

Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective

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Introduction

THERE EXIST TWO GENERAL 'LITERATURES' which touch on the fate of workers and their work, that concerned with class and that concerned with 'occupations and professions.' These exist as somewhat independent or contrasting theoretical streams. In this paper the interrelationships of these sets of ideas about work are examined through the analysis of the historical development of three health care occupations. This analysis reveals that the historical development of occupations within a particular division of labour involves not only such processes and concepts as proletarianization and professionalization, drawn from the literatures mentioned above, but also those of 'systems of professions' and 'medical dominance.' The resulting picture of changes within a specific domain of labour is thus much more complex than the major traditions would suggest. In particular, analysis of three interrelated occupations, rather than simply one in isolation, points to the struggles amongst occupations themselves as contributing to the processes of proletarianization conceived in terms of differentiation within a division of labour.

In descriptions of the history of the working class and working-class occupations much discussion centres around the processes through which previously autonomous manual workers have been transformed into wage workers, brought under managerial control, their work intensified and deskilled, and the reactions of workers to this proletarianization. With the rise of white-collar work in the 20th century (over 70 per cent of the Canadian labour force is now white-collar), these processes of control and routinization have been said to apply to at least the lower levels of this sector and not only to manual workers. Yet, these processes are not universal, there are apparent trends towards more complex forms of work for some workers. Amongst white-collar workers, for example, various professionals, managers, and technical workers, have been viewed as members of a new middle

David Coburn, "Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective," *Labour/Le Travail*, 34 (Fall 1994), 139-62.

class, a new petty bourgeoisie or a new 'service' class.¹ Others view them as in contradictory or ambiguous class locations somewhat resistant to the processes of proletarianization or highly influenced regarding class location by ideological or 'non-work' factors.²

Not much has been said in the class literature about the processes through which upper level white-collar workers attain, retain, or lose control over their work. Most often such literature has been segregated from working-class history generally and has, instead, been viewed as part of the immense literature on the professions.³ Various occupations are said to have 'professionalized' in the 19th and early 20th centuries and numerous others now claim the title of 'profession' and the self-regulatory power, the rewards, and the control over their own work, that such a status describes. Nowhere are such claims made more frequently than in the various service sectors now directly or indirectly financed by the state, for example, in education, social welfare, health, and the legal system. But, fishermen and accountants, miners and doctors are not members of different species, they are all workers and there is a need to integrate the concepts describing them.

In the health field, for example, one contemporary result of the push to professionalize has been that new legislation in Ontario provides for self-governing status for 24 health occupations, ranging from chiropractic to midwifery, medicine to massage therapy.⁴ Each of these will have a college with functions paralleling those of the College of Physicians and Surgeons of Ontario.

At the same time as many occupations lay claim to professional standing through processes of 'professionalization', there are ever-present pressures towards the intensification and routinization of work in the service sector. The industrialization of health care, state involvement as a single payer in health insurance, attacks on the welfare state, and the fiscal crisis of the state have combined to produce a drive towards intensification, efficiency, and effectiveness. Thus, terms such as

¹N. Abercrombie and J. Urry, *Capital, Labour and the Middle Classes* (London 1983); R. Hyman and R. Price, eds., *The New Working Class? White Collar Workers and Their Organizations* (London 1983); P. Walker, ed., *Between Labor and Capital* (New York 1979).

²E. O. Wright, *Class, Crisis and the State* (London 1978); R. Crompton and J. Gubbay, *Economy and Class Structure* (London 1977).

³A. Abbott, *The System of Professions* (Chicago 1988); L. Biggs, "A Review of the Literature on the Sociology of the Professions," in "No Bones About Chiropractic?", PhD thesis, University of Toronto, 1989; T. Brante, "Sociological Approaches to the Professions," *Acta Sociologica*, 31 (1988), 119-42; E. Freidson, "The Theory of Professions: State of the Art," in R. Dingwall and P. Lewis, eds., *The Sociology of the Professions* (Hong Kong 1983); M.S. Larson, *The Rise of Professionalism* (Berkeley 1977); T. Parsons, "The Professions and Social Structure," in T. Parsons, ed., *Essays in Sociological Theory* (New York 1954).

⁴Ontario, *Regulated Health Professions Act, Bills 43-66* (Toronto 1991).

'proletarianization' have begun to be applied to the members even of such an exalted occupation as that professional archetype, medicine.⁵

As noted earlier, the rise of many kinds of complex white-collar work might seem to contradict any uni-linear trend towards widespread proletarianization through deskilling and loss of control over the labour process. While, within waged work, there may be a general pressure toward the routinization of work, is this process necessarily a uni-linear one? In fact, the idea of the continuous revolutionizing of the productive forces and the use of science in production, implies that skilled work will always be created.⁶ However, these positions are then subject to pressures for the separation of the mental and manual components, the division between higher and lower skilled tasks and the strict control and intensification of the labour process said to characterize proletarianized manual workers.⁷

An example of the type of process we have in mind is Abercrombie and Urry's⁸ description of computer programming. Originally encompassing a variety of complex skills, computer programming was later broken down into a series of less skilled functions and jobs. The point of all this is that one could focus either on the rise of this complex occupation and its initial autonomy or on its later fragmentation and de-skilling. The computer instance, however, also indicates that examination of the historical development of a single occupation may, from a broader perspective, be misleading. What is more revealing is change within a particular division of labour or work domain. In the computer case, as some occupations or groups of workers were being de-skilled, others were assuming the more complex processes

⁵J.B. McKinlay and J. Arches, "Towards the Proletarianization of Physicians," *International Journal of Health Services*, 15 (1985), 161-95; J.B. McKinlay, "The Business of Good Doctoring, or Doctoring as Good Business: Reflections on Freidson's View of the Medical Game," *International Journal of Health Services*, 7 (1977), 450-88; E. Freidson, *Professional Powers* (Chicago 1986); E. Freidson, "The Reorganization of the Medical Profession," *Medical Care Review*, 42 (1985), 11-35; V. Navarro, "Professional Dominance or Proletarianization?: Neither," *The Milbank Quarterly*, 66, Supplement 2 (1988), 57-75.

⁶S. Wood, ed., *The Degradation of Work? Skill, Deskilling and the Labour Process* (London 1982).

⁷It is not always clear, however, whether 'skill' is viewed as a real entity or something for which a claim is made, for example, skill as socially constructed. See, for example, S.P. Vallas, "The Concept of Skill: a Critical Review," *Work and Occupations*, 17 (1990), 379-98. Skill, it is assumed, gives workers power because skilled workers are difficult to train and/or replace. White-collar work may be difficult to routinize because at least some of it is 'brain-work' and requires intrinsic motivation on the part of the workers (as opposed to mechanical or bureaucratic means of controlling the work of deskilled manual work). This issue brings up the question of knowledge/power as well as issues regarding the degree to which the 'art' as opposed to the 'science' of professional work is amenable to routinization. See H. Jamous and B. Peloille, "Changes in the French University-hospital System," in J.A. Jackson, ed., *Professions and Professionalization* (Cambridge 1970).

⁸Abercrombie and Urry, *Capital, Labour and the Middle Classes*.

involved in computer work. Skill and control for some is accompanied by work fragmentation for others. Occupations and professions thus are not independent entities but form part of complex processes within work domains. In fact, in the area of the professions and occupations there is now theorization of the 'system of professions'.⁹ The 'rise and fall' of any one occupation does not necessarily reveal more general tendencies in the division of labour of which such an occupation is a part.

In the health care division of labour or 'system of professions' major characteristics of that system are its increasing complexity (in terms of the numbers and types of occupations) and the dominance of this division of labour by one particular occupation, for example, medicine (medical dominance). As originally conceived by Freidson,¹⁰ medical dominance consists of the control by the medical profession over the content of care, over clients, over other health occupations in the health division of labour, and over the context within which care is given, that is, over health policy generally. The notion of medical dominance, however, does not mean that medicine was the 'ultimate' source of power in the health field. All observers, while acknowledging medical control, view this power as dependent (to a greater or lesser extent) on the social context of health and health care, that is, medical dominance is contingent power. While some observers emphasize medicine's relationships with the state or with a 'strategic social elite' as sources of medical power, others make the persuasive argument that such power is class dependent. For example, it has been argued that a curative, individually focused, mechanistic medicine triumphed over more socially oriented alternatives early in the 20th century because the former coincided with, or at least did not contradict, the ideology and interests of the bourgeoisie whereas the latter attacked those interests.

Focusing on medical control over the health division of labour, however contingent this control is, does entail viewing the struggles of many occupations for professional status in the health field, however, as partially aimed at escaping from under the thumb of medicine. It directs attention to inter-occupational/professional conflict.¹¹ The 'system of professions' approach also implies the existence of struggles over professional jurisdictions, over exclusion of some and the inclusion of others, ranging from sub-areas within health care in which there are sub-dominant professions (for example, dentists over dental care; registered nurses over nursing work, etc.) to more general contests amongst occupations or occupational fragments, for example, chiropractors versus physiatrists versus

⁹Abbott, *The System of Professions*.

¹⁰E. Freidson, *Profession of Medicine* (New York 1970); Freidson, *Professional Powers*.

¹¹G. Larkin, *Occupational Monopoly and Modern Medicine* (London 1983); E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, rev. ed. (Sydney 1989). Medicine could be viewed as partially 'mediating' state regulatory authority in the health field, the extent of this mediation declining rapidly in the modern era, see D. Coburn, "State authority, medical dominance, and trends in the regulation of the health professions: the Ontario case," *Social Science and Medicine*, 37, 7 (1993), 841-50.

physiotherapists, naturopaths versus chiropractors, optometrists versus ophthalmologists.¹²

An additional complication is the obvious fact that most of the 'subordinate' occupations in the health field are predominantly female. This may be viewed historically as the development of a complex health care division of labour at a time when males were more dominant than they are now. Many female health occupations were 'born' under the control of medical men at a time when women were 'naturally' subordinate to men and when women were seen as particularly suited 'by nature' to what was viewed as the less complex tasks of caring. Various structural factors (some of which have changed, for example, the access of women to higher education and to medical training) presumably aided and still to some extent, reproduce, this declining male dominance.¹³

Within particular work domains, and within specific occupations, there are contradictory tendencies. On the one hand there is a general pressure towards the intensification, routinization, and fragmentation of work, on the other hand, towards the greater control over the labour process and greater occupational autonomy or self-regulation implicit in the increased work complexity of 'professionalization.'

In this paper I want to examine the historical trajectory of three occupations in the health field examining their development in relationship to one another as well as their separate evolution keeping in mind the differing processes of professionalization, proletarianization, the rise and fall of medical dominance, and the occupational rivalries implied by such concepts as the 'system of professions.' The major themes of this historical description are that professionals are workers and are potentially subject to many of the same pressures towards proletarianization (earlier used to describe the routinization of skilled manual work) already described. Professionalization appears as one strategy for attaining or maintaining control over work. However, in struggling for control within systems of occupations and professions, occupational groups are involved in a process which reproduces, at the level of a division of labour in a particular domain, the very separation between mental and manual labour, expert and unskilled work, which is the essence of the proletarianization (or at least alienation) of work. Workers' struggles for autonomy and control involve, to some degree, reproducing the conditions for others they are fighting against themselves. Occupational identity thus appears as one barrier to more widespread class cohesion at the same time as

¹²There are arguments over whether such struggles are best viewed in class or in 'social closure' terms. See for example, T. Johnson, "The Professions in the Class Structure," in R. Scase, ed., *Industrial Society: Class Cleavage and Control* (London 1977); R. Murphy, "The Concept of Class in Classical Theory," *Sociology*, 20 (1986), 247-64.

¹³Though medicine (and other acknowledged professions) are changing in gender composition (more than 40 per cent of entering Canadian medical students are women), the mainly female occupations remain female.

changing relationships to the means of production, changing class relations, and changing female/male power undermine occupational solidarity.

All three of the occupations treated have a long history, but there is no space here to provide a detailed historical analysis. Rather, based on data more fully developed elsewhere,¹⁴ I want to illustrate the main trends of development of these related occupations. Though mainly focused on Ontario, the events described follow broad trends which are also evident in other provinces.

The term proletarianization, however, is both ambiguous and ambitious. It is necessary first to state in what sense the term proletarianization is used here. There are, at least, two directions from which proletarianization has been viewed. In the first, the term is used from a class perspective to refer to the move to wage work. In the second, the term is used in the labour process literature as associated with the concept of work alienation, meaning the routinization and fragmentation of work. In the latter view the 'ideal type' of alienation is the automobile assembly line worker. Larson has tied these traditions together by noting that, insofar as educated labour is concerned, proletarianization can be envisaged as a process involving: first, the sale of labour power or 'economic' alienation; second, the stage of forced co-operation or 'organizational' alienation; and third, the dispossession of control over the execution of work and the fragmentation of the labour process or 'technical' alienation.¹⁵

¹⁴D. Coburn, "Medicine Nursing and Chiropractic: The Rise and Fall of a Profession," unpublished manuscript, Department of Behavioural Science, University of Toronto, 1989; D. Coburn, G.M. Torrance, and J.M. Kaufert, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" *International Journal of Health Services*, 13 (1983), 407-32; D. Coburn and C.L. Biggs, "Limits to Medical Dominance: The Case of Chiropractic," *Social Science and Medicine*, 26 (1986), 1061-72; D. Coburn, "The Development of Canadian Nursing: Professionalization and Proletarianization," *International Journal of Health Services*, 18 (1988), 437-56; D. Coburn, "Canadian Medicine: Dominance or Proletarianization," *The Milbank Quarterly*, Supplement 2, 66 (1989), 92-116.

¹⁵M.S. Larson, "Proletarianization and Educated Labour," *Theory and Society*, 19 (1980), 131-75.

*Medicine*¹⁶

IN AN EARLIER PAPER, Torrance, Kaufert, and I argued¹⁷ that medicine in Canada has passed through three stages: a rise to dominance (to about the end of World War I), the consolidation of that dominance (World War I to the 1960s), and since about 1962 (the year of the Saskatchewan doctors' strike), the beginnings of a decline in that dominance.¹⁸ While still the most powerful health occupation, medicine is not as powerful as it once was.

The professionalization of medicine and the emergence of medical dominance in North America took place between the middle of the 19th century, when medicine lacked power, wealth, and status, and the early 20th century, by which time it largely controlled the health division of labour. Two problems faced Canadian medicine in the 19th century: weeding out the irregular practitioners and the establishment of a unified, homogeneous occupation. The strength of the public, legislative, and irregular opposition to orthodox medicine is indicated by the failure of numerous attempts around mid-century to pass legislation which would establish a monopoly for "regular" medicine.

The major challenge to medicine came from the healing sects, like the homeopaths and eclectics, which spread to Canada from the United States and gained a considerable popular following. The "irregulars" were strong partly because in the more remote areas they were often the only source of care, while the appeal of homeopathy, with its much less drastic forms of treatment than allopathy, recommended it to influential citizens. As Connor notes, there was a pluralistic medical system in 19th century Ontario.¹⁹ Furthermore, there was not yet an established market for medical care as most settlers were widely dispersed

¹⁶See, for example, R.F. Badgley and S. Wolfe, *Doctors' Strike* (Toronto 1967); B.R. Blishen, *Doctors and Doctrines: The Ideology of Medical Care in Canada* (Toronto 1969); R.D. Gidney and W.P.J. Millar, "The Origins of Organized Medicine in Ontario, 1850-1869," in C.G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Toronto 1969); R. Hamowy, *Canadian Medicine: A Study in Restricted Entry* (Vancouver 1984); J.F. Kett, "American and Canadian Medical Institutions, 1800-1870," in S.E.D. Shortt, ed., *Medicine in Canadian Society: Historical Perspectives* (Montréal 1981); H.E. MacDermot, *One Hundred Years of Medicine in Canada: 1867-1967* (Toronto 1967); C.D. Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Montréal 1986); P. Starr, *The Social Transformation of American Medicine* (New York 1982); G. Torrance, "Historical Introduction," in D. Coburn, et al., *Health and Canadian Society* (Toronto 1983). See also, C.G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Toronto 1984); W. Mitchinson and J.D. McGinnis, eds., *Essays in Canadian Medical History* (Toronto 1988).

¹⁷Coburn, Torrance, and Kaufert, "Medical dominance in Canada," 407-32.

¹⁸D. Coburn, "Canadian Medicine," 92-116.

¹⁹J.T.H. Connor, "Minority Medicine in Ontario, 1795-1903: A Study of Medical Pluralism and its Decline," PhD thesis, University of Waterloo, 1989.

and had little cash surplus. Those physicians that did practice did so as petite bourgeois entrepreneurs.

Through continuous political pressure and lobbying the regulars were finally successful in gaining a monopoly, although, in Ontario at least, both the eclectics and the homeopaths preceded orthodox medicine in becoming self-regulating. In fact the Act that finally established the College of Physicians and Surgeons of Ontario in 1869 included the eclectics and homeopaths as part of the College (orthodox medicine had gained its own college in Québec in 1847). But in Ontario the embrace of orthodox medicine proved fatal for the irregulars. The eclectics soon disappeared and few homeopaths appeared before the College to take licensing examinations (as they had to take all the examinations given to the orthodox in addition to those particular to the homeopaths).

The medical profession not only suppressed directly competitive practitioners but also, after some struggle, gained dominance over the activities of other, more peripheral, health occupations such as pharmacy and midwifery.²⁰ In the late 19th and early 20th centuries, in the face of medical opposition, nursing restricted its function in order to assume a recognized but subordinate place in the official division of labour. Women were viewed as naturally fitted for 'caring' activities. The analogy — doctor-father, nurse-mother, patient-child — was not far-fetched.

By the 1920s medicine was firmly in control of health care (though, as noted, a control contingent on the fit between medical ideology and interests and those of more hegemonic powers). The hospital, previously a charitable institution for the indigent, was replacing the doctor's office and the patient's home as the major locale for the treatment of middle and upper-class patients. Having subdued its own internal dissidents and having then established its authority over competing healers (with the aid of state bureaucracies largely staffed by medical men), an individualistic, curative medicine assumed control over a corps of paramedical workers such as physiotherapy, occupational therapy, and medical laboratory x-ray technology, almost all of these female workers, 'born' under medical control in the hospital.²¹ Medicine had *de facto* control of the new means of production of health care.

Yet, even within the health sphere, medical dominance was not total and medicine always faced challenge. In the early 20th century two new rivals to medicine, chiropractic and osteopathy, moved into Canada from the United States. They presented an alternative to the mainstream medical monopoly as late as the 1920s and 1930s, and chiropractic persists as a visible annoyance to the present (the number of osteopaths in Canada is negligible). As Willis argues, medicine succeeded in subordinating, excluding or limiting its rivals but not totally eliminat-

²⁰See for example, C.L. Biggs, "The Case of the Missing Midwives: a History of Midwifery in Ontario from 1795-1900," *Ontario History*, 75 (1983), 21-35; Appendix 1. Ontario, *Report of the Task Force on the Implementation of Midwifery in Ontario* (Toronto 1987).

²¹G. Torrance, "Historical Introduction," in D. Coburn, *et al.*, *Health and Canadian Society*.

ing them.²² While health care bureaucracies were heavily influenced by medicine, provincial legislatures were less easily swayed.

By the post-World War II period, the medical profession had reached the height of its powers. During the Depression and after the problem for Canadians had become, not one of staying out of the clutches of the doctor, but of gaining access to modern medical care. By the 1960s, Taylor maintained that:

Organized medicine influences legislative policy with respect to the timing and design of public programmes, guides the choice and structure of administrative agencies, prescribes certain of the administrative procedures, participates in the continuing decisions of administrators, and... actually serves as the governmental agency in the administration of major programmes.²³

For example, during the Depression the Ontario government had ceded to medicine the administration of a plan of medical care for indigents which by the early 1960s covered over 200,000 Ontarians. And, by 1963, physician sponsored and controlled medical plans covered over five million Canadians. These plans and their client doctors faced many of the issues over extra-billing, etc., later faced by state administered health insurance. Medicine and the health bureaucracies had close and co-operative relationships. Physicians occupied key civil service posts. Medicine controlled the education and accreditation not only of its own members but also of many types of paramedical workers. In effect, medicine mediated state control over the health care division of labour — medicine was under the loose influence of the state, while itself controlling numerous para-medical occupations. Public policy decisions, later to be made in public with much controversy (for example, regarding banning extra-billing), were then made in the back rooms of legislative assemblies between key elite physicians and politicians.

The power of the profession was as much exemplified in what was not done as in what was done. Medical dominance was one of the major forces producing a provider-oriented medical care system, more concerned with cure than with prevention. The disjunction between health care and the health needs of the Canadian people was never more evident: access to health resources was unequal; the health of isolated or native peoples was neglected; risks to health in the workplace were ignored; socially caused health problems were treated as individual problems of cure. The health care system itself was hierarchical and physician-dominated.

However, events since 1962 (the year a doctors' strike modified but failed to prevent the implementation of government-financed medical care in Saskatchewan) indicate that medicine has lost significant degrees of external control

²²E. Willis, *Medical Dominance*.

²³M.G. Taylor, "The Role of the Medical Profession in the Formulation and Execution of Public Policy," *Canadian Journal of Political Science*, 25 (1960), 125.

and even internal self-regulation. The change from a 'cottage' industry to a situation characterized by 'health factories', state involvement in the insuring of health care services (beginning with federal hospital insurance in 1957 and medical care insurance in 1966-67) and the challenge of other health occupations and patients have influenced all elements of medical dominance.

By 1981, Canadian hospitals employed more people than did automobile manufacturing, iron and steel mills, and pulp and paper mills combined.²⁴ The average size of hospitals, the new 'health factories,' doubled between 1947 and 1981. Research in biomedicine totalled hundreds of millions of dollars. The pharmaceutical and medical supply industries expanded enormously. In this enlarged sphere the medical profession began to lose some of its centrality.

With medicare, medicine lost administrative authority through the demise of the voluntary medical plans which it had sponsored or controlled. The fee-for-service system, computerized medical insurance information systems, and state-administered plans permitted "unprecedented opportunity for surveillance of [local] work and [income] patterns of medical practice."²⁵ Pressure mounted to control health care expenditures. The medical associations no longer had the unilateral power to decide their own fee schedules, but had to negotiate these with provincial governments. Eventually, in most provinces, medical review committees were set up to investigate those physicians who performed a suspiciously large number of services. In many provinces, ceilings were placed on the numbers of procedures a physician could perform. In effect, incomes were loosely capped.

The concerns of state health planners seeking to control costs moved from physicians' fees to income ceilings, to the distribution and numbers of physicians and, then, to total provincial physician costs. Barer, Evans, and Labelle conclude a study of attempts to control physician costs by noting that: "attempts to control fees lead progressively into more extensive management of medical care — controls *do* beget further controls."²⁶

Health insurance also brought a deluge of studies of health care, all of which had as a main or secondary issue criticism of the perceived 'excessive' role of medicine. Medicine was increasingly seen as the major barrier to a more 'rational' health care system.

Across Canada, health care workers such as nurses, optometrists, chiropractors, psychologists, and physiotherapists, began to assert their rights. To enhance their own prestige and power, many of these occupations have been seeking to wriggle out from under the restrictive domination of medicine. Alford points to

²⁴G. Torrance, "Hospitals as Health Factories," in D. Coburn, *et al.*, *Health and Canadian Society*.

²⁵C.A. Charles, "The Medical Profession and Health Insurance: an Ontario Case Study," *Social Science and Medicine*, 10 (1976), 34.

²⁶M.L. Barer, R.G. Evans, and R.J. Labelle, "Fee Controls as Cost Control: Tales from the Frozen North," *The Milbank Quarterly*, 66 (1988), 46.

another group, the new "corporate rationalizers", as presenting an important challenge to the power of medicine.²⁷ The imperative of these accountants, planners, administrators, and academics to coordinate and rationalize health care, conflicts with the aim of the profession to maintain control over the provision of services. In a few provinces, physicians still fill high administrative posts, but in most the vast majority of civil service positions are now occupied by laypersons with managerial rather than medical training. Even the move to train physician-administrators seems more an attempt to co-opt medical leaders than it is a move to give medicine more self-control.

An increasing number of physicians are in salaried or partly salaried work in hospitals, medical schools, and elsewhere. As well, government financing led to a demand to rationalize care to avoid duplication of beds and medical technology. Specifying what technologies could be available where intruded even on the content of care (the core of autonomy or the defining characteristic of a profession according to Freidson). Computer protocols were developed to outline the recommended treatment for particular diseases and conditions. Though doctors still are among the most autonomous of workers, the rationalization of medical work, the introduction of computers, and more intensive efforts to evaluate and formalize doctors' work is reducing physician autonomy.²⁸

Medical power is thus being eroded both by the state and by competing professions. Even from, until recently, passive patients come additional pressures. The efficacy of medicine and its right to determine the form under which medical care is delivered are being questioned by writers such as Illich and McKeown.²⁹ Such authors provide ammunition for academics and government planners in their attempts to 'rationalize' health care. The public now seeks to recover both birth (alternative birthing centres and home births) and death (the living will) from medical control. An indication of changing norms are the increasingly patient-oriented laws governing 'informed consent.' The Supreme Court of Canada in the 1980s changed the criteria to be applied in judging whether or not adequate consent to medical treatment had been given from the information 'a reasonable doctor' would give to the information 'a reasonable patient' would want. The public was also more ready to take physicians to court. In 1956 there were only 10 writs issued against physicians, rising to 80 in 1970, and 915 in 1987. In the entire period from 1932 to 1970 the total damages awarded all patients in Canada through the Canadian Medical Protective Association was less than \$2 million. By 1979, the total was \$5 million, and by 1988, \$25 million.³⁰

²⁷R.R. Alford, *Health Care Politics* (Chicago 1975).

²⁸M. Wahn, "The Decline of Medical Dominance in Hospitals," in D. Coburn, *et al.*, *Health and Canadian Society*; C. Derber, *Professionals as Workers: Mental Labour in Advanced Capitalism* (Boston 1982).

²⁹I. Illich, *Medical Nemesis* (London 1975); T. McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis* (London 1976).

³⁰D. Coburn, "Canadian Medicine," 92-116.

Health policy began to reflect an increasing scepticism about medical efficacy. Increasing costs pushed state planners to begin to emphasize prevention and health promotion as opposed to cure (though this so far has been more rhetorical than real).

One result of this loss of control by medicine has been recent doctors' strikes in British Columbia, Manitoba, Ontario, and Québec. In the most recent doctors' strike in Ontario in 1986, the Ontario Medical Association, despite the longest doctors' strike in Canada, completely failed to prevent a ban on the right to extra-bill (billing the patient more than the government plan pays). While medicine-government conflicts are often directly focused on attempts to gain higher fees, the medical profession clearly views fees as only part of a larger struggle over control of health care policy.

A major characteristic of health care is its hierarchical nature and the subordinate role of mainly female occupations. Within medicine, women have had an uphill fight in gaining access to medical training. From the first, women, excluded from medical schools (as were Jews), in desperation established their own medical schools and hospitals. Only in the past twenty years have women begun to enter medicine in large numbers. Now, although there are large inter-provincial differences, about 40 per cent of entering medical students in Canada are women. However, the 'feminization' of medicine can be interpreted both as a victory for women but also as embodying the potential further to proletarianize medicine through an increasing acceptance of routinely organized work better suited to women's life demands.

Though this description of medicine is largely one internal to developments in health care, an adequate explanation for these developments can only be understood within a transformed Canadian political economy and a changing class structure (an explanation we have attempted elsewhere). Certainly medicine early on was tied to a colonial elite and was later part of a rising petty bourgeoisie. Later, medicine was undermined by the erosion of its class base in the petite bourgeoisie, and the fact that its aims and interests no longer coincided with the corporate elites which had earlier in the century supported, or at least not opposed, the rise of a curative, individualistically focused medicine versus that of an environmentally oriented, public health one. That is, the dominance of medicine was based both on a particular class base and its congruence with the interests of dominant classes. But class influences were often mediated at particular historical junctures by various sets of social institutions from the state to the hospital to the public health movement. As well, in the early 20th century, medicine was joined by numerous other 'professions' (from engineering to social work) all claiming to apply science to social life and all seeking the privileges to which they felt this expertise entitled them.³¹ That is, professionalization was a general phenomenon not confined to the health field.

³¹J.R. Millard, "The Development of the Engineering Profession in Canada, 1880-1920," PhD thesis, University of Toronto, 1982.

In sum, medicine attained full professionalization and dominance within the health care division of labour in the 19th and early 20th centuries, though this power was contingent on its fit within the broader social structure. However, within the past 25 years, it is clear that medicine in Canada has lost some of its previously almost unchallenged power. The state now took more direct control over health care, and the mediative functions of medicine and its power declined. The concepts usually employed to describe the early history of medicine are those of professionalization and medical dominance. In analyzing contemporary medicine, writers focus on loss of dominance and on proletarianization. However, a loss of dominance does not necessarily mean loss of autonomy. If control over work is viewed from the point of a continuum ranging from subordination, through autonomy, to dominance or control over others, then medicine has most obviously moved from dominance somewhat towards occupational and labour process autonomy. But, whether or not this process continues, whether or not medicine is on a 'slippery slope' is much more questionable.

*Nursing*³²

THE DEVELOPMENT OF NURSING is a complex mixture of both professionalization and proletarianization. At its beginnings in the 19th century, nursing, as a full-time, paid occupation for lay women, was already wage work and was created under medical control. Nurses were to be the handmaidens of physicians. This for two reasons, not only were physicians more 'expert,' but women were considered 'by nature' to be both suited to the task of caring and generally subordinate to men.³³ But this subordination was not complete. Both as a nursing service in hospitals and as an organized occupation, 'ordinary' nurses were to be directly supervised by

³²See D. Coburn, "The Development of Canadian Nursing," 437-56. See also, M.L. Campbell, "Productivity in Canadian Nursing: Administering Cuts," in D. Coburn, *et al.*, *Health and Canadian Society*; Canadian Nurses Association, *The Leaf and the Lamp* (Ottawa 1968); Canadian Nurses Association, *The Seventh Decade, 1969-1980* (Ottawa 1987); J. Coburn, "I See and am Silent: a Short History of Nursing in Ontario," in J. Acton, P. Goldsmith, and B. Shepard, eds., *Women at Work: Ontario 1850-1930* (Toronto 1974); J.M. Gibbon and M.S. Mathewson, *Three Centuries of Canadian Nursing* (Toronto 1947); I.L. Goldstone, "The Origins and Development of Collective Bargaining by Nurses in British Columbia, 1912-1976," MSc thesis, University of British Columbia, 1981; P.M. Jensen, "Collective Bargaining of Nurses in Canada," PhD thesis, University of Toronto, 1984; V.V. Murray, *Nursing in Ontario* (Toronto 1970); D. Wagner, "The Proletarianization of Nursing in the United States, 1932-1946," *International Journal of Health Services*, 10 (1980), 271-90.

³³Nursing leaders early on asserted that nurses were to be at the service of physicians, although this assumed subordination was at least partly a political device not to arouse medical opposition. The general subordination certainly did vary by class, some early nursing leaders were of higher social standing than most physicians of the time.

other nurses and not by hospital administrators or doctors (which would not have been proper).

Although full-time nursing began in the hospital setting, until World War II the vast majority of nurses in Canada (and, at different times, nurses in Britain and in the United States as well) were private duty nurses (almost all married women) hired by families to take care of the sick, under the supervision of a physician, either in patients' homes or in the hospital. The regular nursing work in hospitals was mainly carried out by unpaid (and unmarried) student nurses. Hence, the proliferation of hospital nursing schools was initiated by hospitals chiefly to provide hospital staff. Nursing students performed tasks ranging from caring for patients to tending hospital furnaces and polishing doorknobs. Nurses lacked control over the numbers and quality of nursing students. With poor working and living conditions nurses were trained for unquestioning obedience to doctors, hospital officials and nurse superiors.

The lot of private duty nurses was not a prosperous one. Private duty nurses were often unemployed and dependent on doctors' referrals or on the vagaries of nursing registries.³⁴ Even when they did succeed in securing work their wages were well below those of comparable groups such as female school teachers. Private duty nurses, the majority of all nurses until the 1940s, were as much semi-proletarian as they were petty bourgeois. However, most of the population could not afford private nursing care. In fact, the *raison d'être* of the Weir Report on Nursing Education in 1932 was the problem of how to narrow the gap between the nursing needs of the public and the need for a reasonable wage by private duty nurses.³⁵

One of the first tasks of the new breed of 'trained' nurse in the period 1900-1920 was to differentiate themselves as much as possible from the 'untrained.' Although, unlike doctors, they did not succeed in creating a monopoly, by 1922 all nine provinces had laws giving nurses the exclusive right to the title of R.N. Various nurses' organizations were also formed. At first, joint associations were established with similar groups in the United States. Later, managerial organizations and various alumnae groups from local hospitals formed provincial associations and, eventually, in 1908 the Canadian Association of Trained Nurses (to become the Canadian Nurses Association in 1924). All 'untrained' nurses were excluded from the C.N.A. through requiring all members to be registered members of the provincial associations.

The 1930s and 1940s brought a rapid shift from private duty nursing to paid employment in the hospital. The inability of the public to afford private nursing care on a full-time basis, pressure to lessen the unpaid work of student nurses in hospitals, the rise of voluntary hospital insurance plans, and the parlous state of private duty nursing itself all played a role in this process. In 1929, 60 per cent of

³⁴G.M. Weir, *Survey of Nursing Education in Canada* (Toronto 1932).

³⁵*Ibid.*

nurses had been in private duty. Less than twenty years later, in 1948, only 15 percent were in private duty work.³⁶

Once in the hospital, there were continual pressures toward the rationalization of nursing. Paradoxically, the work of nurses began to be more complex, but was also more controlled both by physicians and by hospital management. Higher level nurse supervisors were co-opted and absorbed into hospital management, the only avenue of upward mobility for nurses. They in turn came to be somewhat separated out from the burgeoning educational and professional elite which had heretofore dominated a largely unorganized group of staff nurses.

State financing of hospital care after World War II, through hospital construction and hospital (and later medical) insurance schemes, brought pressures for greater productivity. Nursing was to be rationalized in the name of efficiency. The economic recession of the 1970s and 1980s intensified the search by the state for greater productivity in the health sector, particularly in its most expensive component, the hospital. Tasks which had originally been part of nursing were more divided up between nursing assistants, orderlies, X-ray technicians, and other hospital occupations. Nursing, first subject to economic proletarianization through incorporation into the hospital, now began to feel the full weight of pressure towards technical proletarianization in the routinization of the labour process itself. If not being de-skilled (and there is an argument to be made that nursing in fact became more rather than less complex), nursing work certainly became more intensified, circumscribed, and controlled by managers and planners.³⁷ This routinization was counteracted by strong pressure from a nursing elite towards credentialism, with higher education seen as the mark of professional standing and the key to enhanced status and power.

The changes described were not without their consequences. During and after World War II, the gathering of nurses in ever larger hospitals and the organization of provincial hospital associations provided conditions conducive to the rise of collective bargaining. For many decades a managerial and educational elite of nurses stifled union organization and attempted to steer nursing towards the more 'professional' orientation of altruism, service, and duty to doctors, patients, and hospitals. Collective bargaining was unprofessional and strikes were unthinkable. When rank and file nurses did go on strike their own associations often condemned and opposed them. As late as the 1960s an outside consultant could say of Ontario nurses that the only right they had was 'the right to beg.'³⁸

In the early 1970s, the managerial nature of the nursing leadership was underscored by a series of legal judgements in Québec and Saskatchewan. These

³⁶Canada, *Census*, Various Years. E. Hall, *Report of the Royal Commission on Health Services* (Ottawa 1964).

³⁷M.L. Campbell, "Productivity in Canadian Nursing."

³⁸J.H.G. Crispo, *Nurses and Their Employers: The Need for a Fresh Approach* (Toronto 1963).

disallowed the provincial associations as bargaining agents for nurses because they were dominated by managerial (nursing) personnel. This quickly led to the establishment of separate labour relations divisions within the associations and, eventually, to unions separate from the professional associations.

The major impetus toward collective bargaining within unions, as opposed to organization in professional associations, came from rank and file hospital nurses. Québec and British Columbia were far ahead of the other provinces in collective bargaining. The first Canadian collective agreement in a public hospital was signed in Québec in 1934. In 1946, the first hospital in British Columbia was certified. In contrast, the first certification of Ontario nurses did not take place until 1966. Province-wide bargaining with the new provincial hospital associations followed. By 1983, over 80 per cent of Canadian nurses were protected by collective agreements. The unionization of nurses in Canada was both swifter and more complete than in either Britain, in which nurses were enrolled in many different unions, or in the United States, in which the degree of unionization was much lower.

While union organization came late to nursing, it was preceded, and accompanied by, the drive for 'professionalization.' This took the form of a push for registration laws, control of the education process by nurses, credentialling or the raising of educational standards for students and nursing teachers alike, the development of professional associations, and the promotion of nursing as a science.

A major trend within nursing today is towards professionalization through upgrading educational requirements. The C.N.A. and its provincial affiliates have agreed that the minimum entrance requirement into nursing by the year 2000 should be a university degree (in a case of life imitating art, nurses frequently quote sociologists as stating that a university education is the basis of claims to professionalism). This move is creating enormous tensions between diploma nurses, who see their own training and experience downgraded in favour of nurses with degrees but with little practical experience. The attempt to create a unique 'theory of nursing', focused on care rather than cure, which would make nursing 'separate but equal to' medicine as a health discipline has also led to a consuming interest in nursing theory and research, even if much of this appears excessively formalistic.

The different social bases of nursing work and different aims have resulted in deep divisions within nursing, these divisions partly reflected in occupational organizations. Nursing in many provinces is divided between staff nurses who are part of unions and who regard their work as a 'job', a professionalizing elite of academics, and a group of managerial nurses many of whose interests and ideology are often in direct opposition to those of the nurses they manage.

Unionization appears as a response by nurses to the bureaucratic work setting, to the intensification and to the rationalization of work. Professionalization, as a tactic used in the past by an elite to control nursing and to avoid unionization, is now a means whereby nursing can gain autonomy from medicine. Whereas previously the nursing elite suppressed nursing dissent, the professionalizing elite

now actively seeks to organize nursing discontent in advancing its own 'professionalization project.'

Over the years nursing has made significant advances in gaining independence from medicine. Nurses have replaced physicians as teachers of student nurses. Nursing boards and committees have come to be staffed by nurses rather than by doctors. Nursing is now largely a self-regulating occupation with its own associations and colleges. The nursing service in hospitals has come to be an increasingly autonomous part of hospital life as far as medicine is concerned, even while coming more under the sway of the hospital administration.

The degree to which nursing has come to confront medicine is indicated by the actions of nurses regarding the Canada Health Act (1984). Nurses lobbied hard to eliminate extra-billing by physicians and took out full-page newspaper advertisements to attack extra-billing. They also succeeded in changing the wording of the Act to permit nurses, and not only doctors, to be covered by health insurance (although as yet no province has followed up that opportunity). Nursing as an occupation is now more independent, yet still deeply resentful of continued medical domination in the workplace and regarding health care policy.

A major characteristic of nursing is that it is composed largely of women. In fact, until 1969, registration laws governing nursing in Québec, for example, prevented males from becoming nurses. The subordination of nursing to medicine reflects more general and pervasive patriarchal relationships and ideologies. Recent changes in nursing towards a more militant stance partly reflects the rise of the feminist movement in Canada and the changing relationships between men and women generally.

The trends within nursing toward increased control by employers, yet increased autonomy by nursing as an occupation in relationship to medicine, points to different areas of control — control over an occupation and control over individuals in the labour process.³⁹ The case of nursing is also instructive because it suggests that professionalization and proletarianization are not necessarily complete alternatives or different phases of occupational development. Tendencies or pressures in both directions may appear simultaneously, and their manifestations may change at different stages in the development of an occupation.

³⁹Trends in nursing and other occupations also point to occupational elites and organizations as 'controlling' occupational members and not only 'representing' them.

*Chiropractic*⁴⁰

THE DEVELOPMENT OF CHIROPRACTIC in Canada has most often been described in terms of professionalization⁴¹ or legitimation.⁴² Discovered late in the 19th century in the United States, chiropractic originally focused on manipulation of the spine as the process through which all disease could be relieved. Chiropractors believed that spinal obstructions (subluxations) prevented a proper nerve/blood supply to affected areas, producing disease — relieving the obstruction through spinal manipulation permitted the body to heal itself. Chiropractic was a complete alternative to orthodox medicine.

The medical profession has attacked chiropractic at every opportunity. Early in the century, Canadian medicine attempted to ban chiropractic completely and, until recently, this was the main orientation of medicine to chiropractic. Yet chiropractic has survived and medical opposition is now neither as widespread nor as virulent as it once was (there are reasons for this which we will describe later).

Early in its history, chiropractic had enough popular and labour movement support to prevent medicine from obtaining a complete monopoly in the provision of health care. Even when an early report in Ontario recommended the outright banning of chiropractic, chiropractors had enough public sympathy and legislative influence (as opposed to influence over the health care bureaucracy still largely dominated by physicians and medical ideology) to prevent these recommendations being completely implemented.⁴³

Over the years, chiropractic has managed to attain self-governing status. But chiropractic merely survived before World War II, its most rapid development took place after the War, particularly in the past 25 years and especially in Ontario, British Columbia, and Alberta.

Chiropractic as an organized occupation remained undeveloped in Canada until the establishment of the Canadian Memorial Chiropractic College in Toronto in 1945. Even so, after the first large group of students had graduated shortly after the War (many of these were veterans financed by federal educational grants), there was a continued decline in enrolment until 1961 (in part due to financial problems

⁴⁰H.A. Baer, "A Comparative View of a Heterodox Health System: Chiropractic in America and Britain," *Medical Anthropology*, 8 (1984), 151-68; L. Biggs, "No Bones About Chiropractic?"; I. Coulter, "Chiropractic Observed: Thirty Years of Changing Sociological Perspectives," *Chiropractic History*, 3 (1983), 43-8; I. Coulter, "The Chiropractic Curriculum: the Problem of Integration," *Journal of Manipulative Physiotherapy*, 4 (1981); M. Kelner, O. Hall and I. Coulter, *Chiropractors: Do They Help?* (Toronto 1980); E. Willis, "The exclusion of chiropractic," in *Medical Dominance*.

⁴¹D. Mills and D. Larsen, "The Professionalization of Canadian Chiropractic," in D. Coburn, et al., *Health and Canadian Society*.

⁴²I. Coulter, "The Chiropractic Role: Marginal, Supplemental, or Alternative Health Care? An Empirical Reconsideration," in D. Coburn, et al., *Health and Canadian Society*, 2nd ed.

⁴³F.E. Hodgins, *Ontario Commission on Health Education* (Toronto 1917).

at the College itself). However, since that time, and aided by the implementation of medical insurance (chiropractic in some provinces is partially covered under government health insurance), there has been a steady increase in the number and the quality of students and graduates. There are now about 150 students in each of the four years of training. Most entering students already have a university degree.

Since the watershed year of 1961, chiropractic in Canada has received greater public acceptance, as reflected in increasing utilization, and official or state recognition. It is a self-governing occupation with organized associations in almost all of the provinces. It has been granted official self-governing status in Ontario under the new Regulated Health Professions Act. Its increasing legitimacy is shown by numerous events from its inclusion under most workman's compensation acts as a legitimate source of care, to the listing of the College in catalogues of post-secondary educational institutions. Under the recent Ontario Registered Health Professions Act, chiropractic has received official recognition as one of 24 'health professions.'

But recognition is far from complete. The Canadian Memorial Chiropractic College receives no public funds. The College has yet to establish links with a university. Chiropractors are not fully covered under provincial insurance plans and are denied access to hospitals and other health institutions. Many doctors still attack chiropractors and shun contact with them (although an apparently increasing number do now see a role for chiropractic). For many years, doctors used physiotherapy to try to pre-empt chiropractic claims to expertise in manipulation and to fill the gap in medicine caused by its inattention to physical therapies.

The story of chiropractic in Canada is thus one of movement from a marginal or alternative occupation, violently opposed by medicine, to a more legitimate, if still not fully accepted health occupation. However, the process has not been one-sided. In the process of legitimation, chiropractic not only has reduced its former all-inclusive claims to healing, but it has also, to some extent, become 'medicalized.' The concessions for increased state recognition included the narrowing of its earlier all-inclusive claims. Many chiropractic leaders now describe chiropractic as a limited and specialized form of treatment focused on the back. Chiropractic students are told they are simply part of a 'health team' (this view is held more by the occupational and educational elite than by rank and file practitioners).⁴⁴ Furthermore, the struggle to retain direct contact with patients (rather than only through referral by a physician), considered by most chiropractors as essential to the continued existence of chiropractic, has also produced problems.

⁴⁴This restriction is illustrated by chiropractics' changing relationships with naturopathy. Many chiropractors used to have 'dual practices' of chiropractic and naturopathy because the latter offered more widespread scope of practice under (Ontario) provincial regulations. In the legitimation project the chiropractic elite purposely distanced itself from naturopathy in confining its scope of practice and in order to avoid all taint of 'quackery' see, for example, E.H. Gort and D. Coburn, "Naturopathy in Canada: Changing Relationships to Medicine, Chiropractic, and the State," *Social Science and Medicine*, 26 (1988), 1061-72.

In order to be able to claim to diagnose which problems they are capable of treating and which not, chiropractic education has had to be increasingly oriented to the basic sciences. The early years of chiropractic training are now to some extent focused on courses not much different from those in medical schools. Much of this early training has little to do with chiropractic as a unique discipline.

Even medical opposition to chiropractic is now more muted. Though the medical associations regularly attack chiropractic, in its more virulent forms medical opposition is now confined to those segments of medicine most directly threatened by chiropractic (specialists in physical medicine and also physiotherapy).

The development of chiropractic cannot be adequately understood without examining forces outside the health care system. Early on, chiropractic was characterized by its working-class clientele and practitioners. It received its major support from working-class organizations, particularly unions. There was also support from those, such as the Patrons of Industry in Ontario in the 1890s, who opposed the medical monopoly. There are now indications that patients and practitioners have become more representative of the population as a whole.⁴⁵

However, regarding class position, chiropractors are now, and always have been, solo, self-employed practitioners. The labour process in chiropractic has not come under the direct control of any outside sources, health institutions or bureaucratic regimes. The independent practitioner is still the norm. Although, as chiropractic has become more 'legitimate', the mechanisms for self-evaluation and self-control over professional behaviour have been increasingly formalized, these exert much less pressure on chiropractic than the push for rationalization faced by medicine. Chiropractors display a profound attachment to petty bourgeois political ideology and practice. In this respect, chiropractic has much in common with dentistry and some of the more market-oriented segments within medicine. Although chiropractic formed part of a large number of occupations which saw increasing autonomy in attacking medical control, its fate was partly influenced by an increasing accommodation to medicine and by those larger forces which undermined medical authority.

Overall, chiropractic cannot be said to be becoming proletarianized even in the sense of economic proletarianization. It has gained in legitimacy despite medical opposition and partly because of the weakening of medical dominance. Medicine now has more powerful enemies with which to contend.

It is interesting that the gender composition of chiropractic has varied over time. A number of early chiropractors were women, but women in chiropractic gradually disappeared from the scene until the occupation became almost completely male-dominated. More recently, there has been increasing interest and

⁴⁵I. Coulter, "The chiropractic role," in D. Coburn, *et al.*, *Health and Canadian Society*, 2nd ed.

participation by women, but, as yet, nothing as substantial as the changes in medical education.

In traditional terms, chiropractic is a professionalizing, if not yet a fully professionalized, male-dominated occupation. It has improved its status but it has not changed its class position. It is difficult to place within the proletarianization thesis. In fact, in some respects it still lies outside the 'industrialization' of health care or the capitalist mode of production in health. Chiropractic is still the epitome of a petty bourgeois occupation in work practices, and in ideology and political orientation. Though supported by labour in its early development it has little sympathy for many of the aims of the contemporary labour movement and seems more intent on riding a middle-class interest in 'alternative' or 'holistic' health practices.

Conclusions

MEDICINE has shown a dramatic series of changes during the 19th and 20th centuries. It did attain internal unity, after which it gained control over an emerging division of labour in the health field. In the contemporary era, medicine is losing some of its previously almost unchallenged power. Medical dominance is declining, but is this proletarianization? A lower percentage self-employed and a decrease in medical control over the health care system indicates that some doctors are undergoing some aspects of proletarianization. Physicians are even becoming somewhat more controlled or restricted by the state or by health care organizations regarding the tasks they carry out (autonomy). Doctors can no longer carry all of their technology in a little black bag. Though they assumed control over technology in the hospitals, various aspects of the allocation or use of these technologies are now evading their grasp. Some aspects of medicine are becoming routinized. Medicine in Canada is undergoing the beginnings of what might be a longer term process of proletarianization, but it is a proletarianization which has so far touched only lightly on the control by medicine over the content of its own work. Furthermore, how far the process will go is unclear, and a future counter-trend is not unthinkable. Medicine is not going to be a passive bystander to its own loss of power.⁴⁶

Nursing was born within a division of labour already dominated by medicine. Much of its history is that of the internal and external struggles related to attempts to escape from this subordination. Yet, while gaining self-regulation as an organized occupation vis-à-vis medicine, in their day-to-day work, in the labour

⁴⁶Some physicians still see medical autonomy as tied to a revival of 'private' insurance. A recent move towards 'physician-managers' has somewhat contradictory implications for the power of medicine. While some view 'medical managers' as part of a drive by medicine to re-assert control over health care, others view this movement as the co-opting of a medical elite in the desire by administrators or planners to secure greater physician compliance with bureaucratic directives.

process, nurses are still controlled by hospital administrators and by doctors. Nursing work is now being further intensified and controlled (but not necessarily de-skilled). Professionalization for nursing is one method of resistance to proletarianization, yet the divisions within nursing preclude any one strategy and many nurses, for whom nursing work is just a 'job,' show the form of resistance of wage workers to their employers, that is, unionization and union tactics. These different strategies are uneasy bedfellows. Differential relationships to the means of production in health care has produced clearly separate interests and ideologies within nursing itself (while there are also commonalities).

Chiropractors in Canada were newcomers in the 20th century and were largely based in the United States. They have today gained some measure of state recognition and legitimacy despite facing total medical opposition for many years. Yet, as self-employed solo practitioners they lie somewhat outside of the capitalist mode of production. The main movement of chiropractic has been to gain greater public acceptance and official recognition (legitimation) at the expense of limiting its own scope and potential. The term legitimation underlines the important political and administrative role of the state in inter-occupational struggles. State recognition is an essential component in professionalization and state agencies are the chief adjudicators in inter-occupational squabbles in the health area. The history of chiropractic indicates the differential role of health care bureaucracies and of legislatures and governments, hence the role of 'politics', in the legitimation process.

The changing role of the state has been crucial in the 'structuring' of the professions. Medicine partially controls the health division of labour through its (incomplete and declining) control over state apparatuses but also because of its ideological claims to expertise and authority. Medicine's 'cultural authority' partially resides in the prevalence of the 'medical model' of illness and disease, on the acceptance of medicine's claim to be the most comprehensive and scientific of the health professions, and on the congruence of its interests/ideology with dominant classes.

The hypothesized consequence of proletarianization, unionization, is strongest in nursing, the most proletarianized occupation, and is beginning to be apparent even in medicine (there have been discussions both within the Ontario Medical Association and the Canadian Medical Association about the merits of unionization.⁴⁷ Canadian nurses and Canadian doctors have in recent years gone on strike (or have 'withdrawn their services') numerous times. However, although nursing has almost completely unionized and is now, along with teaching, an active part of the white-collar union movement in Canada, medicine has adopted union tactics but not union forms (which are in any event associated with lower-status occupa-

⁴⁷In Ontario, physicians have gained the traditional labour union right of gathering fees from all of its constituents rather than simply being seen as a 'voluntary association' based on voluntary dues-paying.

tions). Medicine has established no contacts in the labour movement. Rather, organized medicine has leaned towards an alliance with conservative movements in the (unlikely) hopes of reducing government power by partially 'privatizing' health care.⁴⁸

Meanwhile chiropractors, not yet faced with large employing organizations, still have the 'professional association' approach to occupational enhancement and want full health insurance coverage but, having seen the fate of medicine, fear its consequences. If control over the labour process is a major aim of professionalization, and if professional associations are the main vehicles for this process, then these organizations differ little from unions (or other potential working-class organizations such as political parties) which seek to preserve or enhance worker control/autonomy through 'political' means (and often 'exclusionary' tactics). Many professional characteristics and actions (for example, credentialism) can be viewed, not simply as identifying criteria for professional standing, but as causes or consequences of the fight for control over work life.⁴⁹

Larson's contention that professionalization and proletarianization are related processes seems cogent.⁵⁰ Professionalization and proletarianization are (in part) causally related. Some of medicine's success in maintaining control over health care can be attributed to its capacity to hand over unwanted tasks to nursing or to the para-medical occupations. Nursing itself has sloughed off routine work to nurses aides and orderlies (although the existence of 'cheaper' alternatives is always something of a threat to professions). There has been an increasing sophistication (though not necessarily increasing control) for medicine and for nursing at the expense of the production of many routine jobs in health care which require little use of workers' abilities. The point of this is that the proletarianization process, insofar as it involves separation of the mental and manual components of work, also means the creation of occupations, or the enhancement of existing occupations, incorporating skills removed from proletarianized work. Proletarianization is thus not only produced by the general drive for profits or efficiency but also by inter-occupational conflict. Whatever the fate of individual occupations, proletarianization is clearly evident at the level of the health division of labour. The professionalization of some implies the proletarianization of others.

⁴⁸Unlikely because few big corporations relish the spectacle of health care becoming a direct part of production costs. In the United States, big business is highly involved in attempts to reduce costs and increase efficiency in health care, these measures often infringing on professional prerogatives, although there, as elsewhere, there are splits within the business community.

⁴⁹Yet, the case of medicine also indicates that the justifiable limits of worker control are reached when autonomy turns into control over others.

⁵⁰M.S. Larson, "Proletarianization and Educated Labour," 131-75.

I owe much to discussions with Lesley Biggs and to her archival skills. As well, I would like to thank her for the use of material she collected on chiropractic in Canada. I would particularly like to thank George Torrance for the use of material from a paper he wrote on the rise of medicine, and Joseph Kaufert for his collaboration on the paper on which the section on medicine is partially based. Elaine Gort collected much of the data on which the nursing section is based. The paper developed from a monograph and a series of papers emanating from an SSHRC Project — Grant No. 410-85-0539.

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