Changing professions: General Practitioners’ perceptions of autonomy on the frontline

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Abstract

Professional autonomy is a much used concept which has operated with scant empirical attention directed at understanding its meaning amongst practitioners. This study investigates how General Practitioners (GPs) understand their professional autonomy, and what they perceive to be the main threats to it. Four focus groups were attended by 25 GPs in Melbourne. We found that GPs aspire to an ‘ideal type’ of professional who has the freedom to determine what is best for patients, but they believe their autonomy is threatened by financial constraints, greater accountability requirements, and more demanding patients. These findings reveal how GPs understand autonomy in their practice, and indicate that their concerns may have little to do with the deprofessionalisation and proletarianisation theses. Micro level studies of GPs in the workplace, combined with greater understandings of different aspects of professional autonomy, appear useful in understanding how GPs work and autonomy is changing.
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The concept of ‘profession’ in relation to medicine carries with it the central idea of autonomy. Eliot Freidson’s critical writings on how the medical profession attained, maintained and extended its autonomy (Freidson 1970), represented a shift away from the functionalist approach of Talcott Parsons and others (Macdonald 1995). In more recent times, it has been argued that governmental, organisational, technological and societal changes have reduced medicine’s status (Harrison and Ahmad 2000; Eve and Hodgkin 1997; Wilsford 1995; Haug 1988). However, much of this debate has been conducted at a high level of abstraction. Scant empirical research has been directed at understanding what autonomy means in everyday practice, and how changes have been experienced by frontline practitioners (Lupton 1997; Schulz and Harrison 1988).

The research presented in this paper aims to understand how frontline GPs in Australia perceive of their autonomy in relation to the challenges they have faced over the last decade. It then considers these findings in regard to different theories on how the medical professions’ status has changed – in particular, whether medicine is being deprofessionalised or proletarianised.

Professional autonomy

Professional autonomy is the legitimated control that an occupation exercises over the organisation and terms of its work (Elston 1991). Some authors have claimed that professions are being proletarianised or deprofessionalised. The deprofessionalisation thesis asserts that professions are losing their monopoly over knowledge, their expectations of work autonomy
and authority over the client, and public belief in their service ethos, because of changes in the organisation and management of health care services (Haug 1988). The proletarianisation thesis claims that professionals are being deskilled and their work made routine because of technological developments and bureaucratic requirements (Light and Levine 1988).

These theses have been applied to general practice in Australia (White 2000), with the conclusion that a combination of proletarianisation in regard to GPs employment, and deprofessionalisation in regard to the challenges from self-help and other groups, is at work. However, others have taken issue with these theses, arguing they may not be relevant in countries other than the US, and some authors disagree with the analysis even in the US context (Freidson 1988). While there is evidence that these challenges to the medical profession can be found in most Western health care systems, there are doubts about the explanatory power of these arguments (Calnan and Williams 1995). The available data indicates change which looks more like adjustments than a major loss of professional autonomy (Elston 1991).

More recent work on professions has used labour process theory to explain changes in professional work, by analysing the relationship between professionals’ subjective experiences of work and the broader structural context of that work, through a focus on the workplace. One example in regard to legal aid lawyers in the UK concluded that new public management initiatives have led to high output and low morale for these practitioners (Sommerlad 2001). Australian teachers, in another study, reported increased and intensified workloads in more complicated workplaces (Easthope and Easthope 2000). Applications of labour process theory to health also reveal that there is a struggle apparent for control of medical work (Dent 1998). However, such studies also suggest
that the tension between bureaucracy and professionalism is being recast rather than eliminated and the impact on different types of professionals varies enormously (Warhurst and Thompson 1998).

In discussing the medical profession it is important to pay attention to the difference between changes to frontline medical practice and changes to the social status and political power of the medical profession. Eliot Freidson addresses this difference by distinguishing between the macro and micro levels of the profession. At the macro level the elite representatives of organised medicine negotiate with governments and health care organisations, and are responsible for knowledge, training, discipline and administration within the profession. This corporate body of medicine is able to retain its status as it is divorced from the rank and file (micro level) of doctors delivering services (Freidson 1988; Willis 1988).

Light (1995) goes further in arguing that when states or insurers challenge professions, the elite gain power at the expense of their rank and file colleagues. It is possible that policies agreed to by the elite might both strengthen the profession’s social and cultural authority and diminish the autonomy of professionals delivering services on the frontline. A re-stratification within medicine could be the main outcome of reforms, with frontline clinicians losing autonomy (Harrison and Ahmad 2000). Policy change might also strengthen some aspects of autonomy, such as financial control over other health service providers, while diminishing other aspects through increased accountability (Calnan and Williams 1995).

There has certainly been an increase in rules, incentives and pressures to change how GPs work as governments and insurers around the world have increased their attempts to contain the costs of care and increase the accountability of professionals (Saltman and Figueras 1997;
OECD 1996). There are transformations occurring in GP-patient relations, in the rise of health consumerism, and in the corporate and legal climate of practice (Eastwood 2000; Siahpush 1998; Eve and Hodgkin 1997). GPs are also challenged from within medicine and from other health professions. Challenges emerge from specialists taking over areas that were previously the domain of general practice, and there is concern that nurses, allied health practitioners, and complementary health care practitioners are engaging in practices once under GPs’ control (Good 1998; Willis 1988). GPs also fear a perceived medical malpractice crisis instituted by legal professionals, where decisions about practice standards and quality are being taken by lawyers and judges (Good 1998). A newly emerging challenge to the autonomy of GPs in Australia, is the buying up of general practices by corporations (White and Collyer 1998; Collyer and White 1997), which GPs fear will lead to them being subjected to control through quality reviews, incentive pay structures and practice restrictions.

Yet little is known about frontline GPs’ perceptions of these challenges to their role and their autonomy. Empirical studies on this topic are not numerous (Harrison and Ahmad 2000) and few have directly sought the views of practising doctors themselves on these issues (Lupton 1997). One important study of medical autonomy in the workplace (Schulz and Harrison 1986) divided autonomy into social and economic work freedoms, and clinical freedoms, then put forward seven dimensions of autonomy. In their conceptualisation, social and economic work freedoms are partitioned into: choice of specialty and practice location, control over earnings, and control over the nature and volume of medical tasks. They divided clinical freedoms into: acceptance of patients, control over diagnosis and treatment, control over evaluation of care and control over other professionals. This classification provided a useful starting point for our consideration of GPs autonomy. As this study is concerned with
Australian GPs, structural factors affecting their work, and reforms over the last decade are briefly described next.

**General practice reform in Australia**

General practice has been the subject of extensive policy reforms in Australia over the last decade. Reform activities have multiplied the range of financial incentives, administrative rules and normative pressures on General Practitioners (GPs). A variety of programs and activities have focussed on the quality of care, workforce issues, integration between general practice and hospital services and on changing the methods of paying GPs (General Practice Strategy Review Group 1988).

GPs are not poorly reimbursed for their labour compared with other Australians, but the pressure to contain the costs of outlays through the national health insurance scheme (Medicare) over the last decade has resulted in increasing financial constraints on GPs (Power and Aloizos 2000). The concentration of GPs in capital cities, particularly inner suburban areas, (Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare 1998) has added additional pressure. The large numbers of GPs in metropolitan areas explains the high rate of bulk-billing (charging schedule level fees) by GPs – around 80 per cent of services (Harding 2000). The rate of bulk-billing has fallen in recent years, but only slightly. GPs working in metropolitan areas are financially and normatively pressured to bulk-bill patients, while in rural areas where there is a shortage, GPs routinely charge higher rates than the scheduled fees. Almost all of GPs’ incomes (96 per cent) are derived on a fee-for-service basis, and most years since 1993, GP rebates from Medicare have been indexed at half the rate applicable to other services (Power and Aloizos 2000).
Following the introduction of vocational registration for GPs in 1989 and an increased focus on the role of general practice in the health care system (General Practice Consultative Committee 1992; National Health Strategy 1992), a number of initiatives were directed at three main areas. Firstly, the establishment of general practice as a specialty in its own right, through the introduction of specific training and vocational registration for GPs, and the General Practice Evaluation Program (GPEP) to evaluate changes. Secondly, the establishment of connections between GPs and the integration of GPs and hospital services through the Divisions of General Practice. Thirdly, the use of financial incentives to encourage GPs to locate in rural areas, to become accredited practices, and to become more involved in disease prevention activities. These policy initiatives were intended to encourage good quality general practice, but many also had a cost containment agenda (Bollen and Saltman 2000).

A substantial amount of effort has been directed at reforming general practice in Australia. But how have policy changes been experienced on the frontline of general practice? How do GPs perceive the impact of these and other societal changes on their work and their autonomy?

### Methods

To understand how GPs’ perceive of their autonomy, we used focus groups with questions based on a review of the professions’ journals. 343 items, consisting of articles, opinion pieces, editorials and letters to the editor published in the *Medical Journal of Australia* and *Australian Medicine* (Australian Medical Association publications), and *Australian Family
Physician (Royal Australian College of General Practitioners publication) from 1989 to 2000, were selected on the basis that they related to aspects of GPs’ autonomy and work experience. Coding of these items was carried out on the basis of content, specifically the dimension of autonomy. Items were then recoded into more general themes or axial codes (Strauss and Corbin 1990) of which there were six.

One main theme in these publications was related to the meaning of profession and uncertainty about GPs’ place in the professional hierarchy. The second, related theme was of major change in the role of GPs over the last 20 years, specifically in regard to the control of practice organization and type, quality assurance, and funding. The third was one of GPs being under attack from a range of actors. A major change in GP-patient relationships was the fourth theme, and a theme of GPs being overworked and undervalued was the fifth. These were largely negative, but there was one positive theme in the literature, relating to the enjoyment of general practice because GPs are the first point of contact with the health system, can establish continuing relationships and care for the whole person. These themes were valuable in developing the focus group questions.

In one of the few pieces of empirical research on doctors’ perceptions of their autonomy (Harrison, Pohlman and Mercer 1984), few doctors were able to articulate a coherent definition of the concept of autonomy in one to one interviews. We used focus groups because they allow participants to discuss and listen to each others ideas in an informal setting (Morgan 1996). Something one person mentions can trigger the opinions or memories of another participant as they interact, so people can compare their own experiences in the context of the views of others (Patton 1990; Lofland and Lofland 1995).
The focus group questions were developed using the six themes identified in the profession’s publications, and Schulz and Harrison’s (1986) seven components of autonomy. Questions were structured around what GPs like about their work and what they find causes stress; aspects of control in daily practice, including clinical, and social and economic work freedoms, relationships with different organisations and groups in health; professional autonomy; and the impact of reforms on general practice. The focus groups were convened in the evenings and directed by two people – at least one of whom was on the research team. They ran for approximately one hour each, and participants were provided with dinner at the conclusion of the discussion. The four focus groups were held between March and July of 2000. We began by asking each participant to respond in brief to the question of what they like about being a GP to ‘break the ice’. As the groups progressed, participants discussed and listened to each others ideas drawing on their own work experiences, which was useful for examining the complex concept of autonomy.

We were not concerned with generalizing results to Australian GPs, but in understanding how GPs perceive changes and interpret them as threats to their role and their autonomy. Hence, we selected groups that we anticipated would have different views because of their different practice types and locations. This is analogous to multiple case studies, choosing groups of GPs (cases) on the basis that they will produce contrary results, but for predictable reasons (Yin 1989). Two focus groups were held in North Western Melbourne and one in a fringe rural/metropolitan town about 80 kilometres from the centre of Melbourne. Participants for each of these were recruited with assistance from the local Division of General Practice. Another group of all female GPs who worked in different areas across the city was also held in Melbourne and they were recruited by direct contact from the researchers.
A total of 25 GPs were involved (see Table 1). Each focus group was tape recorded and transcribed in full shortly after the interviews. The transcripts were then examined by two of the researchers (JML and TM) and coded into central themes (Strauss and Corbin 1990) relating to GPs’ perceptions of their role and their autonomy, and the perceived challenges and threats to these.

Table 1 about here

**Results**

The GPs in our focus groups operated with an ideal of what being a professional entails, but they perceived that their role and status is undergoing a process of contested reorganization. Social, economic and clinical dimensions of autonomy were all regarded as under threat from actors including government, patients, other health professionals, and lawyers. The specific areas identified by GPs as being challenged include financial issues, in particular billing practices, GP-patient relationships, practice organisation issues, including practice type, hours and location, and clinical autonomy. Our primary interest was in the discussion within the groups. Individual quotes were taken verbatim from the transcripts and identify the group, but not individual characteristics.

**General Practice as a profession: the ideal type**

GPs’ perceptions of their role in its ideal form, as discussed in the focus groups, is that they provide the entry point to, and coordination of, patient care in the Australian health care system. GPs deal with the whole spectrum of health and illness and, self-identify as ‘specialists in generalism’. In this ideal form, GPs have continuing interactions with patients,
act as gatekeepers to the health system, and fulfil a role as ‘physicians of the soul’. A competent GP is seen as one who provides not only appropriately technical and skilled health care in individual consultations, but who also provides comprehensive and continuing care.

The focus groups revealed that GPs operate with an image of their profession which corresponds to the early theoretical discussions of Parsons and other functionalists (Macdonald 1995). Autonomy and control and the possession of special skills were all seen as central, as was the notion that it is a special kind of occupation:

“there is a sense of vocation ... I enjoy it, I think I’m good at it and I feel the need to keep doing it despite sometimes feeling a little bit wretched about it.” (Group 4)

While this ideal type exists in the minds of GPs, they also believe that the reality of their current work life is very different, and this difference is exerting an important impact on their understanding of themselves as professionals. Concerns expressed by GPs around the low levels of remuneration, lack of recognition, and increasing government control, are important not only in themselves, but also because they are indicators for GPs that their autonomy is under challenge. The ‘ideal’ professional that many GPs aspire to, and which they consider to be integral to their position, appears to be increasingly out of reach. This feeling is encapsulated in the comment:

“This profession has been downgraded. We have no say.” (Group 2)

Loss of control was seen as resulting in a downgrading of their own self image:

“... I’m sure that erosion of our sense of professional autonomy and control [has] a really demoralizing effect on us.” (Group 1)

Challenges to financial autonomy
The GPs in our focus groups believed that they have little or no control over their earnings, and that this has a major negative impact on other dimensions of social and economic work freedoms. Medicare and bulk-billing in particular is considered to have fundamentally eroded control over earnings. GPs fear the loss of patients to other practices if they stop bulk-billing, and also claim that they have to work long and hard simply to make financial ends meet:

“One important aspect, which I would like to have control over and which I should have control over, is my income, that's controlled by Medicare. I find myself working very hard, very long hours ... Because of the atmosphere of bulk-billing one doesn't dare to charge the patients because there are so many other doctors they can go to.” (Group 1)

A related theme was the struggle to manage time. The sources of time pressure were diverse, ranging from the desire to spend more time with each patient than they feel they can (in financial terms), to increasingly demanding patients, to the need to balance work and family and social life, to working long hours because there are not enough doctors (in the fringe metropolitan / rural group), to simply not being able to control the events that occur over the course of a day.

In the all female focus group, there was a discussion about male GPs getting through appointments faster than females because they were prepared to focus solely on the problem the patient came in with. On the other side of the doctor-patient relationship was an explicit recognition by female GPs that patients would happily go to male GPs about single problems and simple things, but insist on seeing a female when things were more complicated:

“...[patients] see the male doctors first for coughs and colds and then they come to you and they say but this time I’ve got a real problem...” (Group 4)
The tension between managing time in order to get through the appointments and providing holistic care was exemplified by the following comment:

“... you say to people is there anything else you’d like to discuss, before they leave. That's the classic [mistake] – now I’d like to tell you about my serial abuse ... or the problems that I’m having with my wife or my fears about my daughter who is drug taking ... I’m 12 minutes into this 15 minute consultation and then, shit, the cat’s out of the bag and it’s like 30 minutes after that...” (Group 3)

**Practice organisation issues**

The choice of practice type and style was also discussed at some length in the focus groups. Some regarded moving to a group practice as a positive step in terms of control:

“... with the amalgamation I must say that there’s a lot of merit in it ... I was in a solo practice for 21 years and I had no control at all, absolutely none...” (Group 2)

Others wished to remain in solo practice but were finding this increasingly difficult. While increasing practice size was often discussed, corporatisation as such was not. Type of practice choices extended beyond issues such as managing patients and time, to questions of balancing work with family and other non-work related roles. Choice of location was spoken about positively in the fringe rural/metropolitan area:

“I like working in a small town because it does give you that more holistic sense of care about people ... If you have a better understanding of the environment in which they live I think it helps...” (Group 3)

**Clinical autonomy**
Many GPs in the focus groups spoke of clinical freedom as the most important part of their autonomy. While GPs have control in the surgery, an important element of their autonomy is intact. But here, as elsewhere, there was concern. Participants would often begin by stating that they felt they had clinical freedom, but the discussion would then shift towards a decline of this freedom:

“As far as clinical decision making ... About 95% of the time I'd say that I'm in complete control of my recommendations to the patient ... ultimately clinical decision making and clinical practice, I think I'm in quite complete control of that.” (Group 3)

Such comments were soon followed by exchanges such as:

“I have control over what I do with patients in terms of what advice I choose to give them, what tests I choose to do, whether I choose to bring them back or not.”

“Do you really have control over what tests you order when the government's telling you what tests you can order, what tests you can't? You can't order an ultrasound for a prostate, you can't do this, you can't do that. Do you really have control over what you prescribe to patients? You don't really, plus there are all sorts of authorities, which you've got to comply with.” (Group 1)

Overall, the GPs who participated in these focus groups were experiencing a perceived loss of freedom and control on many fronts. Some participants recognised that it is because of their unique role in ensuring access to health care that they are being increasingly scrutinized:

“As frustrated as we are with Medicare, it really is a fantastic system in a lot of ways in providing equity. I think we have to accept that ... we’re providing a service and it’s so desperately essential that ... the community and the government ... is going to have an inherent interest in what we do...” (Group 1)
Sources of challenges

In analysing the contest over the autonomy of GPs, the Federal Government and patients were identified by GPs as providing the major challenges to their professional autonomy and status. The Federal Government is seen as trying to tighten its control on General Practice. The Health Insurance Commission also came in for criticism in its own right, as did the (Victorian) State Government to a lesser extent. The level of scheduled fees was described by GPs as an example of how their work is being subjected to government control, and is also seen as resulting in them spending more time worrying about financial and accounting issues, to the detriment of their capacity to focus on individual patients. Many GPs considered financial constraints to be in total opposition to the requirement of providing high quality health care:

“I think it's obscene that Government holds us to ransom financially ... I think none of those things actually do anything for the patient, nor do they improve the doctor who cares for the patient.” (Group 4)

A major concern for these GPs was that reforms have shifted control away from the profession to the government. Even practice accreditation and vocational registration, intended to improve the standing of General Practice as a profession, were discussed as a means to increase government control over GPs:

“... they’re telling you we want higher standards, we want better things, you've got to have a computer in the practice, you’ve got to have such and such.” (Group 2)

Reforms of this type are considered by GPs to be the worst sort of paternalism, indicating that they are no longer able to organise their own practices. It is not only governments, however, that are seen as challenging the autonomy of GPs. Even in their relationships with
patients, which GPs find to be the most satisfying aspect of their work, there was a feeling that profound changes are occurring. Patients are becoming more knowledgeable and informed, high technology medicine promises better care, and these factors create high patient expectations which cannot be met. This was sometimes expressed as the need to ration care:

“Now I try to explain to them that you’ve got a cake that has to be cut up so that everybody can have a piece. If we do tests unnecessarily ... the funds are gone completely...” (Group 2)

Other GPs spoke of patients just expecting them to be on tap, 24 hours a day, seven days a week:

“... patients say I rang and you weren’t here. How dare you? What were you doing?” (Group 4)

In contrast to a study of doctors in Sydney in 1995 (Lupton 1997) where the dual discourses of consumerism and the dependent patient occurred in doctors’ views of patients, there was no discussion of patients wanting to place themselves in the hands of their doctors in our focus groups. This may be related to the different ways that patients interact with GPs compared with other specialists and hospital based doctors – which comprised almost half of those interviewed in the Sydney study.

**Strategies for dealing with challenges**

In the focus groups, GPs discussed strategies they are using to deal with their perceived loss of control. For some GPs, this has led to them becoming salaried and/or joining group practices with the hope that this would free them from having to worry about the business of the practice. For others it has meant becoming partners/owners with the expectation that this
would bring a greater ability to control work time. Time management strategies were being employed to change patient appointment making, by encouraging them to think about whether they need a standard or a longer consultation. A different approach was to ask patients to give them a shopping list at the beginning of the appointment, then explain that not all of these could be covered in a single visit, and ask them to chose the one or two things they would like dealt with in this visit. Some GPs said they had moved away from bulk billing, in attempting to contain demand and be in a (financial) position to spend longer with each patient.

Some GPs made use of the Divisions of General Practice as a means of responding to these challenges:

“I’ve never felt particularly supported by organisations like the College of General Practitioners or the AMA specifically, but that I’ve felt for me the Divisions movement provided a much greater on the ground level support and a sense of sharing experiences with other people who were doing the same thing in a non competitive way." (Group 3)

It should be remembered that this and two other of our four focus groups were convened with assistance from Divisions, so the GPs in these groups were more likely to have been involved and had positive experiences with them than GPs in general.

**Discussion and conclusion**

This research suggests that GPs have an ideal of what being a GP entails, which includes dealing with patients in a continuing way, and providing the entry point to the Australian health care system. The frontline GPs in our focus groups also see clinical autonomy as central to their notion of a profession. However, the reorganisation of relations between GPs,
governments, patients, and other groups creates a situation in which GPs perceive that many aspects of their professional autonomy are under challenge. Together with reforms directed at controlling the costs of health care provision, and making GPs more accountable, they feel under challenge from “above” and “below” (Calnan and Williams 1995). They also believe that their ability to make the right clinical decisions for their patients has been circumscribed. While the general tone of each of the groups was negative, the fringe rural/metropolitan group was generally more positive, feeling that they had more control.

In the context of changes over the last decade, GPs express uncertainty as to their role in the health care system which is crucially linked to their perceived decline in autonomy. The government’s control of Medicare rebate levels, the reforms to General Practice training, registration and accreditation, and changes such as an increasingly educated and demanding patient base, combine to produce a situation that GPs find difficult and threatening to their ideal notion of profession. Clearly, medical professionals in Australia as elsewhere view policy changes which impinge on their professional autonomy with alarm, feeling themselves to be under threat (Hunter 1996). This is exacerbated by rising community expectations of health care, and more informed, articulate and demanding consumers.

The concerns expressed about loss of autonomy and control were centrally focused on government ‘interference’, reduced financial control and more demanding patients. Returning to Schulz and Harrison’s framework clarifies how GPs conceptualise autonomy in the workplace. Economic freedoms are seen as having been reduced through the control of the level of scheduled fees and this was linked to reduced control over the nature and volume of tasks – or in the language of the focus groups, time management difficulties. Choice of specialty and location (the third aspect of social and economic work freedoms discussed by
Schulz and Harrison) was spoken of positively by the fringe rural/metropolitan group, and practice style in regard to increasing practice size was seen as positive by some and negative by others.

Clinical freedoms were regarded as the most important and concerns were expressed about ability to control diagnosis and treatment and the evaluation of care (in terms of increasing external quality controls). The other aspects in Schulz and Harrison’s framework (acceptance of patients and control over other professionals) were mentioned infrequently.

Our findings highlight the utility of using such a framework for drawing out a nuanced analysis of autonomy on the frontline. This analysis of the concerns of GPs does not correspond neatly with the central claims of the deprofessionalisation and proletarianisation theses. The discussions in the focus groups had little resonance with the idea that professionals have handed over their knowledge and expertise, or that they now do highly routinised work. The GPs involved in this study strongly identify themselves as professionals, albeit professionals facing major financial and time management challenges. Concerns expressed sit more comfortably with labour process based studies which have found professionals to be experiencing increasing workloads and falling morale.

Deprofessionalisation alerts us to social changes in the control of knowledge, and proletarianisation to the routinisation of expert work. While the cultural status of medicine may be challenged by more educated consumers, that challenge has largely been directed at the paternalism of medicine and the quality of medical care, rather than at the content or status of medical knowledge (White 2000). And while technology is changing medical practice, sometimes making the work more routine, medicine has by and large kept control of
the use and interpretation of new technologies. It is increasing financial pressure and accountability requirements to government and the community that is turning up the pressure on frontline GPs.

Lupton (1997) argued that the deprofessionalisation and proletarianisation debates need to move beyond their primary focus on macrostructural and policy issues to micro aspects of everyday experiences of doctors at work. Contemporary notions of professional practice complicate the power dynamics in doctors’ relationships with patients in ways that do not necessarily involve a loss of professional status or authority. We would rather argue that both of these levels need to be considered if we are to have a fuller picture of professional autonomy and how it is changing. For example, Harrison and Ahmad (2000) have argued that in the UK, medical autonomy is declining at the micro level, but it remains intact at the macro level (which they define in terms of the biomedical model). Elite perspectives on the changing social, cultural and policy making authority of the general practice profession indicate few losses (Lewis 2002) in contrast to the perceptions of GPs in the workplace. It is these important contingencies and distinctions which are often glossed over.

The notion of professional autonomy is highly complex and it is far too simplistic to suggest that doctors of all types (general practice and other specialties) at different levels (the rank and file and the elite) are being deprofessionalised in all countries. Perhaps the debate could be more usefully reoriented from examining deprofessionalisation to examining reprofessionalisation (Lupton 1997). Another way of approaching this problem can be seen in the more recent literature that is calling for new concepts of professionalism (Freidson 1994), which could stress flexibility and professional judgement within the technical core of medical work, while emphasizing accountability to counterbalance autonomy (Hafferty and Light
In reconceptualizing profession, Schulz and Harrison’s framework is useful in drawing out different components of autonomy such as social and economic and clinical work freedoms.

Professional power is constantly renegotiated at the frontline of everyday practice as well as at the macro level of policy making. It is imperative that we distinguish between the power and authority of the medical profession and the autonomy of GPs on the frontline, and that we understand how GPs themselves perceive of their role and their autonomy, if we are to have a more nuanced understanding of what is happening to professionals and professional work. Our findings indicate that GPs’ concerns point to a mixture of deprofessionalisation and proletarianisation occurring through state intervention and consumer demands. However, our findings also indicate that micro level studies that focus on experiences within the workplace also contribute significantly to our understanding of the changing nature of GP work.

We believe that this approach, focussed on the workplace and drawing out different components, advances our understanding of how GPs comprehend autonomy and how they perceive it is changing. Our conclusions are limited by the focus of the study on a small number of GPs chosen to cover a range of opinions rather than representing GPs across Australia. The structural context of our study is also specific to general practice in Australia. For example, GPs in the UK are funded on a capitation basis which provides a different set of financial constraints and incentives to those experienced by Australian GPs working on fee-for-service. Nevertheless, we regard the approach used as one that holds promise for future research concerned with practitioners’ views on medical autonomy in a range of contexts.
References


Table 1

Characteristics of GP focus group participants

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<th>Group 3 (n=8) Rural/urban fringe</th>
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<td>Mean = 38</td>
<td></td>
</tr>
<tr>
<td>Number of years of practice:</td>
<td>Range = 1.5-39</td>
<td>Mean = 20</td>
<td>Range = 20-39</td>
<td>Mean = 31</td>
<td></td>
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* - one missing practice ownership information in Group 3.
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