UNIVERSITE CATHOLIQUE DE LOUVAIN

Socio-économie de la santé

Which are medical doctors' opinions about their profession after the changes in the health system ?

Deliège Denise

Professor at the Catholic University of Louvain – Belgium

An extended version of this paper has been published as follows :
Deliège D, *Des médecins parlent de leur métier, Cahiers de Sociologie et de démographie médicales,* Paris, octobre-décembre 2004, 44(4) : 443-506.

ESHMSS – SISS International Joint Congress
European Perspectives on Changing Health Systems –

Bologna 2-4 September 2004

Ecole de Santé Publique - Clos Chapelle-aux-Champs 30.41 - 1200 Bruxelles
Tel. : 32/2/764.30.99 Fax : 32/2/764.31.83 Email : deliege@sesa.ucl.ac.be

1. New paradigms regarding the medical profession

The paradigms regarding the health system have drastically evolve since half a century ; they pertain to : a) life, health and illness b) the patient and its relations with medical doctors, c) the medical profession and d) the terms of practice. The main changes are displayed in table 1 (see next page).

2. A survey about Physicians' views regarding their practice

Considering such a radical evolution, which are medical doctors' opinions about their profession nowadays ? *Inter allia*,

- Do they consider the "medical charter" to be in danger ?
- Is Herzberg's theory about factors of satisfaction confirmed ?

2.1. Method

Analysis of medical doctors (MDs)' spontaneous comments at the end of a postal survey regarding their career and difficulties encountered. In 1999, 5 546 French speaking MDs in Belgium were contacted (all those settled since 5 to 10 years or since 15 to 20 years) ; 2040 answered, 862 provided extra comments about their career and also about their feelings regarding the professional life ; the latter theme had not been included in the main survey.

The comments were analysed through a qualitative analysis. First, a hierarchy of themes was drawn by two sociologists. Comments were then encoded and handled with QSR-Nudist software. While starting the encoding, 151 files, which were particularly complex, were encoded by two persons, for harmonising the concepts and the way of encoding.

2.2. Results

Results about the career have been analysed in a specific report [1].

Physicians who added comments were mostly practitioners providing mainly care (296 GPs and 396 specialists) ; a third category (170, i.e. 20%) were mainly performing other types of activities related to health (prevention, teaching, research, management, …) ; they will be labelled as "physicians outside care" (POC).

As expected, physicians who had endured many professional difficulties answered more frequently (OR 1.012) ; so did women and physicians having at least 3 children (OR 1.22 and 1.27) ; specialists were less represented (OR .76). Contrary to our expectations, younger GPS did not complain more frequently, in spite of the growing oversupply in their field ; neither did older specialists, in spite of the numerous changes among hospitals which occurred within the latest decade.

As expected too, complaints were more numerous than statements of satisfaction : at least part of the medical profession consider the work to be hard (onerousness), the overall context unfavourable (lack of collaboration, patients' requirements, bureaucracy, political interference) and the terms of practice uncomfortable (insufficient fees, lack of family- and private life). But, contrary to one of our hypotheses, complaints about the so-called "medical charter" were practically absent : hardly any mention of lacks about freedom of choosing a practitioner, free agreement regarding fees, freedom of options for therapy or professional confidence.

[1] Antoine L., Lorant V. et Deliège D., *Charge de travail et « mal-occupation » des médecins en 1998*, UCL-SESA, 2001, 86.

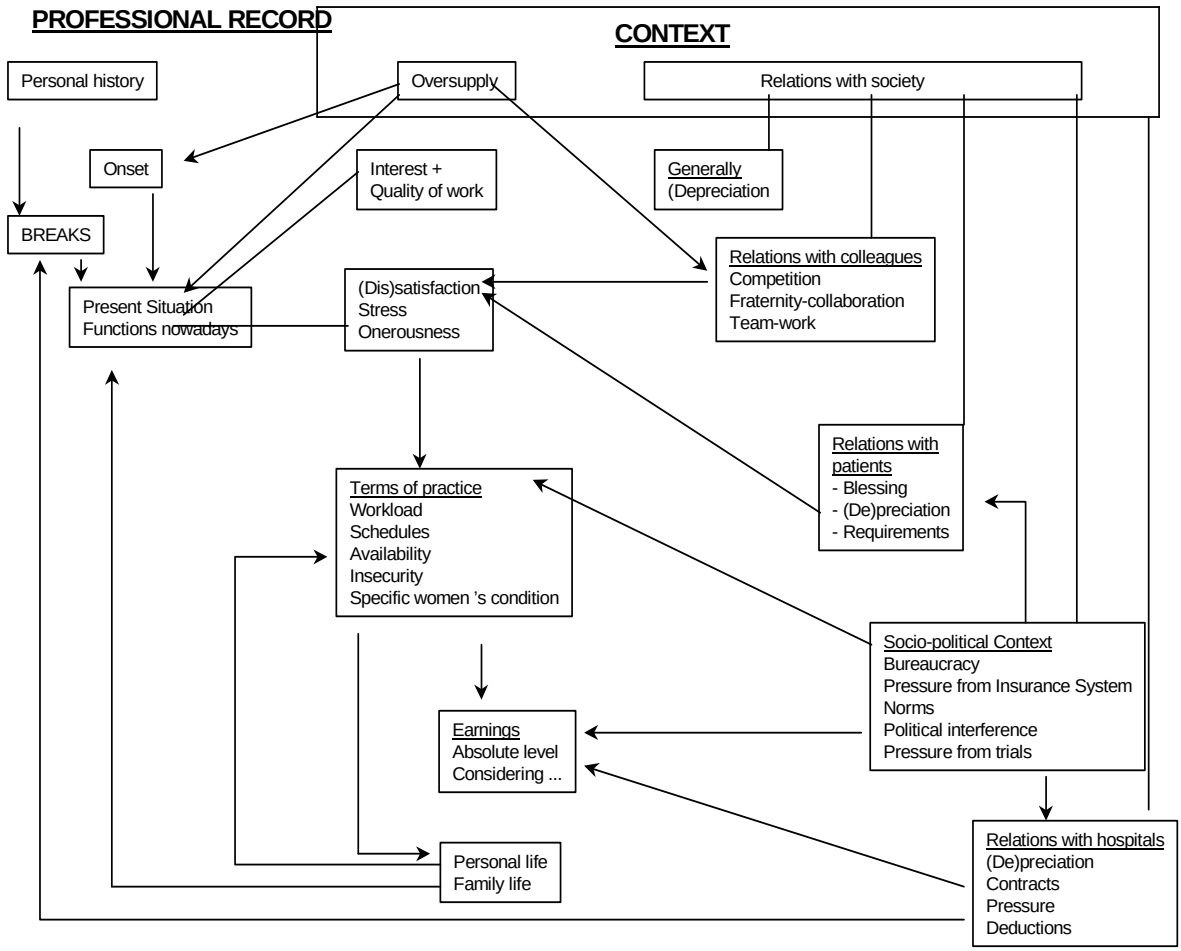
Table 1. REVOLUTION OF PARADIGMS PERTAINING TO THE PRACTICE OF MEDICINE

1. LIFE, HEALTH AND ILLNESS	
- Life is sacred	- Life may be controlled by people : abortion, right to die in dignity, euthanasia
- Health results from medical care	- Health also ensues from hygiene and socio-economic context
- Disease is considered in the context of a bio-medical model	- Disease is considered within a holistic system : bio- psycho- and environmental
2. THE PATIENT, RELATIONS WITH SICK PEOPLE	
- All medical services are good	- One should set objectives and look at results - Services are to be evidence based; discrepancies between utilisation rates should be justified - Medical doctors are responsible for their errors
- Any price is ok for Health (understood as medicine) ; physicians should thus obtain any budget required	- Medical care is costly and expenditures are growing quickly - Costs are heavy for patients, tax-payers and enterprises. - The budget is fixed by third parties, managing the system
- Everything should be granted for the patient	- A complex society has numerous requirements which all deserve attention
- Medicine can achieve extraordinary results	- There are real progresses, but also boundaries and failures.
- Medical doctors have a monopoly for providing care	- Non-physician clinicians become more numerous and obtain legal recognition, even for diagnoses and prescription. Non orthodox ways of practice are competing.
- The relation with the patient is bilateral	- Third parties interfere : hospital administrators, insurance managers, public authorities.
- The patient is ignorant	- The patient wants to be better informed and looks for data.
- The patient is passive; physicians impose on him/her	- The patient negotiates, and imposes his choices and values.
- The patient is trustful and grateful	- The patient is suspicious, requiring and becomes a pettifogger
3. THE MEDICAL PROFESSION	
- To be a physician, means having a vocation	- Medicine is a normal profession which is practised in a market
- This practice involves all required sacrifices	- Quality of life is also an important value
- The medical doctor is behaving for his patients' sake	- The physician also behaves for his own interests
- The profession is prestigious and provides good earnings	- The profession is depreciated ; it is badly paid, especially when the workload is taken into account.
- The profession is a field for males	- More and more women choose this profession.
4. THE TERMS OF PRACTICE	
- Professionals with self-employed status and autonomy for decision-making	- Status of Employee / Management by hospital administrators - Requirements of managed care (expenses control, bureaucracy).
- « Solo » practice	- Networks, group medicine, community services, team-work,
- The hospital was a shelter, then a place for alleviating suffering	- The hospital is also a firm.
- The spouse is responsible for secretarial tasks.	- The spouse has his/her own profession.
- The « medical Charter »	
. Freedom of choosing a practitioner	- Regional sectors of care, Teams sharing work, Gatekeeping - Patients' requirements / Managers' pressure,
. Freedom of options for therapy	- Compulsory guidelines / Control of MDs' amount of services
. Free agreement regarding fees	- Agreements between health funds and MDs' representatives.
. Medical confidence	- Budget fixed per sector ; sanctions in case of overspending - Confidence is shared by several practitioners and allied professions (nurses, secretaries, data managers, …) - Permit from a Health Fund is often required

Sources : see References

Whatever their type of activity, physicians provide comments about the same topics and with similar frequencies. Such topics are displayed in Fig.1

Fig.1. **Themes of the spontaneous comments**



In the presentation hereunder, we will focus mainly on a few differences between categories.

- General Practitioners

General Practitioners (GPs) more frequently mention the important role played by a few factors at the onset of their career (13% versus 7% or less). They also more frequently allude to an oversupply (10% versus 5%). However, other items appear much more often (about 25%) : terms of practice, poor income and poor quality of human relations, mainly with patients. Almost one out of four GPs also deplore hard repercussions on quality of life (versus 13% of the specialists and only 9% of the POCs).

- Specialists

Compared to other categories, specialists more often complain about stress, about lacks during the training (exploitation, poor methods and lacking courses) and defects within hospitals (unethical marketing, business minded, unfair contracts, excessive levies, …).

- Physicians outside care (POC).

POCs more frequently state a reason for being satisfied, mainly about a domain of special interest or (this was unexpected) a feeling of freedom (32% versus 17%). Opposite, their complaints are less frequent (42% instead of 70% in other categories) ; a lower frequency can be noticed in most fields : the overall feeling of dissatisfaction and loss of prestige, complaints about income, onerousness, workload, bureaucracy, human relations, low quality of life and State policy !

- Herzberg's theory : only a partial confirmation

In accordance with Herzberg's theory, aspects of the content of work are frequently mentioned as a source of satisfaction and most complaints pertain to the "hygiene factors". But, opposite to his theory, hygiene factors also induce satisfaction : they form about half of the reasons of satisfaction and a few are even mentioned as effective motivators (e.g. money) ; as to the "quality of work", i.e. an aspect of content expected to be a motivator, it has yielded many more complaints than positive comments.

2.3. Discussion

♦ The Medical Charter

The themes of the medical charter were previously very important in MDs' discourse ; nowadays, either they are not as toppled as expected or they enter in conflict with worries more down to earth.

♦ Herzberg's theory

In our analysis, we took all the positive comments into consideration ; they do not always reflect a large satisfaction, so that the extension might have exceeded Herzberg's concept of motivator
Herzberg's theory might not be universal ; values vary among personalities ; those who provided free comments in our survey have endured more difficulties and might be more prone to be satisfied with compensations. But people might also have different ways of thinking : money may really have become a larger motivator than previously.

♦ POCs' high satisfaction

High scores of satisfaction for POCs were unexpected, as functions outside care are often considered with a patronising attitude by other MDs. Such higher satisfaction is not necessarily related to better terms of practice ; rather, the fact that POCs could choose their career according to their own values and personal history is probably the root of their appreciation.

♦ Encounters with patients

For interpreting the evolution regarding such encounters, we suggest two grids for interpretation :

- a cultural clash between two types of expectations,
- a quartering between the requirements of various paradigms.

- Encounters with patients : a cultural shock

The difficult relations with patients probably not only result from the evolution within the health sector ; other factors are to be scented. Practising medicine involves several difficulties, including requirements of self-denial (e.g. compassion, free services, …), availability (being frequently on duty) and acceptance of inconveniences (e.g. fatigue, night calls, being interrupted by phone calls). A few decades ago, such features could be sublimated in a prestigious profession considered as a vocation. It is probably more difficult to accept them, when one is surrounded by a individualistic and hedonistic culture, where patients can become "tyrannical" and can exploit their strength in a context of

oversupply. In such a situation, professional requirements clash with the three “Cs” that “patients-consumers” expect : competence, comfort, and contacts involving personal attention.

- Contradictory requirements of various paradigms

The practice of medicine does not only undergo a drastic evolution (see section 1), but it is also confronted with the difficulties of meeting contradictory requirements of various paradigms :

- the sociological paradigm, which spreads the concepts of equity, involvement and empowerment ;
- the economic paradigm, which builds on the concepts of effectiveness and efficiency ;
- the medical paradigms, which are numerous but convene on the concept of quality of care.

◊ *The sociological paradigm*

- *Equity* has become the first objective for the World Health Organisation, now that numerous research-works around the world have shown the social gradient which affects all the indicators of health : mortality, morbidity, subjective health, healthy life expectancy, …(Kunst & Mackenbash, 1996 ; Evans et al., 1994) ; policies aiming at improving the situation, e.g. through access to health, induce extra public expenses, which may clash with economic requirements.

- *Empowerment* is considered as a tool towards better health, because it calls on people’s own resources, … It includes sharing decisions (Gromb, 1999 ; Nandi, 2000 ; McIlwain, 1999) ; drawing charters about patients’ rights (Townshend, 1998) and involving patients in various committees (Susciter la Santé, 1998) …However, such progresses can be unduly used by patient-consumers who can take advantage of competition in a context of oversupply.

◊ *The economic paradigm*

Due to the rapid growth of medical expenditures, managers of insurance schemes and public departments aim at controlling such growth and at managing the system. All are trying to combine various aims with contradictory requirements : *effectiveness, efficiency, quality and equity*. Such aims yield various regulations, controls and bureaucracy, that physicians easily resent. They can strongly feel the inconveniences and constraints of the system, and less easily perceive its benefits, e.g. the accessibility of care and, consequently, the warranted financing of the services they provide.

◊ *The medical paradigm*

Aiming to achieve quality of care require various conditions, about which physicians do not always agree :
- about *structure* : equipment, guideline, consensus seminars, peer-review, further training, …
- about *processes* : technical perfection, rational choice of processes, global, continuous and integrated care, evidence based medicine, …
- about *results* : comparing results according to processes, practitioners, hospitals, …

Such aspects of care are gradually being regulated, which easily induces a feeling of loss of autonomy for practitioners.

Conclusions

Medical Doctors have been swamped with idealised images of their profession (e.g. “a trust joining a conscience”). Our survey shows another aspect : patients’ requirements and physicians’ complaints.

We hear a spontaneous cry, which is large enough to reflect at least part of the MD’s opinions. Following conclusions can be drawn from the analysed comments :

- Statements of satisfaction are numerous, but
- Complaints are still more frequent and pertain to a large variety of domains, i.e. :
  - Terms of practice : unfair earnings, onerousness, pollution by bureaucracy and political ukases ;

- Painful relations with society : depreciation, patients' excessive requirements, pressures from hospital managers ;
- Negative impact of the professional constraints on personal and family life (stated as "non compatible")

Similar complaints can be heard in other professions and among Medical Doctors in other countries.

Physicians have also mentioned a negative evolution. Such nostalgia might result from the large disruptions which have hit their profession : quite a paradigmatical upheaval, *inter allia*, for many concepts which lie at the basis of their work : life, health, disease, relations with the patient, image of the profession, terms of practice, e.g. the "medical charter". The transition from a situation of power to a practice in partnership is due to induce quite a few stirs.

Furthermore, several disciplines propose various norms of good practice ; this makes the context more complex and induces some confusion for choosing the adequate landmarks : navigation is difficult between involvement and equity advocated by sociologists, savings and efficiency required by managers, comfort and own values claimed by patients, and quality requirements from peers … A few storms seem unavoidable, but this might be the price of progress.

References

1. LIFE, HEALTH AND ILLNESS

Abelin T., Brzezinski Z.J., Carstairs V.D.L., 1987, *Measurement in health promotion and protection*, Copenhagen, World Health Organization, Regional Office for Europe, Regional Publications, European Series, 22, 658.

Bury J.A., 1988*, Education pour la santé, Concepts, enjeux, planifications*, Bruxelles, Collection Savoir & Santé, Questions, Ed. De Boeck, 233.

Mechanic D., 1993, Social research in health and the American sociopolitical context : the changing fortunes of medical sociology, *Social Science and Medicine*, 36, 2, 95-102.

Monnier J., Descamps J.P. et al., 1980, *Santé Publique, Santé de la communauté*. Villeurbanne, SIMEP, 444.

Roter D., 1995, Advancing the Physician's Contribution to Enhancing Compliance. Co-published simultaneously in *Journal of Pharmacoepidemiology*, The Haworth Press, Inc., 3, n°2, 37-48 and : Advancing Prescription Medicine Compliance : New Paradigms, New Practices (ed : Jack E. Fincham), 37-48.

Siegler M., 1992, The External Control of Private Medical Decisions: A Major Change in the Doctor-Patient Relationship. *Journal of the American Geriatrics Society*, 40, 410-412.

Wecht C.H., 1998, The right to die and physician-assisted suicide medical, legal, and ethical aspects (Part I). *Medicine and Law*., 17, 3, 477-491.

2. THE PATIENT, RELATIONS WITH SICK PEOPLE

Annandale E.C., 1989, The malpractice crisis and the doctor-patient relationship*, Sociology of Health & Illness, A Journal of Medical Sociology*, vol.11, 1, 1-23.

Bal A., 1993, Consumer Protection Act and Medical Profession, *Indian Journal of Social Work*, 54, 209-222.

Beisecker A.E. & Beisecker T.D., 1993, Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism versus Consumerism, *Health Communication*, 5, 1, 41-58.

Ben Sira Z., 1990 (a), Universal Entitlement for Health Care and Its Implications for the Doctor-Patient Relationship: A New Perspective on Medical Care, *Advances in Medical Sociology*, 1, 99-128.

Betz M., O'Connell L ., 1983, Changing Doctor-Patient Relationships and the Rise in Concern for Accountability, *Social Problems*, 31, 84-95.

Clark P.G., 1996, Communication between Provider and Patient: Values, Biography, and Empowerment in Clinical Practice, *Ageing and Society,* 16, 747-774.

Easthope G., 1993, The Response of Orthodox Medicine to the Challenge of Alternative Medicine in Australia », *Australian and New Zealand Journal of Sociology,* 29 (3) : 289-301.

Haug M., Lavin B, 1983, *Consumerism in Medicine : challenging Physician Authority*, Beverly Hills : Sage, 239.

Havighurst C.C., 1987, The Changing Locus of Decision Making in the Health Care Sector, *Journal of Health Politics, Policy and Law,* 11, 4, 697-735.

Hay I., 1992, *Money, Medicine and Malpractice in American Society*, New York, Praeger, 244.

Hyman D.A., 1990, Aesthetics and Ethics: The Implications of Cosmetic Surgery. *Perspectives in Biology and Medicine*, 33, 2, 190-202.

Kronenfeld J.J, Schneller E., 1997, *The Growth of a Buyer Beware Model in Health Care: The Impact of Managed Care on Changing Models of the Doctor-Patient Relationship*, American Sociological Association (ASA).

Lloyd P., Lupton D., Donaldson C., 1991, Consumerism in the health care setting : an exploratory study of factors underlying the selection and evaluation of primary medical services, *Australian Journal of Public Health*, 15, 3, 194-201.

Lupton D., 1997, Consumerism, Reflexivity and the Medical Encounter. *Social Science and Medicine*, 45, 373-381.

May C., Dowrick C., Richardson M., 1996, The Confidential Patient: The Social Construction of Therapeutic Relationships in General Medical Practice, *Sociological Review*, 44, 187-203.

Mechanic D., 1993, Social research in health and the American sociopolitical context : the changing fortunes of medical sociology, *Social Science and Medicine*, 36, 2, 95-102.

Ryan M., 1994, Agency in Health Care: Lessons for Economists from Sociologists. *American Journal of Economics and Sociology,* 53, 207-217.

Parsons T., 1964, *The Social System*. Glencoe, Ill: Free Press.

Shackley P., Ryan M., 1994, What Is the Role of the Consumer in Health Care? *Journal of Social Policy*, 23, 517-541.

Siegler M., 1992, The External Control of Private Medical Decisions: A Major Change in the Doctor-Patient Relationship. *Journal of the American Geriatrics Society*, 40, 410-412.

Starr P., 1982, *The Social Transformation of American Medicine*, Basic Books : New York, 514.

Walker B., Waddington I., 1991, AIDS and the Doctor-Patient Relationship. *Social Studies Review*, 6, 128-130.

3. THE MEDICAL PROFESSION

Clavarino A., Yates P., 1995, Fear, Faith or Rational Choice : Understanding the Users of Alternative Therapies » in G. Lupton and J. Najman (eds*) Sociology of Health and Illness : Australian Readings*, 2nd edition, Melbourne : Macmillan, 252-275.

Cook C., Easthope G., November 1996, Symptoms of a crisis ? Trust, risk and medicine : review essay, *Australian and New Zealand Journal of Sociology,* 32, 3, 85-98.

Cooper R.A., 1998, Roles or Nonphysician Clinicians as Autonomous Providers pr Patient Care, *Journal of the American Medical Association*, 280(9) : 795-802.

Deliège D., 2000, Planification de l'offre médicale en Communauté française et germanophone. Critères - Scénarios de besoins, Bruxelles, *Revue belge de Sécurité sociale*, 1, 103-191.

Gallagher E.B., 1997, *Two Sociological Issues in the Allocation of Health Care,* American Sociological Association (ASA).

Jenkins-Clarke S., Carr-Hill R., Dixon P., 1998, Teams and skill mix in primary care, *Journal of Advanced Nursing*, 28(5) : 1120-1126.

Lupton D., 1997, Consumerism, Reflexivity and the Medical Encounter. *Social Science and Medicine*, 45, 373-381.

Mc Kinlay J.B. & Stoeckle J.D., 1988, Corporatization and the social transformation of doctoring. *International Journal of Health Services*, 18, 191-205.

Midy F., 2003, *Efficacité et efficience du partage des compétences dans le secteur des soins primaires, Revue de la littérature 1970-2002*, Document de travail, Paris, Credes, février : 43

Raschetti R., 1999, La medicina delle evidenze scientifiche e le diverse culture della guarigione, (Evidence-based medicine and the diverse cultures of healing). *Annali dell'Istituto superiore di sanita,* 35, 4, 483-488.

Samra R.J., 1993, The Image of the Physician: A Rhetorical Perspective. *Public Relations Review,* 19, 4, 341-348.

Shackley P., Ryan M., 1994, What Is the Role of the Consumer in Health Care? *Journal of Social Policy*, 23, 517-541.

Van Lerberghe W., 2000, *Medical Errors and Iatrogenesis : What have we learnt* ? Technical note for the Medical Council, Communication personnelle, 24.

4. The Terms of Practice

Bogaerts K., De Prins L., De Maeseneer J., 1999, *Women-Men Powerplanning in de Huisartsgeneeskunde in België, Scenario voor 2010 en 2020*, Univ. Gent : 87 + annexes.

Clark P.G., 1996, Communication between Provider and Patient: Values, Biography, and Empowerment in Clinical Practice, *Ageing and Society,* 16, 747-774.

Elston M.A.C., 1990, *Women Physicians in a Changing Profession: The Case of the United Kingdom,* International Sociological Association (ISA).

Godt P.J., 1987, Confrontation, Consent, and Corporatism: State Strategies and the Medical Profession in France, Great Britain, and West Germany. *Journal of Health Politics, Policy and Law*, 12, 3, 459-480.

Hay I., 1992, *Money, Medicine and Malpractice in American Society*, New York, Praeger, 244.

Kersvadoué (de) J. (ed.), 2003, *La crise des professions de santé*, Paris, Dunod : 329.

Morone J.A., 1993, The Health Care Bureaucracy: Small Changes, Big Consequences. *Journal of Health Politics, Policy and Law,* 18, 3, 723-739 .

Sculpher M., 2000, Evaluating the cost-effectiveness of interventions designed to increase the utilization of evidence-based guidelines. *Family practice*, 17 Suppl 1: S26-31.

Siegler M., 1992, The External Control of Private Medical Decisions: A Major Change in the Doctor-Patient Relationship. *Journal of the American Geriatrics Society*, 40, 410-412.

Vinten Johansen P., Riska, E., 1991, New Oslerians and Real Flexnerians: The Response to Threatened Professional Autonomy. *International Journal of Health Services,* 21, 1, 75-108.

Wegner E.L., 1992, Patient Consent: Issues in the Legal Regulation of a Client-Professional Relationship. Social Process in Hawaii, *Social Process in Hawaii*; 1992, 34, 53-69.

5. OTHER REFERENCES

Antoine L., Lorant V. et Deliège D., *Charge de travail et « mal-occupation » des médecins en 1998*, UCL-SESA, 2001, 86.

Evans G.R., Barer M.L., Marmor T.R., 1994, *Etre ou ne pas être en bonne santé : biologie et déterminants sociaux de la maladie*, New York, Les presses de l'Université de Montréal, John Libbey Eurotext, 359.

Gromb S., Dabadie P., Janvier G., 1999, Medico-legal dimension of informed consent in medicine ; *Annales Françaises d'Anesthésie et de Réanimation*, 18, 10, 1080-1086.

Herzberg F., Mansner B., Syderman B.B., 1959, *The motivation to work*, New-York, Wiley.

Kunst A.E., Mackenbash J.P., 1996, *La mesure des inégalités de santé d'origine socio-économique.* Copenhague, Organisation mondiale de la Santé, 116.

McIlwain J.C., 1999, Clinical risk management: principles of consent and patient information. *Clinical Otolaryngology,* 24, 4, 255-61.

Nandi P.L., 2000, Ethical aspects of clinical practice. *Archives of Surgery,* 135, 1, 22-25.

Susciter la santé communautaire,1998, *Santé conjuguée,* Bruxelles, Ed. Fédération des maisons médicales, 4, 57.

Townshend P.L., Sellman J.D., Haines R., 1998, The Cartwright Report ten years on: the obligations and rights of health consumers and providers. *New Zealand Medical Journal.* 111, 1075, 390-393.