Prevention or Production. Autonomy and Subordination in Occupational Medicine (France, 1970-2010)

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In France, occupational medicine services become institutionalized as of 1942 for large firms, and generalized to all firms in 1946 (Buzzi, Devinck, et Rosental 2006). These laws can be seen as a major achievement of the labor movement to protect worker well-being and improve working conditions, or as a compromise with certain eugenistic ideas considering that such an institution was needed to raise the general « quality » of the population, and certain economic ideas considering that health screening and profiling would help increase general productivity. None of these conflicting traditions was clearly preferred over the others when creating French occupational medicine services. In other words, there is no clear choice between prevention and production. Rather, the history of French occupational medicine until today can be considered one of conflict and compromise between different ideological options, with important effects in the way physicians define their professional mandate (Hughes 1996) and the tasks which they can legitimately perform.

The 1942 and 1946 laws state that all employers must contract either with an in-house physician (very large companies, about 10% of French employees in the private sector) or with a an interprofessional medical service employing occupational physicians (all other companies, about 90% of French employees in the private sector) so as to ensure that their employees receive correct medical surveillance. Occupational health services are paid for by mandatary employer fees. The management of these services is chosen by the board of administrators, which is controlled by an employer majority. To sum up, this means that most occupational physicians are the employees of an employer-controlled organization, and that the remaining minority are employed in in-house services directed by company management.

Physicians are required by law to certify that workers are fit for the job (on medical grounds) ; to « prevent any alteration of the workers' health caused by their work » ; eventually, to help the workers file for an official recognition of the occupational nature of some of their illness.

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In practice, the real nature of the work that is performed differs greatly from one physician to another, as I will show in this paper.

The research question which I develop here is the following: for these occupational physicians, what does it mean to be employees, thus in a relationship of subordination with their employer, as well as at the same time professionals entitled by law to what they call « medical independence », and which sociologists would call professional autonomy? In other words: how does salarial subordination coexist with medical autonomy?

It is first necessary to define what we mean by professional autonomy. In Eliot Freidson's classic work *Profession of medicine*, the sociologist defines autonomy as « the exclusive right to decide who is authorized to realize the work and how it should be realized » (Freidson 1988). In a 1995 article, American sociologists Harland Prechel and Anne Gupman define autonomy as « the control over routine work activities and decisions, and the freedom to be innovative in the work process » (Prechel et Gupman 1995). However, as historian Lily M. Hoffman points out in a study of medical professionals in socialist Czechoslovakia, one should always keep in mind, when considering the matter of autonomy, that infringing on professional autonomy is sometimes realized by influencing the legitimate definition of the « job » to be done, rather than exerting control on the way a certain task is realized (Hoffman 1997). She shows for example that epidemiologists were strongly advised to consider that their job consisted only in making surveys; drawing conclusions was already out of their league, and making public health recommendations was definitely not their job. Therefore, a definition of autonomy as « control over routine work activities » must be dealt with cautiously, as there can exist many alternate and conflicting versions of what these « routine work activities » are made up of.

Thus, the main thesis of this paper confirms Hoffman's discussion: autonomy should be defined not only as the control over routine work activities, but also as the ability to decide what makes up routine, or in other words, what tasks one can legitimately carry out in connection with a given professional mandate.

This work draws on the data collected during a five-year research (2006-2011) in the context of a doctoral essay (Marichalar 2011). The data consists of about fifty interviews (including about thirty with occupational doctors working in different settings) as well as previously unstudied historical documents from occupational physician trade unions, French Ministry of Work, as well as French employer organizations, covering a span of about four decades (1970s till today). Many of the physicians have been interviewed more than once, and documents and interviews have been intertwined as often as possible, so as to give the most detail and historical depth to the data.
Also, my research questions draw on similar studies in other countries, such as Vivienne Walters’ study of occupational physicians in Ontario (Walters 1982) and Elaine Draper’s book on the American company doctor (Draper 2003).

There will be three parts to my presentation today.

First, I show that subordination and autonomy coexist only insofar as physicians agree with their hierarchy that there is a distinction between the « medical » and the « organizational » (or, in French, administratif) parts of their activity. In other words, in all interprofessional occupational health services that I have studied, there is a consensus that it is legitimate to give orders or ask obedience from physicians on « organizational » aspects, such as working hours, workload, some paperwork, etc., except on certain « medical » tasks for which they are entitled to complete autonomy. However, the limit between « organizational » and « medical » is of course negotiated, arbitrary, and subject to evolution following power struggles within the health services.

Second, I show that the definition of the « job » to be done is particularly unclear when considering occupational medicine in France. There are alternate and conflicting versions of the tasks that an occupational physician can legitimately carry out. I show that, especially in in-house health services, company doctors have to negotiate daily with their colleagues to define their professional jurisdiction, as well as fight against certain conceptions of this jurisdiction that are locally strong for historical reasons. They are often unconscious of these negotiations, or at least they do not make a connection between these endless negotiations and the principle of medical independence. However, professional autonomy is of course strongly influenced by the outcome of these negotiations, which sometimes bring physicians to accomplish tasks that did not originally enter their conception of the job to be done.

Third, I discuss the classic idea that being part of the medical community is an asset as far as professional autonomy is considered. Of course, being a physician gives a status which can allow occupational physicians to exert some influence over non-physicians. However, it also gives their physician colleagues the legitimacy to exert a form of power over them, under cover of « peer to peer » relations, what French doctors call « la confraternité ». This is particularly true for occupational physicians because of their very low status in the scale of medical prestige (because of the low social credit given to salaried medicine, as well as the low social status of doctors that cannot choose their patients but have to deal with all workers indiscriminately). My study shows that occupational doctors are always striving to gain some support from other physicians, for example general practitioners, university professors or official medical work inspectors. Moreover, they spend a considerable amount of time and effort fighting against other physicians that indirectly
or directly support employer positions, and try to confine them to a strictly defined professional jurisdiction. The jurisdiction of occupational medicine is thus defined in this everyday struggle with other doctors.

I. The difficult coexistence of «organizational» subordination and «medical» autonomy

How can occupational physicians be at the same time subordinates of an employer, and independent professionals?

The study of interprofessional occupational health services in France shows that the apparent coexistence of autonomy and subordination is possible only inasmuch an «medical» side of professional activity (on which the physician is entitled to complete independence) is distinguished from its «administrative» side (which allows for a legitimate degree of subordination). This distinction is the unstable product of continuous negotiations between occupational doctors and their everyday colleagues and counterparts (other professionals in the health service or in the company, other physicians, work inspectors, human resources employees...).

In interprofessional health services, doctors are issued strict schedules of their work. The directors of these services, chosen by employers of a given region and/or sector, consider that the most important tasks which must be accomplished are medical examinations of workers, especially those that determine if they are fit or not for the job (aptitude). Other tasks such as visiting companies and studying workstations are deemed secondary; occupational physicians are to perform them only if they have time left after their «examinations goal» has been reached. This goal has been limited by law in 2005 to 3200 medical examinations per year; a limit considered very high, even unrealistic, by most physicians, but nevertheless used in most occupational health services as an average objective more than an upper limit. This upper limit has very recently (February 2012) been suppressed by a new law, there isn't any limit anymore.

In one of the occupational health services that I have studied, management's control over the physicians' schedule is very explicit. As of 2004, doctors started receiving a monthly schedule with the name and time of appointment of all the employees they were to receive. Until then, doctors used to determine their schedule in cooperation with their secretaries. However, management then decided to create a new «centralized appointment department» which issues the schedules to each physician. It then became obviously much more difficult for physicians to change their schedule, for example if they wished to spend more time one day doing a study of the workstations in a particular factory. For one physician, this «centralized appointment department» is a sign of the directors «administrative power» over doctors. For another doctor, this reform was implemented because
there is a financial calculation. [...] If [management] could force doctors to only do examinations the whole day, and five days out of seven, it would be perfect, because at least they would know that they are really doing ».

Though doctors often complain about this kind of quantitative control of their activity, they often consider that they cannot do anything about it, that it must be one of the essential characteristics of work in an interprofessional occupational health service. Resistance against this kind of control is very rare and very negatively considered by management, as we can see with the story of one physician, which I will call Bernard M.

Bernard M. is employed in an interprofessional health service in the South of France. In 2005, he decides not to do anymore systematic annual examinations (workers must normally see their occupational doctor every year or two years). Indeed, he prefers concentrating on other kinds of examinations (after an accident, after a period of sick-leave...), which he deems more important considering his general mandate of prevention.

This freedom in the choice of his tasks is not of managements' liking. The president of the occupational health service (an employer) writes to Bernard M. in November 2005, warning him to be careful and threatening him of being sacked. He says this is a « selective disposal » that he cannot accept, reminds the physician that he has a quantitative « examinations goal », and mentions « insubordination »:

« the insubordination and the permanent resistance that you regularly demonstrated over the past few months, against your hierarchy's decisions, cannot be tolerated any longer. […] 2947 workers have been affected to your surveillance for the year 2005, which is below what could be asked from you. So where is this « overload » that you mention in your many letters? […] We are appalled that you have only performed 46% of your « examinations goal » in October 2005, while your colleagues are at levels of 70 or 80%. […] Your position as an employee, and the subordination relationship which is linked to this position, make it mandatory for you to obey the orders that are given and to withhold from any initiative which is not directly within your competence. »

For the president, this subordinate position is absolutely compatible with the medical autonomy that a physician is entitled to by law. This is not the opinion of Bernard M., who will continue fighting during many years for the freedom to determine his own schedule.
II. What does autonomy mean when the job is not clear? Everyday negotiations around the boundaries of the legitimate job

The nature of the job to be done has always been particularly unclear in occupational medicine. This can be seen historically. In 1928, a doctor named Louis-Ferdinand Destouches describes his conception of occupational medicine in an article in a medical journal (*La Presse médicale*) (Destouches 1928); this doctor will become famous a few years later as a writer, under the pen name Louis-Ferdinand Céline (*Voyage au bout de la nuit, Mort à crédit...* are some of his novels). In this 1928 article, the doctor explains the three main principles of occupational medicine:

« 1° we should accept that workers must work the most possible, with the rarest and shortest sick-leave possible ;
2° that most workers can work 3° that they should be cured while they work, using all the possibilities offered by modern industry to continue employing sick workers. »

According to Destouches/Céline, occupational medicine is the new specialty which will ensure that sick workers continue working, creating a new, intermediate state between acute sickness and health, which is more adapted to a society with a large working class. This will serve productive interests and ensure that health insurance does not go bankrupt.

A few years later, another physician, Guy Hausser, proposes a radically different conception of occupational medicine (Bédier 2004). He is a Communist, active in the Confédération générale du travail, the major trade union linked to the Communist party. According to Hausser, « by endless propaganda, we must convince all that occupational diseases are not a myth, that we encounter them everyday and that we must not only indemnify them, but also prevent them. To prevent them, we must implement measures of hygiene, but we think that in a capitalist regime simple measures of hygiene will not be implemented by persuasion ». 

According to Hausser, it is the occupational doctor's job to convince the employer that these measures of hygiene must be implemented, and help defend worker rights, even if this means becoming an « activist » in favor of worker health and security.

Thus, one can see that occupational medicine can be defined as in favor of production or prevention. These two conflicting conceptions still coexist in many companies nowadays. My study shows that, particularly in in-house medical services, most of the infringement on medical autonomy passes by renegotiation of the legitimate definition of the job to be done.

For example, when a new doctor is hired in an in-house service, he must fight against the ghost of his predecessor. All other actors in the company indeed usually evoke what the previous physician « used to do », « did not use to do », invoking traditional legitimacy as a way to curb the new physician's desire to redefine completely the scope of his job. This if of course particular...
blatant when the physician performs tasks that management does not approve of. It is in these first moments that the struggle between autonomy and subordination is settled in a quite permanent way.

However, I have also met doctors that do not feel any infringement on their professional autonomy. I will give the example of a physician in a nuclear power plant, who tells me he feels completely free, management does not exert any kind of control on him. When I get him to speak about his career, he explains that he used to work in a conventional power plant, where he often sided with the worker trade unions, considering this was probably the best way of being efficient in the preservation of worker health. However, this brought him much resistance from management, which tried in many ways to control the way he did his job. He took advantage of a job change, which brought him to the present nuclear plant, to completely change his way of working: « I have had two professional lives », he tells me. In the nuclear plant, he decides that his utmost goal must be to gain management's trust. Only in this way will management listen to him and implement effective prevention measures, he thinks. He accepts various tasks that show his connection with management. For example, he is part of the executive board which decides, every year, which workers should be rewarded for their good work. He also has a fairly conservative opinion healthwise, considering for example that it is not proven that there is a causal link between radioactivity and cancer (except in very high doses).

This example shows that sometimes, feeling completely free is only the consequence of a perfect agreement between the physician and management on what his job should consist of. It is when these two conceptions diverge that autonomy becomes an explicit, everyday struggle. For example, occupational medicine defined as an extension of human resources or as a way of managing risks without stopping production allows easy agreement with management, and hence a greater degree of perceived autonomy.

**III. Being a member of the medical community, an asset or an obstacle to autonomous work**

My study shows that occupational doctors are always striving to gain some support from other physicians, for example general practitioners, university professors or official medical work inspectors. Moreover, they spend a considerable amount of time and effort fighting against other physicians that indirectly or directly support employer positions, and try to confine them to a strictly defined professional jurisdiction. The jurisdiction of occupational medicine is thus defined in this everyday struggle with other doctors. This confirms the idea, developed by Oswald Hall and Eliot Freidson, that the practice of medicine depends of the nature of the « network of physicians » that
one is a part of (Hall 1946) (Freidson 1988). As Freidson puts it, « in one way or another, a physician depends on his colleagues […] Contemporary medicine is not practised in solitude ».

I will give the example of a doctor in an interprofessional health service in the 1970s. She is mainly in charge of the medical surveillance of the 300 workers of a lead mine located in the center of France (Largentière, Ardèche).

In December of 1970, a new occupational physician takes charge of the Largentière mine, as an effect of a reorganization in the local interprofessional occupational health service: her name is Suzanne Blanc and she is 43 years old. In the beginning of 1971, her first important medical decision is to order a series of tests to determine levels of lead intoxication among the 23 workers that work in the washery (at the surface). She considers this a first step before asking for similar tests among the miners.

The physician appears not to trust the independence and seriousness of the laboratory that usually advises the mine (Red-Cross laboratory), and chooses another (laboratory of the Commissariat à l'énergie atomique, a nuclear facility in nearby Pierrelatte). This she does in spite of the Peñarroya national doctor in chief (médecin-chef) Jean Meiningier's strong reluctance for her to do so.

However, the real conflict comes a few months later, when the doctor in chief secretly asks the laboratory to send him the results of the tests, and then writes out a collective and individual analysis of the results which he then sends to the mine director. This analysis is clearly aimed at euphemizing the lead hazard in the mine; also, the doctor discloses all individual results, in breach of the principle of medical confidentiality; finally, all this is done without at any moment informing the occupational physician, who discovers this later on when inquiring on the belatedness of the test results.

Other conflicts occur in the following years. For example, Suzanne Blanc decides to stop sending lung x-rays to the general practitioner that works for the mining health insurance, because she knows he sends detailed reports of individual worker health to the director of the mine. As retaliation, this GP files a complaint in front of the local medical jurisdiction (Ordre départemental des médecins) for « non-confraternity » or « non-peer to peer relationship » (non-confraternité), and this complaint is followed and she receives an official warning.

Finally, she is sacked from the mine's surveillance in 1978, on grounds of « creating an atmosphere of suspicion within the company ». She is replaced by one of her former colleagues, who accepts to become the new in-house doctor for the mine. She refuses to give the key to the
closet where she keeps the medical files of the workers, because she wishes to take away any confidential information from them that they could have given her, however they do not let her in the mine's office anymore. But finally, it is the local « medical inspector of the mines » that helps the employer get a court decision allowing him to break into the closet, and give the medical files to the successor of Suzanne Blanc.

In all these conflicts, one can see that the occupational physician must deal mainly with other physicians. The legitimate jurisdiction of occupational medicine is an everyday struggle with other doctors, and especially against other doctors, who wish to confine the occupational doctor to certain specific tasks.

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In conclusion, this study of occupational doctors in France shows that autonomy should be defined not only as the control over routine work activities, but also as the ability to decide what makes up routine, or in other words, what tasks one can legitimately carry out in connection with a given professional mandate. The autonomy of occupational physicians is curtailed when management succeeds in imposing a large conception of what is « organizational » in the doctor's work ; when there is a collective negociation on what the legitimate definition of the job should be ; and when certain doctors use their power on occupational doctors to keep them confined to a limited spectre of tasks.

Bibliography


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