranks of regular practitioners now appeared as 'insiders' lined up against all 'outsiders' — the unqualified homeopaths, medical botanists, quacks, bone setters and the like who are automatically constituted by exclusion into the 'fringe'.¹⁷

Central to this process was a listing of those legally qualified to practice in the form of a register: a practice still continued in the annual publication of the *Medical Register*. But, as the Merrison Committee on the Regulation of the Medical Profession pointed out in its Report, referring to the responsibility of the GMC

The body maintaining the Register has two duties to discharge. First it will have to assure itself that those admitted to the Register are competent (its education

and licensing role). Secondly, it will have to remove those practitioners unfit to practice (a disciplinary function).¹⁸

Weak though the original Council was, Margaret Stacey considers that

the 1858 Act proved crucial for the establishment of medicine as a profession ... It led to the development of a self-conscious occupation aiming for control of work situation and client, controlling its own labour supply and its own remuneration.¹⁹

And, on top of all those beckoning possibilities, the right of 'self regulation in the public interest.' This, as Stacey argues was, and remains, "the central tension" in medical professional accountability.

Whereas, individual practitioners are accountable to their individual patients, ... a professional body is responsible for seeing that the collectivity of individual practitioners perform appropriately. That body is ultimately accountable to the state through Parliament which set it up in the first place and from which it has derived its powers. However the GMC is independent, self financing and constitutionally directly responsible only to the Privy Council.²⁰

That issue of accountability is underlined by the current composition of the GMC. Overwhelmingly its membership is drawn from the ranks of the medical establishment, whether by appointment or election. A mere handful are lay people - 9 out of 102 - and they are a mix of MPs, JPs, lawyers and two non-medical academics. The state's ratification in 1858 of medicine's claim to be an autonomous, self governing, ethical profession has thus bequeathed to us the inheritance of what has recently been described as a

shadowy body, autocratic and punitive ... whose deeply conservative stance is increasingly out of step with the needs of patients.²¹

The 1858 Act may have been the means of creating a symbolic unity among the practitioners of scientific medicine. But the second half of the 19th century saw the emergence in its modern form of the division within the medical profession between GPs and hospital based consultants. While consultant specialists increased their medical prestige and associated social influence, for many GPs the situation was very different, especially when, as the result of the expansion of medical teaching, the profession became too overstocked for comfort. In such a situation, the GP was

a highly vulnerable individual in a highly competitive buyer's market.²²

Meanwhile, as physicians and surgeons worked together in the hospitals and co-operated in the medical schools,

the differences between them came to be of somewhat less importance than their common interest as hospital consultants. ... [It was this group who] mutually gained in prestige as teaching and research expanded in the new medical schools and hospitals became the centre of medical excellence.²³

The hospital consultants "began to see themselves and to be seen as a superior elite over against other qualified practitioners": a situation that was reinforced both by numbers and referral patterns.

Even as recently as the outbreak of the Second World War, there were only some three thousand consultants compared to more than two thousand GPs. But, even more importantly, as the result of a deal between the BMA and the Royal Colleges, "specialists would not see any private patients except at the request of a customer's GP". This gave the GP the security of sending his more puzzling patients to a consultant colleague for a second opinion. But it also meant that consultants

instead of having to attract their own patients were able to sit back and await the arrival of those referred by their former pupils or by local doctors who knew of their fame.²⁴

By processes such as these a distinct professional hierarchy was created of expertise and social status; a system of patient referral was established mutually advantageous to both sectors of the medical profession involved; and, perhaps most important of all, divisions within the medical profession had clearly emerged that were capable of being exploited by politicians in the 20th century debates about the state and the supply of health care.

III

So far my concern has been with the 19th century origins of the medical profession in its relationship with the state. My focus now changes not only to the 20th century, but also to consider the effects of the processes I have just described. This I wish to do by reference to policy, patronage and patients.

1 Policy

The present century has, of course, witnessed an enormous increase in the role of the state in the British health care system, so that health is now the second largest of the public spending programmes and one that will no doubt be scrutinised by the recently announced Treasury review of public expenditure. Demand-led factors have played their part in the rising levels of public spending: the aging of the population, changes in medical science and technology that have revolutionised the notion of what can be achieved which, in turn, has created a situation of constantly rising expectations. It is scarcely possible to believe that in the 1940s it was widely believed that once the backlog of unmet demand had been met, the costs of the NHS would actually decline. The introduction of charges in 1951, together with the political 'fall out' represented by the resignation of Aneurin Bevan and Harold Wilson over the issue, was the first indication of the shattering of that confident optimism. And all the rest, as they say, is history!

But, equally, the NHS has been a consistently popular part of the Welfare State, almost its sacred cow. In public opinion studies, it has always emerged at the top of the list in terms of popular appeal.

Successive governments, therefore, have found themselves caught between the rising economic costs of health care on the one hand and strong public support for its services on the other. That combination has offered politicians limited room for manoeuvre. Charles Webster, in the first volume of his *History of the Health Services Since The War* quotes an unnamed Conservative politician expressing the view in 1957 that whilst it was possible to cut defence spending, raise taxes or even allow "a dose of unemploy-

ment, but meddle with the National Health? That's political suicide".²⁵ John Butler's recent assessment of the aftermath of the publication of *Working For Patients* in 1989 makes the same point. In contrast to the government's original intention to create a genuinely competitive market, he notes

how the language of the government's spokesmen moderated and their explicit commitment to the values of the market began to recede.²⁶

The shifting use of language, he concludes, was perhaps the clearest public signal of the attitudinal transformations that were taking place. In essence it represented a move towards a more commercial system, but one strictly controlled from the centre by the Department of Health and the NHS Management Executive. As a feature in *The Economist* pointed out early in 1991

The government is terrified that the idea at the heart of the reforms — making money follow the patient — might increase efficiency but lose votes.

But the issues involved are not only economic and electoral. If the state is to be involved — however directly or indirectly — with health care for its population, some kind of concordat is necessary with the medical profession. As Wilding argues

Professionals depend for their development on state action. ... Equally the state needs professions to fulfil the responsibilities which modern governments assume, to legitimate state power, to make available expertise. The state and the professions need each other.²⁸

It is the negotiation between professional groups and the state and the compromises which result that forms one of the fascinating aspects of public policy making. That is as much about what is ignored or set aside in the process of negotiation as about the outcome or end-product in legislation or directive.

In relation to the medical profession, it is interesting that successively they have shunned local authority control of their services first advocated in the Dawson Report of 1920; that consumer interests have featured late and low on both political and professional agendas; and that issues such as hospital complaints procedures have dragged on through interminable discussions, as happened both with the Davies Committee and the ensuing discussion during the 1970s and on into the 1980s.

What is paradoxical in thinking about the state and the medical profession in relation to policy is how often professionals have come to advocate what they had previously resisted. Thus in 1938 in its *General Medical Service for the Nation* the BMA advocated the extension to the wage earner's family of the health insurance scheme it had resisted in the early 1910s; just as in the second half of the 1980s the BMA, which had been

the virulent opponent of Aneurin Bevan in 1946 ... was most forceful in defending the health service, in denouncing the government for threatening its existence, and failing to fund it as was properly required.²⁹

It was, of course, in the 1940s creation of the NHS that the power of the medical profession was most clearly expressed. The process is well enough known, but let me remind you of two elements.

First, while the service was made comprehensive, universal and free at the point of demand, the actual administrative arrangements (with the tripartite division between hospital, GP services and community health provisions) reflected the separate strands in medical training as it had developed since the mid 19th century.

Second, the way in which Bevan used the divisions within the medical establishment in order to bring about a health service that would function on the Appointed Day, 5 July 1948. In order to do so he offered concessions to the consultants — "stuffed their mouths with gold" were his words — to secure the compliance of the humbler general practitioners, among whom resistance was more firmly entrenched.

Not only because of their political usefulness but also because they were the elite corps whose willing participation was regarded by Bevan as fundamental to the image of the NHS as a first class service,

they were offered many fresh inducements without being expected to sacrifice too many of their traditional privileges.

The compromises that resulted were but the harbinger of many on-going controversies within the NHS, not least in its imbalance between hospital based and primary care. The present debate about the future pattern of London's health care in the aftermath of last year's Tomlinson Report is but one example of where past government compromise with powerful professional interests has created the conditions for contemporary controversy.³⁰

2 Patronage

That brief discussion of variegated aspects of policy making serves, I hope, as a useful background to the issue of patronage, which I now wish to consider.

Self regulation and medical monopoly power not only affects the present. It is a system which is perpetuated by patronage and by personal recommendation and selection of the up-coming generation, factors which tend to produce conservatism in the medical profession and which suggest that academic or intellectual or clinical excellence of itself is insufficient for a career at the top in hospital medicine.

That is the conclusion of Isobel Allen's research with doctors throughout Great Britain who had qualified in 1966, 1976 and 1981.³¹ Contrary to her belief before carrying out the study that "very personal patronage might be dying out" her interviews indicated its persisting and indeed increasing importance. Its effect is a consultant grade dominated by white men.

The processes which bring this about are complex. Allen's research highlights the role which certain influential medical figures — nationally or locally — have to advance or restrict the professional progress of members of the next generation.

It was sometimes difficult not to imagine the telephone lines of Britain buzzing with consultants chatting to each other about prospective candidates.³²

The importance of someone pushing your name and influencing the selection has increased in recent years when the number of junior hospital doctors in training posts has been far in excess of the number of available consultant

posts. That brings us back to occupational closure and medical manpower planning within the NHS; another example of the accommodation between the state and the medical profession offering prestige and high incomes to the former and financial savings on the wages bill to the latter. A situation which leads in the hospital sector, to an NHS staffed by hard pressed junior doctors working long hours often without supervision.

If the proposals in the *Calman Report on Medical Education and Training* published in May 1993 are accepted and implemented, the pattern of senior hospital medicine is set to change.³³ The Report recommends shorter, better supervised and more structured training programmes ending with the award of the Certificate of Completion of Specialist Training as the formal indication that an individual is capable of independent practice. Shorter training programmes mean that today's medical students could expect to complete their training in their early thirties instead of waiting until they are on the brink of middle age before being considered for a consultant appointment determined, as I suggested earlier, principally by the 'old boy' network. Furthermore, the award of the CCST at the end of a formal training programme will serve to highlight the numbers of those judged capable of independent practice who are 'in waiting' for consultant specialist appointments, instead of being concealed in what are euphemistically described as 'training grades' as at present.

The Calman Report thus presents the higher ranks of the medical establishment with a significant challenge to its power and prestige. Their numbers look set to increase and, by whatever means that occurs, there are significant implications for both the public and private sectors of health care.³⁴ Private fees were initially set at a premium to attract consultants when skills were scarce. By the simple law of supply and demand it would be expected that any significant increase in the supply of specialists would reduce the price levels to private insurers, assuming that no impediment existed to free market conditions. According to one commentator, increasing the supply of specialists would positively enable the private sector to fight off the competition from the reformed NHS. That is the significance of the Monopolies and Mergers Commission review taking place at present into the BMA guidance on recommended fee rates for surgical procedures.

Meanwhile, in the public sector, increasing numbers of specialists could speed referral between GPs and the hospital sector and shorten the hospital waiting times for surgical procedures. A report published last year by the Royal College of General Practitioners pointed out that, while British GPs refer relatively fewer patients to hospitals than their European counterparts, British patients at present wait longer to see a specialist than in any other European country.³⁵

One last point before I move on. The Chairman of the Junior Doctors' Committee of the BMA heralded the Calman Report as representing one of the most important changes in the medical profession since the inception of the NHS in 1948. That may well be true. But there is a considerable way to go and, I suspect, considerable professional opposition to overcome before its proposals are implemented.

Nor should we forget that, while the Calman review proposes change, the pressures to do so came neither from the

government nor from the medical profession itself. Rather, the impetus came from legal challenges mounted both in the British courts by Dr Anthony Goldstein and in Europe by Uccio Querrici della Rovere, an Italian surgeon; and from the concurrent concern of the European Commission that the British government had unlawfully discriminated against foreign born doctors since 1977 by not recognising qualifications accepted everywhere else in the European community. It was only with a gun at its head that the government acted.

If a shake-up is to be achieved in the higher ranks of the medical establishment, it is paradoxical that it will have been brought about by European concerns about the free movement of medical manpower and not from either the British government or the medical profession's concerns about the nature and quality of education and training for its up-coming practitioners and their work in the changing environment of health care and medical science.

3 Patients

So far, I have indicated how the state-medical monopoly relationship has set the policy agenda and perpetuated a system of medical patronage for senior appointments. Both of these, of course, impinge upon the service that is available and offered to patients. But in a nutshell the message is that the occupational closure which the state has legitimated has worked *for* the profession and *against* the interests of patients.

The immediate challenge to that argument is that a register of legally recognised practitioners acts as an important safeguard to the patient. After 1858 it became a legal offence for those not on the medical register to represent themselves as medical practitioners and to hold any public medical office (as Poor Law hospital doctors, asylum superintendents or Medical Officers of Health). It was a guarantee of proficiency, a safeguard to the patient. That is an issue that regularly recurs in the debate that paternalism is implicit in health care — the 'doctor knows best' syndrome — and any moves to radicalise its structure and deregulate its supply as, for example, by challenging the established referral pattern between GP and hospital specialist.

One alternative, advocated by the King's Fund Commission, is for one-stop health care shops designed for those who find it difficult to conform to the standard hours and type of service presently available in primary care.³⁶ Another is for self-referral to 24 hour clinics run by teams of specialists offering routine treatment round the clock. I do not carry a brief for either of these alternatives; and certainly the latter would significantly affect the role of GPs and no doubt incur their opposition.

What I wish to do is to indicate some of the issues implicit in the present system as they impinge upon patients.

The first is obviously the tension between quality and choice. At present, patients seeking treatment are in a straight-jacket imposed by the established referral pattern between GPs and specialists. Their choice is restricted. But, on the other hand, they have the security of knowing that they are dealing with legally qualified practitioners who can be held accountable for the treatment and services they prescribe. This raises the issue of redress for those with grievances or complaints. Margaret Stacey's recent study *Regulating British Medicine* highlights the bewildering

complexity of the complaints procedure: an array, she considers confusing to members of the profession as well as to the public.

To the public because they are unclear where to go for what purpose, to practitioners because they may be arraigned for an alleged offence by a variety of authorities and for the same offence before more than one.³⁷

NHS doctors, for example, are subject to more regulation than those in private practice. But her other point is that

not only at law but in any circumstance in which medical practitioners may be called to account, the profession has insisted [that it is] their peers [who] should make the judgement. ... Professional self-regulation is clearly implicit in every form of medical accountability. It is *the* principle of essence.³⁸

My second point concerns the restriction of information about specialist services.

This specifically impinges upon the current debate about the *Medical Register* itself and the designations contained within it.

My point, however, is more general. It is to set the attitude of the GMC towards advertising of specialist services in the context of what is now accepted for GPs. While supporting the wide availability to the general public of lists of local GPs and factual information available in practice leaflets, the GMC has been much more circumspect in its approach to information about specialist services. That type of information, the GMC, argued

should be distributed chiefly within the medical profession. ... [To do otherwise] would be to dismantle the present arrangements for medical care. The Council has, therefore, had to balance the advantages for patients of being better informed about the specialist services available to them with the consequences of dismantling the present arrangements for medical care.³⁹

The issue here is how far the GMC is acting in this regard in the public interest and how far in the interests of preserving the status quo from which its members derive considerable benefit?

The third and final issue of medical monopoly power that impinges upon the patient is that of the bio-mechanical model of disease.

The Act of 1858 united those parts of the medical profession engaged in the application of the principles of scientific medicine "curing individuals of episodic bouts of organic disorder in a clinical environment". Practitioners of other methods of treatment were not suppressed but they were henceforward unable to advertise themselves as recognised medical practitioners. They were thus unable to certify any statutory documents or to practice in any public setting. They were excluded from the 'panel' system set up under the 1911 National Health Insurance Act and their activities were further restricted with the advent of the NHS in 1948.

But the predominance, over almost over a century and a half, of the bio-mechanical model has also had other effects. It has importantly constructed our understanding of the nature of health and illness. And furthermore, it has also created the specialisms within medical practice based on the

divisions in the system of the body as biologically defined. It is, for example, only paediatrics and geriatrics which divide their patients on the basis of age rather than a particular part of the body. The origins of the bio-mechanical model may owe much to the Cartesian revolution and the notion of the living organism as a machine. But its long held primacy can also be attributed to the skillful political organisation of those who were practising it. By feeding that power, the legal exclusion of other approaches to 'fringe' status has made the medical profession "virtually immune to outside interference and criticism".⁴⁰ And that, too, has implications for patients and consumers.

IV

My purpose has been to analyse medical monopoly power and the prominence of the producer in health care. My conclusion is that (to quote Stacey):

the tight professional organisation, its exclusiveness, its seeming arrogance have engendered too much hostility for medicine to be able to continue as it is. The strong market domination of health care, which its professional organisation has helped it to achieve, attracts criticism from many more than the radical right. It attracts opposition from practitioners of other healing modes as well as from those occupations which medicine has subordinated in the division of health labour. Increasingly patients are unprepared to accept the subservient position medicine has historically accorded them.⁴¹

It is one thing to indicate the potential catalysts for changing the all too easy past relationship between the state and the medical profession. It is another to suggest the elements of an agenda working towards a new professionalism and a more responsive health care system.

What would be its defining characteristics? Are we talking about modifications to the existing system of medical self-regulation or more radical and fundamental change? In whose interests would it be to have such a revised agenda and what would be the obstacles to change? Is a market solution the only viable alternative? What lessons are there about medical power holding both from our own British past and the present experience of other countries? And, in the changing world of health care, is the future challenge to choice and freedom likely to come not from the medical profession but from a more autonomous managerialism?

The grand logical new design is not the British way. Changes are likely to come about in a piecemeal fashion.⁴²

That is Stacey's concluding assessment and the record of much that has featured in my discussion.

Appropriately, then, the last word is with Francis Bacon:

He that will not apply new remedies must expect new evils, for time is the greatest innovator; and if time of course alters things to the worse and wisdom and counsel shall not alter them to the better, what shall be the end?⁴³

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