Reform and autonomy: Perceptions of the Australian general practice community

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Total word count 7656 (including text, abstract, acknowledgments, references, tables)

Abstract

Reforms in health care in the 1990s across industrialised nations have had profound consequences for the autonomy of general/family practitioners (GPs). Research suggests that the professional autonomy of GPs is declining across countries, related to policy reform processes and to challenges from other actors. Important questions remain, however, around appropriate ways to conceptualise autonomy, and about the perceptions that GPs themselves have of their autonomy. It is these questions in the context of more than a decade of general practice reform in Australia that are the focus of this paper. Using a multi-component model of autonomy, which separates out micro, meso and macro dimensions of autonomy, we undertook an analysis of 343 items on autonomy and reform collected from 3 key general practice journals. We argue that members of the GP community profess an enjoyment for general practice, and operate with an ideal of what it means to be a GP. However, the reform process is perceived to challenge this enjoyment and the ideal of professional practice. In particular, there exists uncertainty as to what it means to be a GP, with members of the GP community expressing a loss of control across important dimensions of autonomy. While numerically most discussion focused on control over earnings, the intensity of feeling was most evident around control over clinical practice. Our results suggest the importance of using a multi-component model of autonomy, as it allows for a nuanced analysis of the relationship between the reform process and autonomy. At the same time, however, our analysis indicates that it is also crucial to recognise autonomy is constituted by the interaction of these components.

Keywords: General practice; Professions; Autonomy; Reform; Australia

Introduction

Conceptualising autonomy in medicine

It is well established in the social science literature that autonomy is central to what it means to be a medical professional (Broadbent, Dietrich & Roberts, 1997; Harrison & Ahmad, 2000; Leicht & Fennell, 1997). What continue to be the subject of debate are the current status of autonomy among medical professionals, the implications of that status for contemporary professional practice, and how that status is being affected by policy reforms (Aasland, 2001; Hernes, 2001; Light, 2001). Underlying these debates are important questions on both the appropriate way to conceptualise autonomy in the context of professional work, and the perceptions that professionals themselves have of their autonomy. In considering questions of autonomy in the context of medicine, a key group are general/family practitioners (GPs). Reforms across industrialised nations in the 1990s have been directly focused on the working practices and autonomy of GPs, addressing a wide range of issues such as quality of care and cost containment. GPs have also experienced challenges to their professional autonomy from other actors related to, but also independent of, the reform process, including patients, corporate actors and other health actors. In considering the question of autonomy, therefore, GPs are a crucial professional group.

Professional autonomy has been defined as the legitimated control that an occupation exercises over the organization and terms of its work (Elston, 1991). Work of theorists such as Freidson (1994), Haug (1988), Light (1995) and others, has suggested that this legitimated control has been the subject of a number of challenges, dating back to at least the 1970s. Concepts such as proletarianisation (McKinlay & Arches, 1985), deprofessionalisation (Haug, 1988), and restratification (Freidson, 1994), have all been used in an attempt to capture the shifting terrain of autonomy for the health professions in the face of challenges from both within and outside of the profession. Policy makers, patients, corporate actors, and lawyers are contesting the scope of autonomy held by the medical profession, while there are also boundary contests occurring within

medicine as GPs experience challenges to their domain of practice from medically trained specialists, nurses, and allied health workers (Good, 1995).

One area that has been relatively understudied empirically in these debates is the perceptions of medical professionals themselves about challenges to, and transformations of, their autonomy. While approaches emphasising processes such as deprofessionalisation and proletarianisation have provided crucial frameworks for analysing structural transformations in professional power, there is a growing awareness of the need to analyse the context-specific experiences of frontline professionals. The research that has been done in this area suggests that medical professionals have generally viewed changes which impinge on their professional autonomy with alarm, feeling themselves and their expertise to be under threat (Hunter, 1996), and seeing greater management control and increased competition with colleagues as having severe negative impacts on the profession. Further, this research suggests the importance of focusing on specialties within the medical profession, and of exploring the means by which specialties seek to negotiate and manage perceived challenges to their autonomy (Calnan & Williams, 1995; Good, 1995; Lupton, 1997). In addition, it is necessary to consider contextual factors, since cross-country studies have highlighted that medicine takes on a different professional character in each country, being shaped by prevailing institutional configurations (Hafferty & Light, 1995).

Insert Table 1 here: Framework for analysis of physician autonomy

An ongoing challenge within these debates about professional autonomy is how to conceptualise autonomy so that it can be the subject of empirical research. In an important contribution to the literature, Schulz and Harrison (1986) developed a multi-component model of autonomy in medicine (see Table 1). They argued that it is necessary to distinguish different types of freedom that have underpinned autonomy at the micro level of everyday medical practice. On the one hand, clinical work freedoms such as control over diagnosis and treatment, and control over the evaluation of care, identify the choices that a doctor has in an individual consultation with her

patients. On the other hand, social and economic work freedoms, such as control over earnings and control over the nature and volume of tasks, exist independently of, but in relation to, clinical work freedoms.

In a more recent contribution, Harrison and Ahmad (2000) revisited this conceptualisation of autonomy, introducing a specific discussion of dominance. This involved including in the model of autonomy a meso level affecting clinical, social and economic work freedoms, involving institutionalised relations between the medical profession and the state, and a macro level, related to the dominance of the biomedical model for medical practice.

The application of the model to empirical situations by Harrison and his colleagues indicates that the model does capture important dimensions of autonomy in general practice. In their comparative research Schulz and Harrison (1986) found that, while doctors in various countries were experiencing challenges to their autonomy, the dimensions of autonomy were being affected differently, related to the historical, social and institutional context of medicine in each country. While the autonomy of GPs may be declining across all countries (Wilsford, 1995), there are important variations between countries, which a multi-component model of autonomy is able to capture. Recent research from Norway (Grytten & Sorensen, 2001) and the United Kingdom (UK) (Hausman & Le Grand, 1999), which found that physicians are motivated not only by financial considerations, but more importantly by professional norms related to clinical practice, is also suggestive of the potential significance of a multi-component model of autonomy.

Importantly for the current paper, Schulz and Harrison (1986) also suggested that more work needs to be done on understanding what autonomy means to physicians. While work has been done since 1986 on the experiences of physicians, much of this has focused on issues such as stress, satisfaction, physician well being and the like (for recent contributions, see the papers published in *Social Science and Medicine*, 2001, 52(2)). There has been less direct focus on the understanding that physicians have of the concept of autonomy itself, and on their perceptions of the impact of reform on their autonomy.

A crucial step that is required before a clear view of contemporary professionalism can emerge is a fuller comprehension of what is occurring in the process of delivering primary health care. This relies on an improved grasp of how GPs are practising, and how they understand their work and autonomy. Without this interim step, the picture of how health professions are changing and of possible future directions for their work will remain inadequate. As a contribution to this task, we analysed the experiences and perceptions of the general practice community in Australia in the context of more than a decade of reform.

Reform and the profession of general practice in Australia in the 1990s

General practice medicine has been the subject of extensive reforms in Australia over the last decade, with reform activity increasing the range of financial incentives, administrative rules and normative pressures on GPs. A variety of programs and activities directed at general practice have focussed on the quality of care, workforce issues, integration between general practice and hospital services and methods of financing general practice. Many of these activities, which have come to be known as the General Practice Strategy, have been intended to encourage good quality general practice, while also seeking to introduce financial accountability into everyday practice (Bollen & Saltman, 2000; General Practice Strategy Review Group, 1998; National Health Strategy, 1992).

The reform initiatives introduced to address the perceived problems of general practice are not unique to Australia. Significant policy innovations such as various forms of managed care in the United States (US) (Robinson & Steiner, 1998), and general practice fund holding in the UK (Allsop, 1995), represent similar but more direct attempts to change how GPs work.

Little research on the perceptions of Australian GPs on the relationship between reform and autonomy has been undertaken. Evaluation of the changes in general practice has focussed on changes in quality of care and the provision of better value for money. GPs report high stress, low morale, decreasing incomes and problems with time pressures (General Practice Strategy Review

Group, 1998). While such research indicates important components of GPs' perceptions of their work, it does not directly identify how they perceive their autonomy.

Methods and data

We undertook a content analysis of literature published by medical associations that represent GPs in Australia. The purpose of this content analysis was to improve our understanding of how GPs perceive their work and autonomy, by analysing the experiences and perceptions of members of the general practice community through their own words.

Medical associations' journals (*Medical Journal of Australia* (MJA), *Australian Medicine* (AM), *Australian Family Physician* (AFP)) were hand-searched for items related to autonomy and GP reform from 1989 to 2000, the period corresponding to the general practice strategy. All articles in the journals were read, and items were selected on the basis that they discussed some aspect of the organisation and terms of the work of GPs. Key words and themes used to guide the selection process included, but were not limited to, 'work', including work relations with patients, professionals, and the state; 'earnings'; 'finance'; 'GP reform'; 'autonomy'; 'control'; 'quality'; and 'specialty'. The items collected included opinion pieces, editorials, news items and letters to the editor. Ten items were then removed when, on re-reading them it became clear that they were not relevant to the key themes. The MJA and AM are journals of the Australian Medical Association (AMA), while the AFP is the journal of the Royal Australian College of General Practitioners (RACGP). These journals were selected for analysis because both the AMA and the RACGP are important and active stakeholders in the health policy process in Australia, and because the AMA and RACGP 'collectively represent the majority of GPs' in Australia (Woollard, 1998, p. 10). We would expect contributions to policy debates, reforms and program implementation to occur in the pages of their journals. Among the contributors to these journals are GPs, representatives of organized medicine (the AMA and RACGP), academics, and journalists, as well as more occasional contributions from government representatives,

lawyers, and others. For the purposes of our analysis we defined the main contributors (GPs, representatives of organized medicine, academics, and journalists) as the general practice community.

The process of data collection yielded 73 items from the *Medical Journal of Australia* (MJA), 204 items from *Australian Medicine* (AM) and 66 items from *Australian Family Physician* (AFP), resulting in a final sample of 343 items. The larger number of items appearing in AM is related to the fact that it is a fortnightly journal, while the other two journals appear monthly. In addition, AM tends to include many more short news items.

The coding and analysis of our data involved two major steps. First, coding was carried out by content, including: the author's position (GP, representative of organized medicine, academic, journalist, other), the reform focus of the item, and the dimensions of professional autonomy affected by the reform. These dimensions were identified and coded by matching the points of discussion in each item with the components of autonomy identified in Table 1. Items that covered a number of topics were coded for each of the dimensions identified. In addition, the items were coded according to whether the author had a positive, negative or neutral attitude towards the impact of the reform on the micro, meso and macro dimensions of autonomy. These data generated a detailed picture of which reforms were being discussed and perceptions of the impact of reform on the autonomy of GPs.

We then conducted a thematic analysis, in which we sought to identify the meaning that contributors were making of the reform process, by coding and re-coding until key themes were identified.

Both steps in the coding process were conducted by a single researcher (TM), who is an experienced coder (Marjoribanks, Good, Lawthers, & Peterson, 1996). For the quantitative analysis, a coding sheet was devised by both authors, derived from the model developed and applied by Schulz and Harrison. Initially, a small number of items were coded as a pilot, revealing the dimensions of the coding schedule to be appropriate for the data and the research questions. As the complete coding process took place over several months, it was possible to check for intra-rater reliability by recoding selections of data a second time. This process revealed that the coding was stable over time. In relation to the qualitative analysis, the congruence between the themes that emerged and the results of

focus groups on GP autonomy conducted by the authors (Lewis, Marjoribanks, & Pirotta, 2001) was taken as another indicator of reliability.

Results-Quantitative

The contributors

Insert Table 2 here: Contributors and attitudes to reform

The largest number of contributors to the journals writing on issues of reform and GP autonomy did so in their capacity as representatives of organized medicine (see Table 2). While many of these contributors are also GPs, it was evident that they were writing from an organizational perspective-for example, representing the AMA or the RACGP. The second largest group of contributors were journalists, followed by academics and GPs. There were also a small number of contributions from other health professionals, lawyers, politicians, and others (see Table 2).

The attitudes expressed towards reform varied significantly between different kinds of contributors. Representatives of organized medicine contributed the highest proportion of negative items (62.8%), journalists the highest proportion of neutral items (35.4%), and GPs and academics the highest proportion of positive articles (41.5% and 35.8% respectively). This variation can be explained by the fact that the general practice strategy has been understood in particular by the AMA and the RACGP as having been developed and implemented without sufficient consultation with, and contrary to the wishes of, organized medicine. By contrast, academic and GP contributors perceive that at least some dimensions of the reform process have the potential to improve general practice, even where they are also concerned about the place of GPs in the reform process.

Insert table 3 here: Reform topics and attitude of contributors towards them

The results in Table 2 indicate that the attitudes expressed towards reform varied significantly between different kinds of contributors. However, once we commenced a more disaggregated analysis of the relationship between reform and autonomy it became necessary to group the contributors together as the cell sizes became too small to perform reliable chi squared tests. Grouping the contributors together allowed an analysis of contributors' attitudes to different reforms, which was important in examining the contribution of a multi-component model of autonomy to research in this area.

A wide array of reform issues perceived to be affecting autonomy were discussed in the journals, with the majority of reforms being discussed in terms of their impacts on clinical, social and economic work freedoms (Table 3). In relation to clinical work freedoms, the most frequently discussed reforms were the role of the GP, and quality. Reform of the role of the GP was discussed by over half (53.8%) of the contributors negatively, but more than a third (36.9%) spoke of this topic positively, and the remainder were neutral. Exactly half of the items discussing quality reforms were negative, with the remainder being almost evenly divided between positive (26.7%) and neutral (23.3%) attitudes.

In relation to social and economic work freedoms, reforms addressed at the financing of general practice attracted most attention, with the majority of contributors expressing concern about the impact of financial reforms on the earnings of GPs. The majority (60.6%) of contributors understood financial reforms as having a negative impact on earnings, and a minority (10.6%) of the remaining contributors were positive in their assessment of the impact of financial changes.

Reforms perceived as affecting the institutionalised relations between medicine and the state were most frequently discussed in relation to the overall progress and impact of the general practice

reform strategy. While one-fifth (21.6%) of contributors regarded the general practice reform strategy as positive, a clear majority (60.8%) saw it as having a negative impact on the institutionalised relations between medicine and the state. None of the reforms were discussed as primarily affecting biomedicine as an appropriate model of practice.

Table 3 indicates that more than half of the contributors (54.9%) expressed a negative attitude to reform, but this negative attitude is low for some components (26.9% in relation to practice issues) and very high for others (75.0% for GP supply and 78.6% for competition). The attitudes of the contributors are different for the various reform topics, and these differences are statistically significant.

Impact of reforms on autonomy

Insert table 4 here: Attitude of contributors to impact of reforms on specific dimensions of autonomy

Table 4 presents the attitude of contributors to the impact of reforms on the specific dimensions of autonomy. The results in Table 4 suggest that while reforms may be focussed on, or have a primary impact on, one dimension of autonomy, they can also impact on other dimensions. This table also highlights the variation in attitudes to different impacts on autonomy, with earnings and evaluation representing the extremes. Two-thirds of contributors expressed a negative attitude to the impact of reforms on earnings compared to just over half for evaluation. The influence of the reform process on biomedicine as a system arose on very few occasions and, when it did, was predominantly viewed as positive (62.5%).

The interaction of reform and different dimensions of autonomy becomes more evident as we turn to the thematic analysis.

Results-Thematic analysis

Six key themes emerged from the analysis of the literature on reform of general practice and professional autonomy. These themes covered all dimensions of autonomy, while also indicating how micro, meso, and macro dimensions of autonomy overlap. The central theme to emerge was uncertainty about what it means to be a GP, and this central theme generated further themes focused on specific aspects of this uncertainty.

Uncertainty about what it means to be a GP

General practitioners seem to be struggling for identity: to some we are family practitioners, to others we are generalists. The reality is that our area of expertise seems to be an ever diminishing one, under threat from within our own profession by the specialists and from without by the burgeoning group of naturopaths, osteopaths, and other purveyors of alternative medicine (Deputy Medical Editor of AFP) (Clearihan, 1989, p. 443).

Apparent in many of the discussions about the role of GPs in the provision of health care in an era of reform was uncertainty as to what it means to be a GP, and a feeling of loss of control over practice. This uncertainty among contributors is related to the perception that current experiences of being a GP diverge markedly from the ideal of general practice. The dominant ideal of what it means to be a GP was one engaged in a professional vocation where one has the privilege of caring for the whole person in an ongoing relationship.

For many contributors, however, the current emphasis of general practice reform on cost containment and externally imposed quality control mean that such an ideal is increasingly impossible to attain. As one GP contributor wrote:

There are also times when I wish I were doing something else. Demands from patients and receptionists, the pressure of time, government regulations and interference in the way we practice, the increasing threat of litigation, and never ending paper work frustrate me immensely at times (Kourdoulos, 1997, p.1100).

The frustration of this contributor, and of others, is linked to perceptions that the autonomy of GPs is declining, in particular in the context of clinical freedoms. That the uncertainty that accompanies this perceived loss of control affects all aspects of autonomy becomes evident in the remaining themes that focus on specific aspects of uncertainty.

Diminution in GP control of practice issues

During the past 30 years there has been a move from the traditional Australian model of deliberative and definitive general practice with a procedural component to a triage and referral model...The majority of (urban general practitioners) have lost this esteem by divesting themselves of clinical responsibility due to: a lack of education and training; specialist opposition to GP hospital admissions; the skewed remuneration system; the failure of private health insurance; and the cost of medical indemnity insurance (RACGP President) (Joseph, 1998, p. 11).

For a number of contributors, the most important elements of GP autonomy are those that relate to the freedom to control clinical practice. As the quote above suggests, however, control in the clinic is closely related to, and influenced by, social and economic work freedoms. For example, perceived financial constraints linked to Medicare, the system of national health insurance, which negatively affect the economic control of earnings have a flow-on effect into areas such as freedom in the acceptance of patients, and time management. As another example, the introduction of a quality measure such as accreditation is interpreted as removing the capacity of GPs to respond to patients on an individual and flexible basis. Financial pressures, externally imposed quality measures, and the

like, all contribute to a situation in which members of the GP community understand their control of practice issues to be diminished.

GPs feel under attack from reformers

[The profession has] endured a hammering from a succession of interventionist health ministers hell-bent on an agenda of control and nationalisation. We saw the denigration and vilification of the medical profession. Doctors were seen as class enemies who needed to be subjugated and brought to heel (AMA President) (Woollard, 1998, p. 10).

The attitude of members of the GP community towards health care reformers is one of often barely disguised hostility, in particular on the part of those who represent organized medicine. An important dimension of this hostility is related to the perception that reformers are challenging the institutionalised relations between medicine and the state, in an attempt to control medicine without adequate consultation with the GP community. The federal government, politicians in general and policy bureaucrats come under attack for their attempts to control medicine, for example, through financial limitations, through controlling quality with the imposition of standards, and through continued threats to restrict the numbers of practitioners and the locations in which they can practice. Such measures are seen as restricting the autonomy of GPs, with negative consequences for the quality of practice.

Transformation of GP-patient relationship

There exists today an uneasy tension between the traditional role of the doctor, as an authority figure, and the more modern emphasis on a patient's freedom to choose for themselves (Academic) (Hassed, 1999, p. 274).

There is a degree of ambivalence among members of the general practice community towards their relationship with patients. Two related examples provide evidence of the transformation in the

GP-patient relationship. First, contributors discuss the shift in self-definition among patients from patients to consumers. For a number of contributors, this shift poses a fundamental challenge to the role of GPs, who see general practice being transformed from a profession to just another commercial industry. Second, there is the emergence of supermarket clinics that provide 24-hour, seven day a week services across a wide range of health services. Often owned and managed by corporate entities, these clinics represent a major shift for many GPs, not only in the organizational structure of practice, but also in the relationship that GPs have with their patients. Individual GPs become just one of a number of GPs that a patient or customer may see. The ongoing relationship between a GP and her patients is challenged. While the development of these corporatised clinics is welcomed by some as taking away the financial and time constraints of managing a practice, for a number of the contributors it also signifies an unwelcome development in the control of GPs over clinical practice.

GPs are overworked and undervalued

General practice has changed enormously over the years. It is now quite political, much harder and people want more of my time. Some tend to shop around, are not as loyal and can be unreasonably demanding. Naturally they don't like paying for medical services. Paper work now takes up a great deal of time (GP) (Davies, 1998, p. 102).

A common perspective that emerged among the contributors was the concern that GPs are overworked and undervalued. Financial constraints, increasingly demanding and well informed patients, competition among GPs especially in urban areas, and increasing amounts of paperwork and information processing associated with various quality assurance programs, are all considered by members of the general practice community to have increased the workload of GPs, in many cases to intolerable levels. These sorts of changes led a number of contributors to lament that if they had their choice all over again, they would not choose to become GPs.

Members of the GP community also feel that they are undervalued, in particular by governments that will not allow GPs to practice medicine as they think is best. In relation to patients,

there emerges an interesting contrast in perspectives. On the one hand, contributors suggest that patients are happy with the care they receive from their GPs, and on the other hand, there is a general concern that patients are now unreasonably demanding, and do not value their GP. This takes the form of practices such as doctor shopping, demanding lengthy consultations armed with material from the internet, and expecting access to latest technologies.

Enjoyment of general practice work

I consider it a privilege and a joy to be a patient's 'GP' to coordinate their care, to be involved in their happiness and sadness, to be their confidante and their advocate. These are the rewards that overcome all the frustrations, disappointments and long hours of general practice (GP) (Jane, 1998, p. 533).

The one positive theme that emerged from the data was that for many GPs, and despite all their concerns, general practice remains an enjoyable profession. There is a tremendous satisfaction among contributors in being the point of first contact for patients, and then not only providing them with care but also directing them to other health and related services as necessary. In addition, there is a high level of satisfaction among GPs in perceiving themselves to be the only professionals in the health system who deal with patients as whole people on an ongoing basis, and not as biomedical objects separate from a social context.

Discussion and Conclusion

Our research reveals that members of the GP community are committed to an ideal of professionalism in which autonomy is central, and they believe GPs should have the freedom to control all dimensions of patient care without external interference. In the context of reforms that have been introduced over the last decade in Australia, however, there is uncertainty as to the role of GPs in the delivery of health care. This uncertainty is crucially linked to concerns about the perceived

decline in the autonomy of GPs, especially in the micro contexts of clinical, social and economic work freedoms, but also in the meso context of institutional relations between medicine and the state. The feeling of uncertainty that emerged from our analysis indicates that GPs are concerned that they are losing control over the organization of crucial aspects of the terms and conditions of their work. As these transformation processes continue, so the practice of frontline GPs further diverges from their ideal, resulting in even greater uncertainty around what it means to be a GP. At the same time, however, there is also recognition among the contributors that some reforms have the potential to enhance the work of GPs.

Before examining the theoretical significance of our findings, it is vital to consider the adequacy of our methods. We suggest that our approach in this paper is innovative in undertaking a systematic qualitative and quantitative examination of a rich and understudied body of material contained in the publications of influential GP organizations. While reading all articles from the time period was a time-intensive means of collecting data, it did provide some assurance that our sample was complete, as opposed to alternative search methods such as reading headlines or conducting keyword searches. Nevertheless, while our data represents contributions from many members of the GP community, it is important not to assume that the views expressed in those journals are representative of all GPs, or the total GP community. Factors such as who has the time to write for journals, and editorial selection processes, shape what material is published. However, media research indicates that publication of items in journals such as those included in our study, which have a high circulation rate within the GP community, has the capacity to set agendas and frame debates in the broader community (Street, 2001). In addition, our data captures a diverse and wide range of opposing and neutral viewpoints on autonomy and reform, suggesting that even where certain perspectives predominate, alternative views have been given space. Further, we conducted a series of focus groups with GPs, exploring the relationship between autonomy and reform, and similar themes emerged. This suggests some congruence between the journal data and the views of members of the GP community who do not necessarily contribute to the journals (Lewis, Marjoribanks, & Pirota, 2001). Future research could extend and test the findings of this paper around autonomy and reform

in a variety of ways, including comparative research with similar journals in other countries, interviewing editors about selection policies, or by interacting with GPs more directly using methods ranging from interviews to surveys.

At a theoretical level, our findings indicate that a multi-component model of autonomy allows for a focused examination of how the relationship between reform and autonomy is experienced and perceived, and allows for an analysis of the different ways in which autonomy is being affected. For example, while numerically most discussion focused on control over earnings, the intensity of feeling was most evident around control over clinical practice. Similarly, the lack of discussion around the biomedical model suggests that while there is concern around GP autonomy, biomedicine is settled as an appropriate model and is not challenged by current reforms (Lewis, 1999). In a context in which the dominance of biomedicine is assured, our research indicates that, while issues around social and economic work freedoms are important, it is ultimately control of what goes on in the surgery that is the defining element of general practice and of what it means to be a GP. Such insights are made possible by adopting a multi-component model of autonomy as a means of sharpening the focus of empirical research.

Our analysis also suggests that the attitudes to reform of different groups within the GP community vary significantly, with representatives of organized medicine being the most negative. Many in the GP community are concerned about current reforms, but still profess an enjoyment of their work. Similarly, different aspects of reform were seen to be more or less negative in their impacts, with clinical freedoms such as diagnosis and evaluation being written about less negatively than social and economic work freedoms such as practice location and earnings. The attitudes of contributors to different reform topics suggest the importance of considering the relationship between autonomy and reform as multi-dimensional, and of adopting a model of autonomy that allows for variation in the impact of reform on different dimensions of autonomy.

These findings are significant because they further suggest the importance of a multi-component model of autonomy for improving our understanding of GPs' autonomy. In particular, the findings support and enhance the theoretical argument of Harrison and others that a more complete

understanding of GP autonomy can only be gained through context-specific research, and by taking seriously the perspectives of GPs about the different dimensions of autonomy. While the limited research that does exist suggests that there are broad parallels between the experiences of Australian GPs and their professional colleagues elsewhere, the institutional and policy context of Australia means that the different dimensions of autonomy have developed and are being transformed in quite specific ways. GPs in Australia are clearly going through similar experiences to their colleagues elsewhere. For example, in common with findings from the UK (Allsop, 1995; Calnan & Williams, 1995), we found that while GPs want to practice high quality medicine, ‘impositions’ on practice from outside the profession make this increasingly difficult, in particular where the capacity of GPs to exercise their own professional judgment is being restricted. State regulations concerning competition and accreditation, and the increasing corporatisation of practice, are examples of perceived impositions that emerged from our data. The experiences of GPs in Australia resonate with those of their counterparts in the UK, and in the US under managed care arrangements (Scott Collins, Schoen & Sandman, 1997; Robinson and Steiner, 1998). But the context of health care in Australia, as in other countries, means that the ways in which such challenges are developed and contested are in an important sense context specific. For example, the relatively recent establishment of universal health insurance in Australia (in 1983), compared with the far more established systems in New Zealand and the UK, and the absence of universal insurance in the US, is vital in shaping the context in which clinical autonomy is experienced by GPs.

The approach adopted in this paper also adds a level of complexity to claims made in favour of the deprofessionalisation and proletarianisation theses, which tend to adopt universalistic arguments in an attempt to explain transformations in professional autonomy. In particular, while those theses are important in providing insights into the changing structural contexts of professional practice, exploration of the experiences of frontline GPs suggests that research should focus on the specific and sometimes contradictory ways in which professional autonomy is experienced in the workplace (Lupton, 1997). To provide one example from our research: although GPs believe that their micro work freedoms are being diminished, as patients become more assertive, resulting in role

uncertainty for GPs, they continue to express enjoyment in their work, in particular in their clinical interactions with those same patients.

The research in this paper contributes further to the theoretical debates around professional autonomy by illustrating the importance of understanding the micro aspects of everyday experiences of doctors at work. By listening to the voices of GPs, we begin to see how professional autonomy is being constantly renegotiated at the frontline of general practice, and how GPs seek to manage their professional identity and autonomy through such negotiations (Lupton, 1997). The analysis in this paper indicates, for example, that these negotiations are taking place in a context of uncertainty. Using the transformation of the doctor-patient relationship as a specific example, while many of the contributors recognise that the paternalistic model of medicine, in which the GP directs all aspects of the doctor-patient relationship, is no longer appropriate, there is uncertainty as to how to proceed from that recognition. This uncertainty can be attributed in part to the belief among the contributors that much of the reformulation of the doctor-patient relationship is being driven by the demands of patients, who are directly challenging clinical freedoms. As another example, the sometimes conflicting debates within these journals about the appropriate relationship between GPs and the state can be understood as an instance of members of the GP community negotiating the boundaries of their autonomy. In revealing the importance of such processes, our paper contributes further to contemporary understandings of autonomy by showing that future research must be sensitive to the negotiations that occur between professionals and others on autonomy at the micro, meso and macro levels.

Finally, our findings indicate that in many instances members of the GP community perceive several dimensions of autonomy as being affected by the same reform. This came through clearly in the perception that a diminution in an economic work freedom such as control over earnings also diminishes the clinical freedom to accept patients. Similarly, the theme of uncertainty cut across many dimensions of autonomy. Ultimately, while it is analytically vital to separate out the different dimensions of autonomy in order to achieve a nuanced conceptualisation autonomy, it is also

important to recognise that the ideal of autonomy that remains central to GPs' self-understanding is also constituted by the interaction of those different dimensions.

Acknowledgments:

This research was funded by an Australian Commonwealth Department of Health and Aged Care General Practice Evaluation Program seeding grant. One of the authors (JML) was supported by an Australian National Health and Medical Research Council Post Doctoral Fellowship during this research. The authors thank Helen Smallwood and Merryn Ekberg for their roles in collecting the material for analysis, and our co-researcher Marie Pirotta in the Department of General Practice at The University of Melbourne. Thank you also to Karen Farquharson, Stephen Ziguras, Peter Davis, and two anonymous referees for comments.

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Tables

Table 1
Framework for analysis of physician autonomy ^a

Micro work freedoms	Meso work freedoms	Macro work freedoms
(A) Clinical work freedoms <ul style="list-style-type: none"> • Acceptance of patients • Control over diagnosis and treatment • Control over evaluation of care • Control over other professionals 	<ul style="list-style-type: none"> • Relations between profession and state 	<ul style="list-style-type: none"> • Acceptance of biomedical model
(B) Social and economic work freedoms <ul style="list-style-type: none"> • Choice of specialty and practice location • Control over earnings • Control over nature and volume of tasks 		

a. Adapted from Schulz & Harrison (1986), and Harrison & Ahmad (2000)

Table 2
Contributors and attitudes to reform. ^{a, b}

Contributor	Total n	Positive %	Negative %	Neutral %	Total %
Organized Med	137	24.1	62.8	13.1	100
Journalist	82	13.4	51.2	35.4	100
Academic	53	35.8	50.9	13.2	100
GP	53	41.5	41.5	17.0	100
Total	325	26.2	54.5	19.4	100

a. Table excludes 'other' contributors'

b. $\chi^2 = 27.5$, df = 6, p = 0.00

Table 3
Reform topics and attitude of contributors towards them ^{a, b}

Reform	Total n	Positive %	Negative %	Neutral %	Total %
<i>Clinical work freedoms</i>					
GP role	65	36.9	53.8	9.2	100
Quality	60	26.7	50.0	23.3	100
Malpractice	9	0.0	66.7	33.3	100
<i>Social and economic work freedoms</i>					
Finance	66	10.6	60.6	28.8	100
Practice issue	26	53.8	26.9	19.2	100
GP supply	24	16.7	75.0	8.3	100
Competition	14	7.1	78.6	14.3	100
<i>Meso work freedoms</i>					
GP reform	51	21.6	60.8	17.6	100
Organized medicine	22	40.9	31.8	27.3	100
<i>Totals</i>	337	25.2	54.9	19.6	100

a. Table excludes category 'other reforms'

b. $\chi^2 = 45.0$, df = 16, p = 0.00

Table 4
Attitude of contributors to impact of reforms on specific dimensions of autonomy ^{a, b}

Dimension of autonomy	Total n	Positive %	Negative %	Neutral %	Total %
<i>Clinical work freedoms</i>					
Accept patients	85	34.1	64.1	11.8	100
Diagnosis	98	30.6	56.1	13.3	100
Evaluation	98	31.6	52.0	16.3	100
Other professionals	63	30.2	54.0	15.9	100
<i>Social and economic work freedoms</i>					
Location	89	19.1	66.3	14.6	100
Earnings	150	14.0	67.3	18.7	100
Nature/Volume	130	29.2	56.2	14.6	100
<i>Meso work freedoms</i>					
State-profession	88	19.3	60.2	20.5	100
<i>Macro work freedoms</i>					
Biomedical	8	62.5	12.5	25.0	100

- a. Many items dealt with more than one aspect, so the total number in this table (809) is much larger than the number of items collected (343)
- b. No significance tests were performed on this table because multiple codes were used per item

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Title:

Reform and autonomy: Perceptions of the Australian general practice community

Date:

2003

Citation:

Marjoribanks, Dr Tim and Lewis, Dr Jenny (2003) Reform and autonomy: Perceptions of the Australian general practice community.

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