Physicians and Professionalism

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INTRODUCTION

"Physician" is a term mainly used in the United States to describe medical doctors who are trained to practice and provide orthodox, Western, scientific, and medical care. The occupation has been characterized by sociologists as the archetypal profession with high social status and prestige. Recruits undergo an intensive training and socialization process which aims to give them not only the necessary skills and expertise but also the social identity of a doctor – what a *good* doctor should be like as a person.

At least in capitalist countries, physicians were traditionally white men from higher social class backgrounds, often from families where other members were established in the profession. In recent years, however, the occupation has become increasingly diverse. In the United Kingdom, more women than men are now being trained as doctors and there have been considerable pressures in many developed countries to recruit more people from lower social classes and minority ethnic backgrounds. Medicine has become less of a vocation (i.e., a way of life), with more defined and regular working hours, scheduled by managers rather than at the discretion of the professional. Many practitioners have responded by emphasizing their right to balance work with other aspects of their lives.

This article begins by comparing the assumptions in the traditional sociological theories of medical professionalism which try to explain how the powerful position of the medical profession was attained and sustained. This is followed by an analysis of the extent to which this powerful position is under threat and how new forms of medical professionalism and its governance have emerged in the light of the abandonment of self-regulation.

THEORIES OF MEDICAL PROFESSIONALISM

In the early years of medical sociology, there was a major focus on attempts to explain how and why doctors had attained, and managed to sustain, their professional status and power. These sociological writings were informed by a number of different theoretical perspectives but basically divided into two categories: those which argued, or assumed, that the profession's actions were influenced by altruistic motives (i.e., the interests of their patients) and those who argued that their actions were influenced by their own self-interest or that of other groups (Calnan 2020).

The former category included those sociologists who attempted to identify what was distinct about a profession as opposed to other occupations. This approach – sometimes described as the *attribute* approach – attempted to list the essential features of those occupations that were conventionally defined as professions: for example, the presence of a prolonged, specialized training; an abstract body of knowledge; and a service orientation. This approach tended to be atheoretical and somewhat tautological: it used the characteristics of the medical profession to develop its list of attributes, which were then used to define medicine as an example of a profession. The more explicitly theoretical, functionalist approach located the profession in the wider social system and accounted for its special position in terms of the vital functions performed

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for the society as a whole. Expert knowledge was used in the community's interest with the profession's altruistic service orientation as a safeguard against the exploitation of medical expertise. In return for performing this special and valuable role, the doctors were accorded higher status and given greater financial rewards than other occupational groups.

The second category can be further divided between those who see the medical profession as working on behalf of other, more powerful interests and those who see the profession mainly as working to advance their own interests. The former approach is particularly associated with analyses influenced by Marxist thought, where members of the medical profession act as agents of social control either as part of or in alliance with a ruling class. This controlling role is often exemplified through the way in which physicians may or may not exempt people from the expectation of employment or the use of biomedical ideology to translate problems with social and economic causes into individual, biological conditions.

The latter approach, more influenced by the work of Weber, rejects the functionalist idea that doctors naturally came to dominate a division of labor because of their superior skills and knowledge and their ability to perform vital functions in industrial society. Professionalism was characterized as a process of political struggle between groups intent on achieving higher status. The challenge was to explain why doctors had been so successful in competition with other occupations. For Freidson (1970), the key distinction between professions and other occupations lies in the former's legitimate organized autonomy. This is usually granted by state patronage: protection by the state aids occupations in the pursuit of professional status. It is not the intrinsic quality of an occupation that makes it superior to competing groups but the way expert knowledge and other attributes are used as ideological tools for attaining professional status.

Autonomy varies according to the health system in which doctors are employed. In the English National Health Service (NHS), for example, where health care has historically been both provided and funded by the state, economic autonomy has been limited. However, doctors have enjoyed considerable clinical autonomy and freedom from external scrutiny. The state has sheltered doctors from the uncertainties of the market. The analysis of medical professionalism in the NHS also provides some insight into the variation in professional development between different branches of medicine working in different clinical settings. The key to this hinges on the degree of autonomy, not least from patients. Hospital specialists managed to do this from the earliest years of the NHS both by distancing themselves from patients through their association with scientific, specialist, technological medicine and by creating an organizational barrier, where all patients had to be referred through a general-practitioner gatekeeper. This facilitated the professional development of hospital doctors but hindered that of general practitioners, who then lacked either a distinct body of knowledge or an organizational barrier of their own to regulate patient access. The professional development of general medical practice in England can be explained through changes in the relations between the state, hospital doctors, and patients (Calnan and Gabe 2009). This suggests that professional identities within medicine vary in terms of status and power, and some such doctors providing abortions or doctors working in areas of mental health such as dementia care might be stigmatized and others working in public health might be marginalized because of their focus on population health and nonclinical care.

This Weberian analysis of professionalism has been criticized for its lack of attention to gender issues as professionalization was seen to have led to the transfer of healing from the hands of women to the control of men as medical practice moved from the domestic to the market arena. Professionalization was seen as a gendered occupational strategy (dominated

by men) which was reflected in women's initial exclusion from entering medical schools.

MEDICAL PROFESSIONALISM UNDER THREAT

These different sociological positions have been evident in recent debates about whether the "golden age" of Western scientific medicine was over because of growing challenges or threats to medical professionalism. These challenges included those from *above* reflected in an increase in state regulation or corporate control and the rise of managerialism (sometimes described in terms like proletarianization, corporatization, and bureaucratization: see Calnan and Gabe 2009) and from *below* in the so-called rise of the enlightened and critical consumer (known as deprofessionalization). Coburn, Rappolt, and Bougreault (1997) argued that managerialism had undermined the profession as whole through the state co-option of medical organizations and elites. They argued that medical institutions were being used by external forces, such as the state, to constrain their own members and to implement policies over which they had no control. Others, however, have argued that doctors are, at least at the elite level, able to respond to, or anticipate, possible challenges and use the opportunities to maintain or even enhance their autonomy. Freidson (2001) advanced a theory of professional restratification which identified increasing divisions between the rank and file of "practitioners" and the "knowledge" (research) and administrative medical elites. Freidson (2001) argues that, while power within the profession may have shifted toward these elite groups, the profession itself was still dominant. For example, the elite practitioners and medical researchers play a central role in developing the clinical protocols and guidelines being used by the rank and file, while the increasing number of medical doctors taking on managerial roles suggests that the profession may be reclaiming monitoring and regulatory roles.

The rise in consumerism has been linked to a supposed shift from organized to disorganized capitalism which has led to a culture of "shopping around" and cultural pluralism that has permeated the use of health care. This may also reflect a shift toward a postmodern culture in which science, including biomedicine, has been deprivileged. Active trust and citizenship have become more common features of critical modern reasoning that are increasingly contesting professional expertise. Consumerism is also promoted by neoliberal ideology, which has led to the greater marketization of medical work. The more direct or overt link between financial and clinical interests may raise doubts about whether doctors are still driven by altruistic motives.

The alleged decline in trust in doctors associated with the rise of the critical consumer has been disputed. For example, empirical evidence, at least in England, suggests that public and patient trust in doctors still remains high although the meaning of trust may have changed from blind or assumed trust to conditional or earned trust (Calnan and Rowe 2008). This change in the meaning of trust applies not only to relations between doctors and patients but also to those between doctors and managers, where tension has been created by introduction of new public management with its emphasis on audit, performance, and risk management. This conflicts with the more individualized approaches of clinicians.

NEW FORMS OF MEDICAL PROFESSIONALISM

There has been a sociological debate about the extent to which these changes have spawned new forms of medical professionalism. Freidson (2001) argued that professionalism might represent a "third logic," an alternative to state bureaucracy or market efficiency: doctors act as mediators between the interests of the state and the needs of patients. Such a role, according to Freidson (2001), encourages trust

and confidence in public services and reduces the costs of governmental action. It has been argued that there is increasing evidence of new forms of professionalism, reflecting the greater diversity and context dependency of medical work. For example, it has been suggested (Calnan and Gabe 2009) that a new type of general practitioner may have emerged in the United Kingdom, like a "street-level bureaucrat," mediating between external bureaucratic pressures to adhere to clinical guidelines and everyday patient care based on experiential knowledge. Another example is the emergence of doctors as "public service entrepreneurs" who adopt the values of the market in order to meet the needs of the patients but are not driven by a profit motive. This might be seen as an alternative type of professionalism within medicine that features both self-interest and altruism (Calnan and Gabe 2009).

The salience of altruism in the values of doctors working in the pluralistic health system in the United States (Hafferty 2003) has been examined. The study suggests that most of the students entering medical school in the early part of this century can identify a lay role model who epitomizes the altruistic person but these same students will view altruism, when applied to their own (anticipated) practice of medicine, with suspicion and dread. They equate altruism with burnout and vulnerability, and they fear that demanding and/or manipulative patients will take advantage of them. They see a new species of physician, the physician-as-victim, which might also be shaped by the stories reporting increasing violence against doctors in many high- and low-to-middle-income countries of the world. This difference in approaches to medical professionalism might reflect the argument proposed by Freidson (2001) that the medical profession has undergone a process of restratification with the elite espousing altruism as a core value and with the rank and file adopting a more pragmatic and less idealistic approach.

The increasing prevalence of violence against doctors has led sociologists (Brown, Elston, and Gabe 2015) to suggest that the doctor–patient relationship has changed. Their data suggest that general practitioners, especially younger ones, tend toward a more informal yet limited engagement with their patients and with the communities in which they work. These new relations might be a basis for mutual respect between professionals and patients in the consulting room but may also generate uncertainty and misunderstanding leading to tension. These authors also found some support for the idea that an apparent "golden age" of patient deference is receding (Brown, Elston, and Gabe 2015).

Other sociologists argue that the influence of these institutional changes has been exaggerated. Some authors continue to characterize medical professionalism in more traditional terms of autonomy over their work, which enables doctors to resist enforced changes and/or use them to enhance their social position. This conclusion has some empirical support. An English study (Spyridonidis and Calnan 2011) documented clinicians' accounts of their lack of use or acceptance of clinical governance. They continued to articulate traditional concerns about the importance of clinical freedom and discretion. Both general practitioners and hospital doctors adopted strategies to avoid top-down modes of control, such as National Institute for Clinical Excellence (NICE) guidelines, which they perceived as unacceptable restrictions on their professional right of clinical judgment and self-regulation. Other writers have suggested that the concept of "new professionalism" is too simplistic since there are aspects of continuity as well as of change within the medical profession. It has been argued that the contemporary workplace has placed increased pressure on professionals to be flexible and construct multiple occupational identities, where English general practitioners have maintained, negotiated, or reinvented their professional identities as both "professional" and "business owner" (Spyridonidis and Calnan 2011).

MEDICAL GOVERNANCE AND THE END OF SELF-REGULATION

The traditional, self-regulatory approach to governance adopted by the medical profession in the United Kingdom began to change during the early part of this century and medical practices became increasingly responsive to collegiate and managerial mechanisms of control. This shift appeared to be in response to a mixture of policies associated with a series of scandals about medical performance which had in part been fueled by the media coupled with the continued emphasis on the new public managerialism such as audit and performance targets. The traditional self-regulation form of governance adopted by the medical profession was associated with a culture of high trust and limited state involvement whereas this shift in approach cultivated a culture of low trust with greater state-sponsored managerial intervention. In light of pressure from the government to modernize, there was a recognition by the profession of a need for a "strengthened professionalism" and a promise for a more effective, inclusive, accountable, and transparent General Medical Council (GMC) with increased lay membership which was seen as a means of securing public trust while, at the same time, safeguarding the independence of the profession in the face of threats of external control (Calnan 2020).

The Shipman Inquiry (Calnan 2020) proposed reforms to the GMC to address concerns with how doctors are regulated and their fitness to practice monitored. Consequently, the GMC was reconstituted to reduce medical dominance, and it gained powers to oversee not just professional misconduct but poor performance. More recently, the 2008 Health and Social Care Act introduced significant changes to the regulation of the medical profession and the performance management of doctors through the introduction of the performance appraisal tool revalidation. This process was further defined by the Responsible Officer (ROs) Regulations 2010 and 2013. Revalidation involves an assessment of a doctor's fitness to practice using a mixture of appraisals, patient feedback, and continuing professional development.

This shift away from self-regulation-based governance was significant – not least because the changes clearly involved the curtailment of the profession's powers. Perhaps surprisingly, there was limited resistance from the profession to this reconfiguration, and evidence suggests a general acceptance by clinicians of the need for stronger regulation as a means of reassuring the public. This development seems to support an explanation that aligns with Freidson's thesis of the medical profession undergoing a restratification, that is, the emergence of a distinct group of regulatory elites from within the profession, who oversee practice and performance (Calnan 2020). While the policy changes led to some erosion of power, evidence suggests that the medical profession may have yet retained a substantial degree of self-regulatory power – although in their role of surveyor of professional practice, the priority for the RO does not focus on the protection of clinical discretion.

Spendlove (2018) makes a distinction between embodied trust which is part of self-regulation and enforced trust and shows the challenges associated with implementing mechanisms of enforceable trust, such as revalidation, as control was not taken over by the organizational and regulatory elites or wider government structures as anticipated. As a result, medical professionals were able to, directly and indirectly, influence the implementation and management of revalidation and thereby maintain self-regulatory power. Moreover, this indicated that the existing debate regarding enforceable trust, through top-down governance, does not adequately consider the impact of organizational factors and professional countervailing power upon the contemporary professional state regulatory power struggle. Spendlove (2018) has also shown that implementing mechanisms of enforced trust, such as

revalidations and performance assessments, is very difficult – and how, no matter what, they cannot be fully taken over by government bodies. Others have still argued that this control-oriented approach to stewardship is paradoxically fostering a culture of distrust within the U.K. health system – with falling levels of trust across all relations between doctors, managers, and the public (Calnan and Rowe 2008) – suggesting that a form of stakeholder governance and stewardship model that fosters mutual trust with an emphasis on explicit accountability and transparency is the optimal way forward (Kane and Calnan 2023). Others suggest that the dominance of the new public management perspective founded on neoliberal values of marketization and individualism has, at least in the past (Calnan and Rowe 2008), provided little space for the incorporation of the stakeholder model, with doctors putting more value on individualistic trust relations with patients than institutional trust. This individualistic, as opposed to a collective, approach might have been shaped by the emergence of what is seen as the new elite power structures and governance regimes through which neoliberalization has claimed to have been developed and sustained as a long-term political project. This in turn has led to the hybridization and fragmentation of professional services and the expert occupational groups which provide them (Reed 2011). This, it is argued, is associated with the emergence of a distinctive state regime which facilitates and supports financialized modes of capital accumulation by re-engineering the organized power through which markets are constructed and can function in ways that favor the long-term interests of corporate capitalism (Reed 2011). Such structures therefore enable the development of the commercialization of medicine or at least strengthening the private or business sectors' control over the medical profession (Freidson 2001).

In summary, traditional sociological narratives of medical professionalism have highlighted both the altruistic values of the medical profession and their self-interested motives. However, the increasing fragmentation and hybridization of the medical profession shaped by neoliberal forces such as commercialization and the neoliberal state might mean that these meta-narratives are beginning to have limited explanatory power. Thus, further research might explore the extent to which there has been a change in the values of the new generation of physicians and if the altruistic narrative has a different meaning and salience for those practicing everyday medicine. However, practicing physicians' current values should also not be divorced from their experiences of the impact of the COVID global pandemic, particularly in the context of an understaffed environment where there is a lack of investment and support.

SEE ALSO: General Practitioners; Health Professions and the State; Health Professions, Sociology of; Medical School Socialization; Patient–Physician Communication; Professional Ethics and Accountability; Professional Trust; Professional Work, Managing; Professions and Professionalism; Professions and the Public

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