## Title: Understanding medical profession in changing health care

Author: Pravinkumar Ruprao Shirsat,

Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

***Abstract***

*The acquisition of the professional status is through a rigorous process of professionalization. Medical professionals have contributed to the code of profession to strengthen the status and the professional autonomy. The entry of the capital in the health care delivery has changed the orientation of the profession from altruistic to profit making questioning the very basis of formation of the medical profession. The market in playing a key stakeholder in determining the space of medical profession in changing health care. More organised capitalistic health ventures are having implications on the autonomy of the medical profession.*

**Introduction**

Professions have always had an important space in society and were conceived to be selected body of occupations (1). Essentially among the myriad of occupations some could establish value around its functions and gain status of profession. However, value of different occupations varied across time. ‘During the ancient Greek era, when manual labour was considered demeaning and acquired a secondary status to contemplation, work did not lead to acquiring social status. In modern times, when work became the central human activity, occupations acquired importance, particularly during and after the industrial revolution’ (2). During pre-industrialization period occupations were judged based on their contributions to the good life and their effect on the service provider (1). The essential component of this understanding was more precisely related to the social status and the freedom to choose one’s life the way s/he wants to live. However, obtaining such position was not easy, it required complete freedom to act and right of exclusive evaluation of activities of production in the domain of occupation. The occupations which could secure this freedom and right became professions and gained significant importance in the public life.

The freedom and right of occupation primarily operate in the social sphere and then extend into legal domain. The award of such status is attributed to the importance of the services delivered by the profession. T H Marshell observed, “The professional man, it has been said, does not work in order to be paid: he is paid in order that he may work.” (1 p. 325). Thus a professional is not seen as someone engaged in pursuit of personal profits, rather a person acting on his sense of righteousness (1 pp. 329-30). This is particularly true about professions such as medicine; society has a different view of looking at this profession; the essential part of it is that, medicine is for the benefit of human kind and is used to save life. Thus medical profession is perceived as being altruistic (3; 4).

**Understanding medical profession and its autonomy**

Medical profession uses the virtuous image to demand complete autonomy, and thus assumes full accountability of the professional acts. This monopolization is a result of authority over knowledge, legal sanction, regulating entry, trainings, and setting the standards. This exclusive control over the aspect of work is understood as professionalization, the process through which occupations excel into professions. Exclusive right in the domain of profession is associated with moral responsibility to act in the interest of society. A professional person assumes dual responsibility, one is functional and the other is moral. A professional is a person having legitimate claim on a repository of abstract knowledge which is acquired through a formal system of training. He/she is also identified through moral obligation of the profession. Thus in case of profession delivering the services is not merely a physical or cognitive process, but also is about morality, ethics and power. The person who is expected to act in such a manner indeed needs to have social status.

Freedom to take independent decisions requires autonomous power, this in turn requires a status position. No one would put her/his trust in a pauper, a man who has no future and freedom; trust requires a degree of reputation in the society (1). A patient puts her/his trust in the doctor hence the doctor needs to be a man of repute, a person who can be trusted. To build on the trust it is crucial for the professional to demonstrate that her actions concur with the right virtues. In the process of professional service delivery the trio (profession, client and society) engage in a mutual understanding to grant the authority and freedom demanded by the profession (5). Because of these two features profession gets entrusted with colossal power. However this power is not unconditional but is assigned with self-accountability. The indicator of the profession is the esteemed position it acquires by assuming mystic knowledge, autonomy, and high moral accountability. Each prerogative comes with a responsibility to deliver, in our case the responsibility of the doctor is to deliver in the interest of the patient and to build a trust with the patients. In this fiduciary relationship the professional holds the power position. The esotericism associated with the process of treatment gives commanding position to the professional, the client of a doctor have no control over the process of treatment and is supposed to comply with the doctors prescriptions.

The code of honour and service are key factors to maintain such relationship and the status of the profession. According to Wilensky, “the degree of professionalization is measured not just by the degree of success in the claim to exclusive technical competence, but also by the degree of adherence to the service ideal and its supporting norms of professional conduct” (6 p. 141). The professional acts are assessed by devotion of a professional to a set of those moral norms that characterize profession. These norms command technical and the virtues aspect of the esoteric knowledge and its application (6)**.** Such norms do not really exist in the organization of service delivery of craftsman, although he has a set of skill and knowledge acquired from formal schooling one factor that differentiates between occupation and profession.

The nature of function of medicine is such that, medical acts are not carried out by the medical professional alone, it needs a formal set of delivering services such as nursing, and other support functions available in the hospitals. The professional ideals and norm of the medical profession thus embrace all the allied functions associated with delivery of medical services. This increases the arena of the rules of the medical profession to other people who have a direct stake in the process such as the profession of nursing, physiotherapy. Therefore a set of code of conduct is also required for the formal centres of health care delivery. Thus the jurisdiction of medical norms gets extended to all the components of a hospital or any service delivery centre. And these norms gives a higher status position to the doctor among all the service providers in the scheme of health care. Freidson recognized this status position as autonomy (7). According to Cruess, ‘After identification of the role of the service in the maintenance of the society the professions are granted a considerable degree of autonomy, status, prestige and substantial rewards on the assumption that professionals would be altruistic and moral in their day-to-day activities’ (5). The function of society here is to accept the function of medicine as crucial to the functioning of society. This acceptance is granted by providing certain prerogatives typically the autonomy. Sullivan emphasizes the link between professionalism and social contract, stating that “social contract became the moral basis of professionalism” (8 p. 673). For Friedson, autonomy becomes the central criteria of profession. He pointed out that, ‘in America the free market has little relevance when it comes to health care. The health care is controlled by the health professionals and it is upto to their discretion, that how much of health care the client will consume. The client is not free to decide what services he requires’ (9).

The process of professionalization culminates into a status position. Once this status is acquired then what the working professionals do is typically their own prerogative, the way they do it, and the technical criteria by which that work is organized and evaluated, remain in the domain of the professions.

Even though the medical profession is perceived as altruistic, some of the scholars have pointed out that all these efforts are directed towards economic end. Accordingly after going through this process a profession gets empowered to protect itself from external market threats (3; 10). The whole process of professionalization accordingly is a concerted effort to gain market control and lock in monopoly powers by recruiting the state to its cause (11). Wilensky brought the issue of market and economic interests as well. According to him ‘taking control, eliminating competition, securing positions in the marketplace using external factors such as technological advancement are the key drivers to create medical profession’ (6). But these two issues are not mutually independent, to control market, autonomy is essential. What primarily drives the process of professionalization whether autonomy or the market control could be a matter of debate. The patient, however in any case is not in a position to take rational decisions because of the esoteric nature of the profession. Along with that, there is an emotional dimension of pain associated with the problem that will also stop the patient from taking a rational decision to an extent. In such situations apparently market will be controlled by those who are providing services. Service providers’ control on both economic and social domain ensures the right of the fraternity to decide on the ethical and moral dimension of their actions. The affairs of the profession get controlled by professional’s own conscience thus shrinking societal role in judging professional acts. This gives sanctity to the medical work.

The code of conduct that the profession develops derives from its social milieu. There is an element of negotiation between the professionals and the society. Hence it is not always true that professional matters are internal to the body of the profession, but rather professions are shaped by the social-cultural and political factors (12). Further, in all these explanations, the crucial actor, ‘the consumer of the professional services, does not seem to be driving or playing a major role.

Important source of power for the medical profession is its relationship with the patient. As discussed earlier, the nature of this relationship is fiduciary; the responsibility is on the doctor to act rationally and ethically. The patient does not have an understanding of the complexity of the profession. The patient is sick and vulnerable and not in the position to make any judgement on the processes he is undergoing, she thus surrenders herself to the doctor. The patient understands that the purpose of the doctor is to restore and maintain health, this understanding result from the values and virtues that the medical profession professes. The most difficult part in restoring health of a client is the correct diagnosis of the ailment. This is the only profession where the diagnosis of the problem is done by the professional and not by the client. The fact that both diagnosis of the ailment and its successful treatment is done by the doctor bestows immense power and authority to the profession. Such authority places the doctor at the upper ladder of the society (13; 5). Apart from the client’s inability to understand the profession, the self-accountability position taken by doctor adds to her authoritative position. The profession convinces the society of its value to gain social and political support (7). Profession derives its power from the services, deemed essential, that it renders.[[1]](#footnote-1)

Being crucial to the profession, authority is guarded by the fraternity strongly and any intrusion into this relationship that questions the doctor faces strong protest from the fraternity of professionals. Ritzer observed, ‘any attempt to guide values of profession by external agencies creates a conflict of interest between the profession and the force dictating the values’ (Ritzer & Source, 1988). There are possibilities of conflict in the bureaucratic system where authority is vested in the position of power, which might not necessarily be a medical professional, generally in the government system. In such cases there is often resistance from the profession. But medical profession, over a period of time, has positioned itself in such a way that it has potential to thwart such intrusions. The key strength of this profession is its agility. This profession is highly agile towards technological, social, ideological, and economic change. Such agility helps it in managing external power structures. The profession has moved from magico-religious to the scientific nature and has successfully adopted the capitalist mode of functioning. This quality has made it possible for the profession to occupy almost every area of medical activity. Such activities are ‘distribution of services, allocation of costs, assessments of quality, recruitment into medical work, organization of care, ethics of practice, the traditional medical view is that these matters are to be decided solely by doctors’ (14).

In protecting the personal interest the profession of medicine has seldom failed to adhere to the highest moral principle that it has claimed. However, it kept on enjoying the social status accorded to the profession on the grounds of the very same moral standards. As a result professional autonomy has been put to scrutiny and has often faced challenges (15). Social scepticism has resulted in compromising the power of the profession and has reduced its autonomy; a commonly discussed example is General Medical Council (GMC) in England (Cruess et, al. 2000). The similar scepticism and repeated challenges to authority was faced by the profession in United States (US) also. The US example enlightens us about the social implications on the authority of the profession and that it is not absolute. The Social change corresponding to the economic development has also contributed in challenging the authority of physicians. During 1980’s in US when consumers started comparing and choosing the services they became autonomous in choosing doctors also; accelerated consumerism led to the erosion of trust relationship between doctor and patient (16). Change in social norms also contributed in challenging professional hegemony. The case of homosexuality and the debate between the American Psychological Association’s understanding of homosexuality and the society to accept it as sexual preference instead of a disease deserves special mention in this aspect (17). The prevailing social norms and the understanding between society and the profession is crucial in maintaining autonomy. Failure to act in accordance with the norms could result in loss of autonomy. Therefore how the society thinks and on what principle it is operating is critical to maintain the autonomy for the medical profession. The US experience implies that the autonomy of the profession is not immune and absolute, it is dynamic and corresponds to the external political and social environment.

### **The new change and salaried class in the profession**

In recent past the health care delivery system has gone through tremendous changes in most part of the world. Navarro pointed out that, ‘the world is witnessing conflicting ideas of perception of medicine by the society and the professionals along with a change of the medical field in terms of alliances with forces within the medical profession and the market. The situation is resulting in commodification and corporatization of medicine and emerging as a threat to the well-being not only of the people but also of physicians’ (18). Individual professionals are merging or acquired by the corporations. The private sector hospitals are luring the government doctors with attractive higher pay scales and an open system of consultancy; experienced specialists too are moving away from the public sector to private (19). More and more medical practitioners are willing to give-up their individual practice to join hands with capitalist ventures and work as salaried employees (20). This dimension is strengthening the private market of organized health care. Professionals are aiding this growth by either merging or metamorphosing in multispecialty entrepreneur venture with high end health care. It is not only the interaction between buyer and seller that is promoting this growth, rather it is a complex set of relationships between profession, corporations, and the state in which each party is striving to achieve its goal by building new associations in the market space. In this development the medical professionals have an important role to play (20). The professional association and individuals are finding opportunity to serve their personal interests. But how does this growth serve the medical professionals? One view suggests that health care is becoming the domain of managers, and the doctors are losing their autonomy. Whereas another view indicates that medical professionals are party to this growth and are consolidating their position in this new era of health care. If we consider the hypothesis of salaried class loosing their autonomy to the market forces to be true there should have been resistance from the doctors to these hospitals and to the growing privatization. Instead more doctors are joining such hospitals. So the question is whether the professionals are ready to compromise their autonomy for some gain. If we have a look at the history of the profession it does not seem to be true. In fact any blow on the autonomy of the doctors has faced a serious resistance.

The British doctors in England first oppose to the NHS and in later time they also opposed privatization this is a classic example of such resistance (18). Being salaried or non-salaried the professionals have always resisted any threat to the autonomy and social status of the profession. At times the profession is found to be making some compromise but not to the extent that would surrender the autonomy of the profession. However the present economic system is changing this equation and simultaneously nature of the medical profession. Zero resistance, from the medical fraternity, to the growth of corporate health care is indicative of some mutual purpose being solved with this alliance.

This leads us to think about the new dimension of private sector's growth and its impact on the profession. To further understand this we need to see what the corporations and the professions are bringing to the table. Primarily it is capital by the corporates and skill and knowledge by the professional. The corporates with their capital have injected need for infrastructure and high end technology for health care. The most important is the technology of diagnosing the disease which is expensive and difficult to employ for an individual. In the shifting health care scene the most difficult task of diagnosis is taken up by technology. This technology has come as a boon to the doctors. Even though it has posed a new challenge to the doctor-patient relationship, by making it easy for the patients to understand the complexity of the medical practice, it has hugely strengthened the medical profession. With the introduction of expensive sophisticated technology the most difficult task for the doctors has been made easy, thereby increasing the chances of success in diagnosing and treating patients. But this expensive technology is not in the reach of every physician, individual practitioners cannot afford to establish them. For success the doctors in today’s time need this technology and therefore the doctors aspire to work with such advance technologies.

Installing such advance expensive technology is capital intensive and is not possible to be established in individual capacity. In such a situation capitalist ventures come to the rescue of doctors. The capitalist enterprise can afford these technologies and large bureaucracies can manage them. To gain access to these technologies doctors are even prepared to subordinate themselves and work as employees of these organizations. But on the other hand, the high price of these technologies puts pressure on the capitalist venture to generate returns. This enhances the role of administrators in the decision making process which was initially only the domain of doctors (21). However it was not the case in the past, the physician owned (simple) technologies, or else had ready access to simple technologies in hospitals owned by fellow physicians, now that is less the case (22). The technology is getting complex, expensive with institutional ownership.

The capitalist bureaucratic system is shaping the profession by creating the new structure of capitalist bureaucrats’ and physician complex. Within large-scale corporate hospitals, chains, Heath Management Organizations (HMOs), etc., the power of professional managers is rising (23). In their quest to maximize profits, these managers are committed to a full-scale formal rationalization of their procedures. The procedures that were done by the doctors are now delegated to paramedical staff, standard treatment protocol and investigation protocol are being introduced. This rationalization has a profound effect on physicians, especially if they are employed by a hospital (24 p. 191). As members of these rationalized hospitals, physicians are forced to work more efficiently, quantify many hereto qualitative elements of their work (Starr 1982), operate in a predictable manner from one time to another, utilize advanced technologies as much as possible, and allow themselves in an increasing number of domains to be replaced by non-human technologies, and submit to external control, often by superiors who are business people rather than fellow professionals (22).

Freidson observed, “When one elite formulates the standards, another elite directs and controls, and other professionals perform the work, something important has happened to the organization of the profession as a body and to the relations between its members which may have serious implications for its corporate character in the future” (25 p. 17).

**Conclusion**

This alliance of doctors and capitalist has put the patient in a more vulnerable situation to surrender to two authorities: doctors as well as administrators. Professional and patient relationship now takes place in an organizational context which is moulding the classic doctor- patient relationship (26). No services are delivered free and the doctors have no say in the fee structure. Given the bureaucratic delivery systems for professional services, the patient is faced not only with the authority of the professional as a practitioner, but also as an administrator, armed with the regulations and rules of the institutional setting. At the same time, the professional herself is limited by the organizational milieu in which she works (15). The emerging private health care market where the doctors are employed by big corporate firms could result in to moral dilemma for doctors, apparently having implications on their professional autonomy. The private healthcare market operates in the environment of information asymmetry between the provider and the client. The patient has little idea of what is being prescribed and what is being consumed, even if the patient has an idea, she does not have control on the decision about how much and what to consume. The decision rests with the provider; the principal-agent problem is always present in health care delivery. When the services are delivered though corporate health care delivery services (whose goal is profit making) this problem manifests even more and results in a dilemma for doctors. The doctors delivering their services through such a system assume dual responsibility: first is the fiduciary relation to the patient; and the second towards the firm. This raises a question on the autonomy of the doctors within such a set-up and whether the domain of control for the doctors is shrinking, and whether this alters the idea of the profession.

# References

1. *The Recent History of Professionalism in Relation to Social Structure and Social Policy.* **Marshell, T H.** s.l. : The Canadian Journal of Economics and Political Science, 1939, The Canadian Journal of Economics and Political Science, pp. 325-340.

2. **Ardent, Hannah.** *Human Condition.* Chicago : Unniversity of Chicago Press, 1998.

3. **A.M. Carr Saunderes, P A Wilson.** *The Professions.* Oxford : Clarendon Press, 1933.

4. **Parson, Talcott.** *Eassay in Sociological Theory.* US : Free Press, 1949.

5. *Professionalism: a contract between medicine and society.* **Sylvia R. Cruess, Richard L. Cruess.** 2000, JAMC, Canadian Medical Association, pp. 667-69.

6. *The Professionalization of Everyone?* **Wilensky, Harold L.** 1964, American Journal of Sociology, pp. 137-158.

7. **Freidson, Elliot.** *Profession of Medicine.* New York : Harper and Row, 1970.

8. *Medicine under threat:professionalism and professional identity.* **Sullivan, William M.** 2000, CMAJ, pp. 673-5.

9. *The Centrality of Professionalism to Health Care.* **Freidson, Elliot.** 1990, Jurimetrics Vol 30 No 4, pp. 431- 45.

10. *Professional Autonomy and Revolt of the Client.* **Marie Haug, Marvin Sussman.** 1969, Social Problems, pp. 153-61.

11. **Light, Donald W.** The Medical Profession and Organizational Change:From Professional Dominance to Countervailing Power. [book auth.] Peter Conrad and Allen Fremont Chloe Bird. *Handbook of medical sociology 5th edition.* s.l. : Prentice Hall, 2000.

12. *The Study of Medical Institutions : Eliot Freidson's Legacy.* **Sydney Halperan, Renee Anspanch.** 1993, Work and Occupation, pp. 279-95.

13. *A Re-Examination of the Hypothesis of Physician Deprofessionalization.* **Haug, Marie.** 1988, The Milbank Quarterly,, pp. 48-56.

14. *The Changing Structure of Medical Practice.* **Mechanic, David.** 1967, Law and Contemporary Problems,Vol. 32, No. 4, Medical Progress and the Law, pp. 707-30.

15. *1975 NCSA presenditial Address The Deprofessionalization of Everyone?* **Haug, Marie.** 1975, Sociological focus, pp. 197-213.

16. *The Continued Social Transformation of the Medical Profession.* **Stefan Timmermans, Hyeyoung Oh.** 2010, Journal of Health and Social Behavior, pp. 94-106.

17. *Homosexuality and the medical profession: A behaviourist's view.* **Bancroft, John.** 1975, Yournal of medical ethics, pp. 176-80.

18. *Professional Dominance or Proletarianization?: Neither.* **Navarro, Vicente.** 1988, The Milbank Quarterly, pp. 57-75.

19. *Medical Tourism in India: Progress or Predicament?* **Sunita Reddy, Imrana Qadeer.** 2010, Economic and Political Weekly, pp. 69-75.

20. **Lefebvare, Bretrand.** Bringing world class health care to India, The rise of corporate hospitals . [book auth.] Alain Vaguet. *Indian Helath Landscpae Under Libralization.* Delhi : Manohar, 2009, pp. 83-99.

21. **Watts, Sheldon.** *Disease and Medicine in World History.* London : Routledge, 2003.

22. *Rationalization and the Deprofessionalization of PhysiciansAuthor.* **George Ritzer, David Walczak Source.** 1988, Social Forces, Vol. 67, No. 1, pp. 1-22.

23. **McConnell, Charles R.** *The Health Care Supervisor: Effective Employee Relations.* Canada : Aspen, 1993.

24. **Ritzer, George.** *Exploring in Social Theory: From Metatheorizing to Rationalization.* London : Sage, 2001.

25. *The Changing Nature of Professional Control.* **Freidson, Eliot.** 1984, Annual Review of Sociology, pp. 1-20.

26. *Healing relationships and the existential philosophy of Martin Buber.* **John G Scott, Rebecca G Scott, William L Miller, Kurt C Stange, Benjamin F Crabtree.** 2009, Philosophy, Ethics, and Humanities in Medicine, pp. 4-11.

27. *The movement towards the professionalisation of medicine.* **Waddington, Ivan.** 1990, BMJ, pp. 668-90.

28. **Sokolowsky, Robert.** The fiduciary relationshi and the nature of professions. [book auth.] Robert MVeatch, John P Langan Edmund Pallegrino. *Ethics trust and the professions Philosophical and cultural aspects.* USA : Georgetown unversity press, 1991, pp. 23-43.

29. **Starr, Paul.** *The Social Transformation of American Medicine.* New York : Basic Books, 1984.

30. *The Reorganization of the Professions by Regulation.* **Freidson, Eliot.** 1983, Law and Human Behavior, pp. 279-90.

31. *The Prospects for Health Services in the United States.* **Freidson, Eliot.** 1978, Medical Care, Vol. 16, No. 12, pp. 971-83.

1. any service connected with the maintenance of public health and sanitation including hospitals and dispensaries is deemed essential in India by Essential Services Maintenance Act 1981 [↑](#footnote-ref-1)