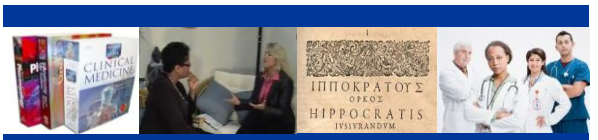
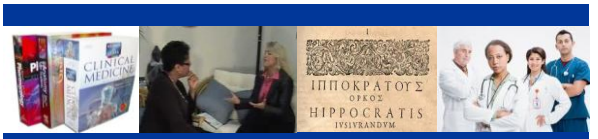


PROFESSIONS, POWER AND TRUST

Sara Shaw

When you have completed the reading and participated in the taught components for this week, we hope you will be able to….

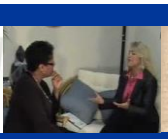
Outline the main approaches to understanding and analysing the role of the medical profession in healthcare



3 main areas:

1. Historical development of a medical profession
2. Key concepts: deprofessionalisation, proletarianisation, countervailing powers
3. Taking stock and reflecting on the clinical relationship

And then a brief introduction to discourse analysis




1: Historical development of a medical profession

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Pre-professionalisation
(18th century)

- Unregulated
- No collective entity
- Competence variable
- Free-market in healing
- Patients judgements based on face-to-face encounters


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Professionalisation
(mid-19th century onwards)

- Increasing organisation of society and of medicine
- Individual doctors increasingly incorporated into professions, institutions and bureaucracies
- Organised university training for doctors, with limited access by the wealthy elite
- Definite social and cultural relations to civil society and the State




Reinforcing medical profession
(twentieth century onwards)

- **Scientific** – gatekeepers for pharmaceuticals, use of technologies, surgical advances (e.g. transplantation)
- **Religious** – doctors 'secular priests', assumed to be altruistic
- **Political** – professionalism advocated as antedote to capitalism ('standing over against markets'), NHS development in the UK

NHS NHS NHS NHS

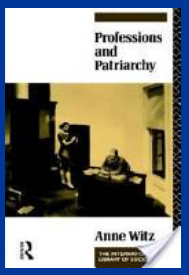
Beyond medicine, e.g.

Health visiting:

- transition of informal, voluntary 'sanitary mission' workers into more formalised, credentialised, health visitors (e.g. Dingwall, 1983).

Nursing:

- long history seeking to establish an autonomous area of competence within health care (e.g. Witz 1990, 1992)



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What is a 'profession'

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An (ideal) 'profession'

- Use of skills based on theoretical knowledge
- Education and training
- Competence ensured by examinations
- Code of conduct
- Public service
- Professional association

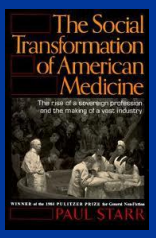
Medicine's authority over others

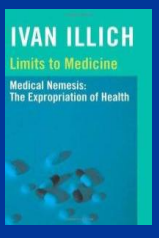
- **Social authority** i.e. medicine's control over the actions of others through giving commands
- **Cultural authority** i.e. the probability that medical definitions of reality and medical judgements will be accepted as valid and true

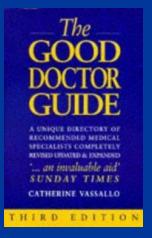
Legitimated control that an occupation exercises over the organisation and terms of its work

- **Economic** autonomy (e.g. control over pay)
- **Political** autonomy (e.g. re shaping policy)
- **Technical** autonomy (e.g. setting standards)

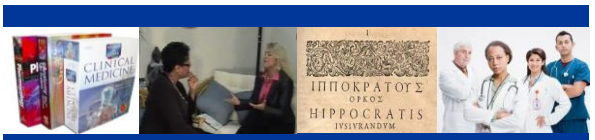
An emerging view of medicine as a 'dominating profession'







"*By the 1970's…historical and contemporaneous evidence indicated that the medical profession was a kind of self-serving monopoly operating within protected markets*" (Light, p270)



2: Key concepts

deprofessionalisation
proletarianisation
countervailing powers

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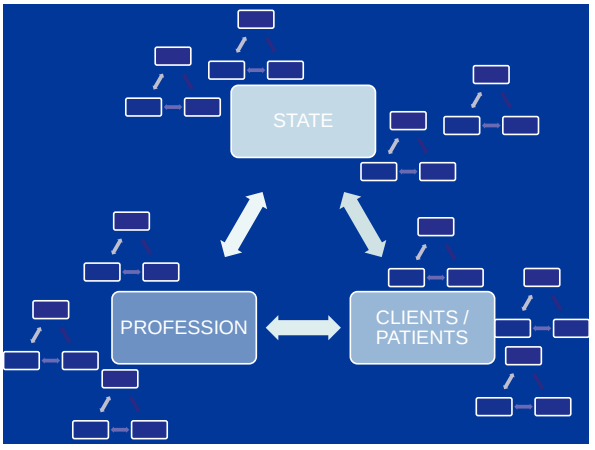

DEPROFESSIONALISATION

'*a loss of professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients*'

Haug MR (1973) Deprofessionalisation: an alternative hypothesis for the future, *Sociological Review*, Monograph, 195–212.

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Medicine's professional status has been undermined by...

1. A general trend of rationalisation and codification of expert knowledge
2. Diminishing knowledge gap between doctors and service users has diminished
3. More critical public attitudes that challenge to clinical autonomy

1. Rationalisation of medical practice


Social Science & Medicine

Disciplined doctors: The electronic medical record and physicians' changing relationship to medical knowledge

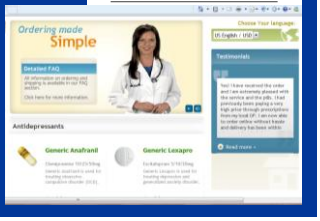
The EMR is powerful…not only because of its technical efficiency but also because of its ideological effects…it changes doctors' relationship to medical knowledge in such a way that doctors' understanding of their professional roles become consistent with their subordination to bureaucratic authority' (p1021)

2. Diminishing knowledge gap

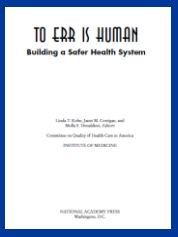
- Rise of social movements
- Emphasis on consumer preferences
- Expert patient
- Role of industry / media


Health consumer groups in the UK: a new social movement?

Judith Allsop, Kathryn Jones and Rob Baggott



3. Challenges to clinical autonomy

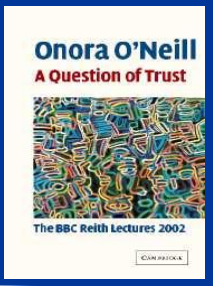


Government Academia Media

A crisis in public trust?

Reputations and performance increasingly doubted, but

- Are professionals less trustworthy?
- How good is the evidence for a crisis?
- Do systems of accountability and transparency remedy any crisis?



PROLETARIANISATION

'the decline of medical power as a result of deskilling and the salaried employment of medical practitioners'

McKinlay JB and Stoekle JD (1988) Corporatization and the social transformation of doctoring, *International Journal of Health Services*, 18(2): 191–205

Medicine's professional status has been undermined by…

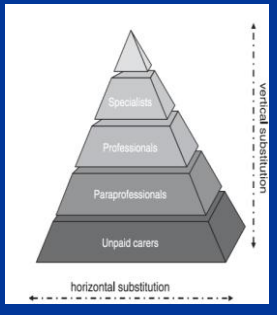
1. Shifting occupational boundaries
2. Loss of economic independence
3. Development of managerialism and the requirement to work in bureaucratically organised institutions under the control of managers

1. Shifting occupation boundaries

Traditionally maintained professional dominance through:

- Subordination of other workers
- Restricting the occupational boundaries of other workers
- Exclusion, by limiting access to registration
- Incorporation of work of other disciplines into medical practice

1. Shifting occupational boundaries



- shortage of GPs
- medical roles usurped by nurses and AHPs
- development of specialist roles (e.g. GPSIs)
- less influence over the professional registration and roles of other groups

Loss of independence


Salaried Doctor

Vol 3, No 3 July 2006

Official magazine of the Australian Salaried Medical Officers' Federation, Industrial Organisation of Employees, Queensland

- Independent contractors to 'wage labourers'
- Steady increase in salaried positions

- Managing budgets
- Commissioning healthcare
- GP 'elite' (e.g. fundholders, CCGs

2. Loss of (GP) economic independence?

3. New managerialism


SOCIOLOGY OF HEALTH & ILLNESS

Review article
The impact of management on medical professionalism: a review

Dino Numerato[1], Domenico Salvatore[2] and Giovanni Fattore[3]

- Search for more effective and efficient heathcare
- Mix of hierarchical discipline and market incentives'
- Increased managerial 'control'
- Monitoring professional behaviour

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How robust are these concepts?
Is medicine deprofessionalised and/or proletarianised?

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Review

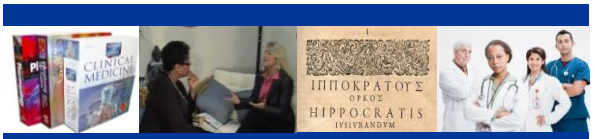
- Are reports exaggerated? What's the evidence?
- Is this really a decline in medical dominance?
- How international are studies? And how relevant are debates to other countries/settings?
- How relevant are concepts outside of specific medical settings (e.g. general practice, hospital medicine)?
- Are sociological concepts of 'medical dominance' and 'professional autonomy' adequate for robust empirical research?

Health-Care Professions, Markets, and Countervailing Powers

Donald W. Light, University of Medicine and Dentistry of New Jersey

- Role of markets key (but still US/UK focus)
- Self interest, self-commercialisation and business enterprise
- Corporate co-option
- 'New Professionalism' based on accountability and value

Professions as marketed and colonised



3: Taking stock

Summary

Major changes ARE taking place in healthcare systems and in medical power and authority

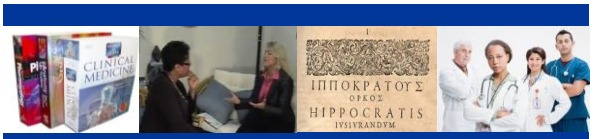
There IS common ground between those advocating proletarianisation, deprofessionalisation and countervailing powers

NONE appear to offer a complete picture of the medical profession

ALL appear to claim "….*that medicine is finally falling victim to general social trends affecting all occupations*" (Elston p62)

Shaping the clinical relationship

- Different types of doctor/patient relationship
- Tendency to view strongly directive or paternalist approaches as 'old fashioned' and the more equal partnership approaches as modern.
- But range of preferences exist: from a directive, 'doctor knows best' model through to a completely consumerist , self-determined model where the patient relies on their own resources to make treatment decisions.
- People's preferences about consultation style are not static



Virtual seminar - discourse analysis

Describe what discourse analysis is
Search the literature – briefly describe one study that uses discourse analysis
Two bullet points on how you think the study has – or has not – enriched your understanding of health and illness

Some characteristics of qualitative research

- A search for meaning rather than measurement
- Interested in 'how' and 'why' questions
- Has flexible research strategies
- Tries to engage with and explore wider influences rather than 'controlling' them out of a study
- Inductive rather than deductive reasoning
- Is 'naturalistic' – studying phenomena in their natural environment

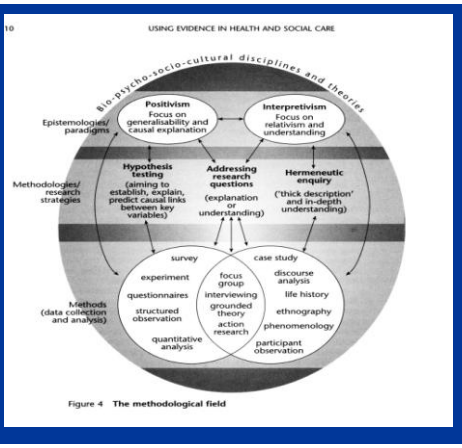


Figure 4 The methodological field

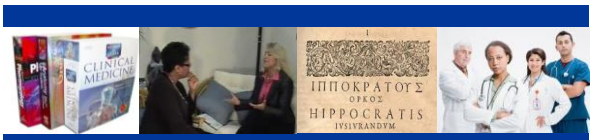
Example of a DA study


communication

Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications

Four categories of patient talk contributing to misunderstandings

- pronunciation and word stress
- intonation and speech delivery
- grammar, vocabulary and lack of contextual information
- style of presentation



Virtual seminar

- Read paper by Shaw and Bailey
- Prepare/post brief summary

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