



Governing Medicine: Medical Autonomy in the United Kingdom and the Restratification Thesis

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Abstract:

This paper outlines the development of the sociological study of medical autonomy and how recent reforms in medical regulation in the United Kingdom illustrate how medical elites are proactively introducing formal performance surveillance and appraisal mechanisms and processes within medical training as they respond to challenges to traditional professional self-regulatory privileges, such as greater state, inter-professional and non-medical involvement in the governance of medical expertise. The paper highlights how such developments reinforce that social scientists have paid too little attention to the restratification thesis when analyzing an apparent decline in medical autonomy. It concludes by arguing for the need to conduct further empirical research into doctor's educational and clinical freedoms, while also noting the importance of paying close attention to broader changes in how 'good governance' is conceptualized and practiced within modern liberal democracies.

Key words: deprofessionalisation, medical autonomy, medical regulation, professional self-regulation, proletarianisation, restratification, revalidation.

**Resumen:****Gobernando la medicina: autonomía médica en Gran Bretaña y la tesis de reestratificación**

Este trabajo subraya el desarrollo del estudio sociológico de la autonomía médica y cómo las recientes reformas en la regulación médica en Gran Bretaña ilustran el modo en el cual las elites médicas están introduciendo proactivamente una vigilancia de rendimiento formal, de mecanismos y de procesos de valoración dentro del entrenamiento médico para responder a los desafíos planteados a los tradicionales privilegios profesionales auto-regulados, tales como el mayor involucramiento estatal, inter-profesional y no-médico en la gobernanza (*governance*) de las habilidades médicas. El artículo resalta cómo estos desarrollos demuestran que los científicos sociales han prestado escasa atención a la tesis de reestratificación (*restratification thesis*) al analizar la aparente declinación de la autonomía médica. Se concluye argumentando la necesidad de conducir investigación empírica adicional sobre las libertades educacionales y clínicas de los médicos, mientras que a su vez señala la importancia de prestar más atención a los cambios más amplios que se producen en la concepción y práctica de la “buena gobernanza” en las modernas democracias liberales.

Palabras clave: desprofesionalización, autonomía médica, regulación médica, autorregulación profesional, proletarización, reestratificación, revalidación.

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Introduction

This paper is concerned with the concept of medical autonomy. Specifically, it discusses how current policy developments within medical regulation and training provide supportive evidence for the restratification thesis, as well as reinforce that sociologists need to pay greater attention to how medical elites ensure individual doctors stay up to date and fit to practice in their chosen specialty. The paper is divided into two main sections. The first section outlines current developments in the governance of the medical profession in the United Kingdom, while against this background the second section focuses upon the sociological analysis of medical autonomy.

Reforming Medical Regulation in the United Kingdom

Traditionally the medical profession in the United Kingdom has been regulated by a single institution - the General Medical Council (GMC). The GMC was brought into being by the 1858 Medical Act (Moran, 1999). GMC members are medical practitioners who are either elected by the medical profession as a whole, or who represent medical elites such as the royal colleges and medical schools (Chamberlain, 2010). Indeed, it is only in the last three decades that non-medical GMC 'lay members' have begun to make their presence felt, and even then they have remained in the minority (Elston, 2004). In principle the GMC is responsible to parliament through the Privy Council, but in practice it has remained autonomous. Its responsibilities are twofold - to maintain a register of qualified medical practitioners and to define the nature of the qualifications necessary to obtain registration. The 1858 Medical Act is often held by members of the medical profession to be a landmark in the governance of medical training and regulation in the United Kingdom (i.e. Irvine, 2003). For through its enactment medicine entered into a regulatory bargain with the state. It gained the privilege of professional self-regulation in return for promising the public they could trust the competence of registered medical practitioners. Through its control of the GMC for 150 years medicine has collectively possessed an occupational monopoly over its members training, discipline and practice. Other professions such as law have similarly possessed monopolistic control over entry onto and exit from state registers of qualified practitioners (Gladstone, 2000). However, in recent times, in response to a series of high profile medical malpractice cases - such as the general practitioner and mass murderer Dr Harold Shipman who killed over two hundred and fifteen of his patients - the state has intervened and sought to 'open up' medical regulation and make it more transparent and publicly accountable (Chamberlain, 2010). Indeed, as the paper



will now discuss, on the surface it appears that the 2008 Health and Social Care Act has significantly reduced the stranglehold medical elites have traditionally possessed over the GMC and so the regulation of doctors.

Throughout the 1980s and 1990s it had become increasingly clear to politicians and social commentators that medical regulation needed to be reformed. A series of high profile cases reinforced that greater inter-professional cooperation and managerial and lay involvement in the regulation of professional expertise was urgently needed (Irvine, 2003). For example, the Royal Bristol Infirmary case saw several newborn babies die as a result of botched surgical procedures which the surgical team successfully covered up until one doctor horrified by events blew the whistle on his colleagues. Cases such as Bristol reinforced to medical elites such as the royal colleges that they needed to adopt more open and transparent governing regimes (Irvine, 2006). They acted quickly to establish clear standards which could be operationalised into performance outcomes against which the 'fitness to practice' of members of the profession could be regularly checked (Irvine, 2003). This process was bound up with the emergence of a 'new medical professionalism', frequently called 'professionally-led' regulation (Irvine, 2006). As the chairman of the GMC of the time, Donald Irvine, noted (2001, p. 1808), "the essence of the new professionalism is clear professional standards". Medicine's new professionalism led to the GMC's disciplinary procedures being overhauled, with independent investigation subsequently revealing that "there has been a distinct shift in disciplinary proceedings towards protecting patients and a 'repudiation' of...closed ranks, self-interested regulation. Fraud, dishonesty or the abuse of a privileged position is also treated harshly" (Allsop, 2006, p. 631). Furthermore, the GMC also enforced a move towards a competence-focused outcome-based approach to medical training and career progression by means of formal performance appraisal (Black, 2002). This signalled the beginning of the proactive surveillance, inspection and control programme of the delivery of medical training at undergraduate, postgraduate and continuing levels (Stacey, 2000).

However, for many victims of medical malpractice these self-imposed reforms were not enough, and if one case could be said to have highlighted the need for further reform, then it was the Shipman case (Chamberlain, 2010). Certainly Dame Janet Smith (2005, p. 1174), at the end her governmental review of the Shipman case, was "driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on". Smith (2005) argued forcefully that the self-elected nature of members of the GMC made the central issue of protecting the interests of the public difficult. She noted that "it seems....that one of the fundamental problems facing the GMC is the perception, shared by many doctors,



that it is supposed to be 'representing' them. It is not, it is regulating them....In fact the medical profession has a very effective representative body in the BMA, it does not need – and should not have – two" (Smith, 2005, p. 1176). Smith's 2005 report made several key recommendations concerning the future of the GMC, and it concluded as the then Secretary of State Alan Milburn made it clear at the time, "the GMC...must be truly accountable and it must be guided at all times by the welfare and safety of patients. We owe it to the relatives of Shipman's victims to prevent a repetition of what happened in Hyde" (quoted in Gladstone, 2000, p. 10). In 2007 the Health and Social Care White Paper was announced as a direct result of the Smith (2005) report. This subsequently passed through parliament as the 2008 Health and Social Care Act (Chamberlain, 2010).

The 2008 Health and Social Care Act introduced two key reforms of note in regards to the regulation of the medical profession. First, the membership of the GMC will be reduced from thirty-five to twelve, all of whom will be elected via an independent system overseen by the Public Appointments Commission. Six of these twelve members will be non-medical lay members. Perhaps most importantly, the GMC is to lose its power to adjudicate on fitness-to-practice cases, which will now be independently considered. Furthermore, such cases will now be judged on a civil standard of proof - on the balance of probability. At present, they are based on the criminal standard - beyond all reasonable doubt. This situation has frequently led social scientists to argue that the GMC's disciplinary procedures have first and foremost protected underperforming doctors instead of members of the general public (i.e. Stacey, 1992; Allsop, 2006). In short, the GMC is now left to concentrate on investigating complaints against doctors, but will not be responsible for deciding on sanctions. Additionally, what is to be known as a 'GMC affiliate' will be embedded within local National Health Service (NHS) accountability structures. This affiliate's remit includes coordinating the investigation of complaints at a local NHS trust level. This leads to the second key part of the current reform agenda. Namely, that the affiliate will work with the royal colleges concerning the arrangements for ensuring every doctor is 'fit to practice' in their chosen specialty. Known as revalidation, this process consists of two elements - relicensing and specialist recertification (Donaldson, 2006). Doctors currently have to undergo an annual check of their performance, known as annual appraisal, as part of their NHS employment contract (Black, 2002). Smith (2005, p. 1048) strongly felt that as it currently operates appraisal would not have identified Shipman and does "not offer the public protection from underperforming doctors". Under the new proposals appraisal will still occur annually, but it will now be significantly strengthened, with greater direct testing of a doctor's competence in regards to the completion of key day-to-day work tasks. All doctors will now have to pass the relicensing requirement that they have successfully complete five annual



appraisals in order to stay on the medical register (The Secretary of State for Health, 2007). Specialist recertification is new and like recertification will occur every five years. It will involve a thorough 'hands on' assessment of a doctor, by the relevant royal college, of their 'fitness to practice' in their chosen medical specialty (Donaldson, 2008). It is expected that a mixture of clinical audit, direct observation, simulated tests, knowledge tests, patient feedback and continuing professional development activities, will together ensure specialist recertification (Chamberlain, 2010). Relicensing and specialist recertification elements of the revalidation process will be formally introduced nationally from late 2010 onwards (Donaldson, 2008).

The Sociological Study of Medical Autonomy

As the preceding discussion highlights, we are currently sitting on threshold of far reaching reforms in medical regulation which seem to indicate that the state has intervened to substantively reform medical governance and curtail medical autonomy. However, closer analysis reveals that medical autonomy has been transformed rather than curtailed. But before this point can be explored further, it is necessary to outline how sociologists have conceptualised medical autonomy. The sociological study of medical autonomy is grounded within the sociology of the professions literature (Elston, 2004). The historical development of this literature is well known (Albrecht, Fitzpatrick & Scrimshaw, 2000). By the early 1980s sociologists were emphasising how professionalism operated ideologically as an exclusory self-regulatory strategy for organising the performance of professional work. This revolves around the principle that members of a profession must exercise control over their work, as well as the standards by which work outcomes are judged, due to the specialist nature of their expertise (Friedson, 1994). Occupational control over members training and discipline forms a logical part of this viewpoint (Friedson, 1970). Yet as the 1980s progressed it was gradually becoming clear that changes were occurring inside and outside of the medical profession. Rapid advances in medical knowledge made it apparent that medicine was becoming less homogenous and fragmenting into sub-specialities, as new diagnostic and therapeutic technologies developed due to the advent of the computer age and advances in pharmacology, molecular biology, genetics and immunology (Gabe, Kelleher & Williams, 1994). This caused medicine to become ever more dependent upon non-medical occupations operating outside of its direct jurisdiction to treat illness and disease. Concurrent with the rapid growth in medical expertise and the growing internal fragmentation of the profession was a rise in managerial attempts to control medical work. There was the ascendancy of health care managers, or 'corporate rationalisers', as the state sought to contain burgeoning health care costs (Coburn & Willis, 2000). The



invasion of the state via management into 'medical turf' was also related to growing public concern with the risks involved in modern medical treatment. High profile media cases engendered doubts in the consciousness of the public concerning the ability of medicine to ensure individual doctors possessed high ethical standards (Gladstone, 2000). They also contributed further to an already burgeoning consumerist demand for greater patient choice and control over medical encounters as well as health care organisation and delivery. This was reflected in the growth of alternative medicine, an increase in the threat of patient complaints and medical litigation, as well as the presence of a high level of dissatisfaction amongst patients with the doctor's communication and information sharing skills (Dingwall, Fenn & Quan, 1991).

These changes were conceptualised by sociologists under the banner of the respective proletarianisation and deprofessionalisation theses (Elston, 2004). The deprofessionalisation thesis focuses upon topics that indicate that there has been a decline in public trust of medicine and the threat this poses to the principle of professional self-regulation (Elston, 1991). The growth of media coverage of gross medical malpractice cases, such as the general practitioner and mass murderer Harold Shipman, who was convicted of killing 215 of his patients, are utilised by the deprofessionalisation thesis to illustrate its arguments. For it focuses upon the fact that attitudes to traditional forms of authority are changing and highlights that the public increasingly expects their governing institutions to operate in a transparent and accountable manner. In contrast, the proletarianisation thesis highlights the existence of the potential for expert work in general, and medical work in particular, to become subject to rationalisation and routinisation. It focuses upon how this causes medical work to become subject to managerial bureaucratic control in the name of controlling costs and promoting consumer choice (Elston, 2004). It is undoubtedly the case that the proletarianisation and deprofessionalisation theses illustrate how two broad general trends – the rise of health care managerialism and the growth of consumer power - are actively challenging internationally traditional professional freedoms (Gabe et al, 1994). Including the historical right of occupations classified as professions to manage their own affairs and so possess monopolistic occupational control over members training, practice and discipline (Gladstone, 2000). Nevertheless, the deprofessionalisation and proletarianisation theses do not fully encapsulate the nature of the contemporary situation faced by professions such as medicine (Allsop & Saks, 2002). It is not a simple case where professional autonomy is in long-term decline due to the rise of health care managerialism and a more critically aware and demanding general public. Rather, two key points need to be noted. First, the applicability of the respective deprofessionalisation and proletarianisation theses, both inside and outside of their point of origin, the United State of America, is open to serious question (Elston, 2004). Certainly critical commentators within the United Kingdom have argued



convincingly that neither thesis fully reflects the nature of the contemporary professional practice context (i.e. Elston, 1991). Additionally, even the most ardent advocate of the proletarianisation or deprofessionalisation thesis must acknowledge that there is a lack of empirical evidence to support their claims (Ahmed & Harrison, 2000). While, when such evidence is found, it further reinforces their limitations as explanatory frameworks due to their inability to fully encapsulate the impact current challenges to traditional professional privileges are having on rank and file practitioners autonomy 'at the front line' (Gray & Harrison, 2004). Second, the proletarianisation and deprofessionalisation theses tend to focus solely upon external factors held to be acting upon the professions, such as the growth of a more informed and demanding general public (Elston, 2004). They therefore do not fully consider the internal changes professions such as medicine are currently undergoing, as professional elites response to challenges to professional privileges by subjecting rank and file practitioners to greater peer surveillance and control (Stacey, 2000). The dominance of the deprofessionalisation and proletarianisation theses within the literature belies the fact that sociologists are guilty of paying little attention to internal reforms within the professions when analysing current changes in how professional expertise operates in today's society (Chamberlain, 2010). It is certainly arguable that sociologists have paid little attention to how professions like medicine are reforming their training and regulatory arrangements as they respond to calls to become more open and accountable for how they manage their affairs (Davies, 2004). Consequently, they have only considered half of the picture in relation to the changing position of professions within contemporary society (Harrison, 2004). As this paper will now discuss, the restratification thesis redresses this imbalance by firmly refocusing sociological analysis so it also considers internal reforms occurring within the professions. Furthermore, it also highlights the need for sociologists to analyse doctors educational as well as their clinical activities (Elston, 1991)

Eliot Freidson was passionate critic of the deprofessionalisation and proletarianisation theses (i.e. Friedson, 1985, 1994). He agreed that changes were occurring in medicine's relationship with the general public, and acknowledged that this was due to medical knowledge and expertise expanding, as well as becoming formalised into rules and procedures; particularly with the advent of computer technology and the information and communication revolutions. However, he held that medicine was not losing control of its monopoly over its expertise. Furthermore, he believed that the development of new techniques to monitor the efficiency of performance and the allocation of resources did not in itself reduce medical autonomy. What matters is whose criteria for evaluation are used and who controls any ensuing action. This is an important point, for to function ideologically as a method of occupational control professionalism requires that occupational members control the technical evaluation of work



activities (Stacey, 2000). In the context of the proletarianisation thesis, the growing threat of bureaucratic-managerial control over medical work does challenge medical professionalism as it typically introduces non-medical criteria from which to judge work performance. Freidson recognised this. However, he retorted that while the individual autonomy of doctors was affected by this state of affairs the collective institutional autonomy of the profession as a whole remained intact (Freidson, 1994). He discussed the growth of co-opted medically qualified managers, charged with controlling the surveillance and evaluation of medical work (Harrison, 2004). Freidson believed that the loyalties of these co-opted doctors ultimately lay with their clinical colleagues, not their 'corporate masters'. Furthermore, he held that the key affect of these managerial elites placing the rank and file members under ever more formal surveillance and control was the maintenance of collective privileges. Freidson's arguments rest upon the truism that due to the esoteric nature of their expertise, any attempt to raise standards and cut costs requires the cooperation of the medical profession, with elites such as the royal colleges consequently possessing a powerful bargaining chip when changes are proposed (Gray & Harrison, 2004).

Following Freidson's lead, from the mid-1990s onwards sociologists in the United Kingdom began to argue that instead of undergoing a period of decline, medicine is undergoing a process of restratification, which is sustaining medical privilege and power, albeit in a new 'risk aware' best-evidenced standards-driven form (Chamberlain, 2010). By the beginning of the new millennium it was certainly apparent that a medical administrative elite had emerged, grouped around 'the academy' and royal colleges, and charged with standardising the everyday clinical decisions of rank and file doctors (Kitchener, 2000). Primarily using evidence-based medicine and "formalised tools such as audits, clinical guidelines and protocols" (Armstrong 2002, p. 1772). Additionally, as we come to the end of the first decade of the new millennium it is also clear that medical training and regulation are being modernised in such a manner as to reinforce the legitimacy of the restratification thesis (Chamberlain 2010). Certainly current reforms in medical training and regulation reinforce how medical elites are increasingly subjecting rank and file practitioners to greater peer surveillance and control as they seek to maintain collective regulatory privileges, albeit in a new and more transparent form. Bound up with this has been the introduction of formal portfolio-based performance appraisal throughout medical school and junior doctor training, in later specialist training, as well as to support the implementation of annual appraisal of doctors as part of their National Health Service (NHS) contract (Snadden, 1998; Wilkinson et al, 2002). A state of affairs which has led some sociologists to argue that recent changes in medical training and regulation further reinforce the decline of medical autonomy (Elston, 2004). However, it needs to be recognised that medical



elites, such as the British Medical Association and the Royal Colleges, still play a key role in setting the standards governing medical regulation and training (Bruce, 2007). For example, take the much vaulted medical competence test known as revalidation. As the paper has already noted, this is currently being readied for national implementation in late 2010, and allegedly involves a thorough 'hands on' assessment of a doctor's 'fitness to practice' in their chosen medical specialty, which they must pass to stay on the medical register and be able to practice medicine (Donaldson, 2008). NHS management, patients and other health care professionals will all have input into this process. It is therefore no surprise that medical elites use revalidation to argue that they are being responsive to the need to be more open and transparent (i.e. Catto, 2006). However, revalidation will be overseen by the Royal Colleges. Not least of all because it is expected that a mixture of clinical audit, direct observation, simulated tests, knowledge tests and continuing professional development activities, will together ensure a doctor is regarded as competent. In the final analysis, the state has to accept that peer review remains the key criteria by which the quality of medical work can be judged and the potential for risk in the application of medical expertise minimised (Friedson, 2001). Consequently, and in line with the restratification thesis, the current situation concerning the governance of medical expertise in the United Kingdom is perhaps best summed up by Moran (1999, p. 129-30), who argues that: "...states are more important than ever before, either in the direct surveillance of the profession or in supervising the institutions of surveillance...[this] has not necessarily diminished the power of doctors; but it has profoundly changed the institutional landscape upon which they have to operate".

In reviewing current developments in the regulation of the medical profession this paper has highlighted the continued relevance of the restratification thesis as a conceptual tool for establishing areas for empirical inquiry and theoretical consideration in relation to contemporary developments in the governance of professional expertise. One clear such example is of course the introduction of portfolio-based performance appraisal for medical trainees and qualified practitioners (Chamberlain, 2009), yet not all observers have agreed that the restratification process medicine is currently undergoing has served to sustain medical autonomy. For Harrison and Ahmed (2000) non-medical managerial 'corporate rationalisers' are seeking to curtail the autonomy of doctors using the outcomes generated by medicines own 'corporate rationalisers' working in the academia and the guideline industry. They hold that the guideline industry is gradually replacing of the 'tacit' dimensions of medical expertise with algorithmic rules to be followed in a step by step sequence, regardless of particular situational contingencies. This process forms a key part of the strategy by which the state is seeking to engender trust in systems of professional accountability (Slater, 2007). Similar arguments have



been made internationally (Chamberlain, 2010). The United Kingdom is not alone in seeing the rise of a rationalistic-bureaucratic discourse of performance appraisal which sees medical practitioners increasing being co-opted into the surveillance of medical work and non-medical criteria being included into the evaluation of the appropriateness of doctor's clinical judgments (Coburn & Willis, 2000). In the American context, McKinlay and Stoeckle (1988) argue that the interests of their organisational masters dictate co-opted medical managers' actions. Similarly, Coburn et al (1997) argue that in the Canadian context the state partially controls medicine via health care management because of a process of restratification. Barnett et al (1998) do the same when analysing medical autonomy in New Zealand. The work of these authors reminds us that the previously dominant position of medicine in health care arena has been challenged internationally by an interventionist state intent on subjecting medicine to the surveillance and control (Slater, 2007). However, these authors do not rely on systematic empirical data to make their arguments (Coburn & Willis, 2000). Consequently, their work reinforces the fact that more empirical data is needed, particularly from the perspective of doctors themselves (Elston, 2004). Furthermore, a key problem with the arguments of authors such as Ahmed and Harrison (2000) is that they focus upon reforms in the health care system in which clinical judgements are made, and pay little regard to the key role played by control over educational credential processes in ensuring the continued legitimacy of occupational control over regulatory arrangements (Friedson, 2001). Yet as this paper has already discussed, the 'shoring up' of professional training, due to the presence of external threats to occupational control over self-regulatory functions, logically forms an important part of the restratification thesis (Elston, 1991). It would certainly be reasonable to assume that elite members within professional groups will attempt to retain control of the use and interpretation of their specialist knowledge, through submitting 'rank and file' members to formalistic methods of surveillance and control within the educational as well as the clinical context (Elston, 2004). Indeed, as this paper has discussed, this is exactly what has happened (Chamberlain 2009).

Conclusion: Research Agendas and (Neo) Liberal Mentalities of Rule

Now is an opportune moment for sociologists to focus upon internal reforms affecting how medical training and regulation is undertaken. This paper has highlighted two important points relevant to this. First, sociologists have conducted little empirical work with doctors concerning their educational activities, particularly how they keep up to date and 'fit to practice' in their chosen speciality. Current developments, such as the planned introduction of revalidation nationally within the UK in late 2010, reinforce the need to undertake a dedicated



research programme into doctor's educational practices in order to obtain a clearer and more rounded picture of the full impact of the current developments in medical governance. Second, it is apparent that the current medical accountability agenda utilises a rationalistic discourse of standard setting and performance appraisal when seeking to subject rank and file practitioners to greater surveillance and disciplinary control (Chamberlain, 2009). Designed to ensure effective and economic risk management, this discourse of performance appraisal involves the functional analysis of work roles and tasks in order to break them down into their constitutive parts and translate them into measurable outcomes with minimum performance standards (Searle, 2000). This brings an important issue to the foreground. Namely, that there seems to have been a change in the conditions under which 'good governance' can be practiced within society as a whole, not just within previously 'closed shop' institutions such as the GMC (Stacey, 2000). Power (1997) and Rose (1999) note that a key facet of advanced liberal society is its central concern with disciplining the population without recourse to direct or oppressive intervention. Yet it also sees the encroachment of demands for standardisation and transparent accountability associated with Audit and performance appraisal, into all aspects of social life (Burchell et al, 1991; Hanlon, 1998). Governmentality theorists such as Rose (1999) argue that Audit is a key large-scale activity for governing the activities of experts 'at a distance' in order to minimise the costs and risks associated with the application of specialist expertise. The changes underway in medicine can be found in other contexts, and sociologists should bare this in mind as they conduct research into the impact of reforms in the governance of medical expertise. Not least of all because this highlights that changes in how professional expertise operates are directed towards the object of 'good governance' - the population in general and the individual subject-citizen in particular – as much as they are the professions themselves (Rose, 1999). For medicine, and indeed the health and social care professions as a whole, form but one part of a complex array of governing calculations, strategies and tactics which seek to promote the security, wealth, health and happiness of the population (Rose and Miller, 1992). It is important to recognise this. As in terms of Berlin's (1969) famous dichotomy of 'positive' and 'negative' liberty, although liberal mentalities of rule may appear at first to promote 'negative liberty' (i.e. the personal freedom of the individual subject to decide who they are and discover what they want to be) they in reality promote 'positive liberty' (i.e. that is a view of who and what a citizen-subject is and should be). This carries with it the very real danger of authoritarianism and totalitarianism (Dumm, 1996). Which is something all social scientists, not just those concerned with the governance of professional expertise, must be mindful of and guard against.



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