S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 21: The Medical Profession1

* The idea of medicine as a profession is relatively new (about 50 years), but now it is the stereotypical profession

* 3 ways to think about professions:

(1) as a specific occupation (the "trait approach")
(2) in terms of processes of occupational change
(3) as an ideology

* Goode: The "*trait approach*": Professions involve prolonged training in abstract knowledge & a service orientation. Traits include:

1. Setting own standard of education/training
2. Stringent educational requirements
3. Legal recognition/licensing
4. Profession sets licensing/admission standards
5. Most relevant legislation set by the profession
6. Relatively high power, prestige & income
7.Relative freedom from lay control & regulation
8. Norms of practice more stringent than legal controls
9. Stronger identification/affiliation than with other occupations
10. Members usually stay members for life

* These largely apply to medicine, though they do implicitly accept self-serving ideology of the profession, ignore the power of the profession, doesn't consider changes over time, & ignore the relationship between the profession & the rest of society.

* Profession as *process*: historical study of how an occupation becomes a profession through gradual development of association, education,

legal status/ licensing, a code of ethics, & peer control:

- Johnson: the power analysis approach where occupations evolve into professions as they increase in power & the ability to define reality for clients seeking their services. This power depends on (1) extent of esoteric knowledge; (2) social distance; & (3) homogeneity of professionals vs. heterogeneity of clients
- Willis: allopathic medicine achieved dominance by subordinating competitors (e.g. nursing), limiting the activities of others (e.g. pharmacy), & excluding others (e.g. naturopaths)
- Increasing moves to restrict professional dominance/ regulate alternative practitioners

* Profession as *ideology*:

- professionalization as descriptive beliefs to explain & legitimize certain practices & viewpoints
- Parsons: professions are *supposed* to act universally, be functionally specific, display affective neutrality & a collective orientation
- Friedson: medicine's claim to professional status rests on ideological assumptions of complexity & objectivity of scientific knowledge & that doctors will place the welfare of the public before their own (these worked well for a time, though now they are being increasingly challenged due to health care crisis)

A Brief History of Medical Education in North America

* After 1800, first fir profit medical schools: poor training compared to Europe. Many North Americans traveled to Europe to study 1870-1914

* Carnegie & Rockefeller Foundations began to fund medical research in early 20th century; medical education revised & upgraded after Flexner

Report. By 1920's, the power of doctors as healers were generally assumed

Medical Education in Canada Today:

* McGill was the first Canadian medical school (1824), followed by 6 more by the turn of the century. 17 schools currently, more opening

* Peak enrolment (1983), falling since. Numbers buttressed by immigration

* Becoming a doctor: 3 steps: (1) undergraduate degree
(2) graduate medical degree
(3) minimum 1 year internship

* After internship doctors write qualifying exams; may go on to specialize

* Most doctors come from mid-upper middle class. Once predominantly a male profession, though women gradually have come to outnumber men (though with lower salaries)

* Despite expense, there are far more applicants than available spaces (13:1)

The Process of Becoming a Doctor:

* Becker: medical students became aware of 2 dominant values: clinical experience & medical responsibility. These values guided & directed strategies used to manage huge study load (e.g. selection of material, emphasis on life & death situations)

* Merton: medical socialization a continuous process where 2 basic traits developed: (1) an ability to remain emotionally detached; & (2) an ability to deal with inevitable, constant uncertainty. Over time,

previously upsetting issues became medical ones; idealism became cynicism.

* Sexism & homophobia in medical education (e.g. unwritten quotas, literature based on men, fear of treating gays/lesbians). Programs?

Getting Doctored:

* Shapiro (1978) the 2 most important features of medical education are experiencing alienation (from their excessive labor, in competing with each other, etc.) & developing an authoritative personality

* Conrad (1998): medical training:

- discourages & prevents caring
- focuses on disease rather than illness
- doesn't teach how to talk to patients
- teaches medical knowledge/technique, but not humane/caring values
- technological fix-it mentality avoids doctor-patient relations
- long hours, sleep deprivation, excessive responsibility & arrogant superiors inhibits growth of compassion & empathy

* Nevertheless, there are some doctors who work for social justice issues

Organization of the Medical Profession: Autonomy & Social Control

* Physicians are self regulating through the College of Physicians & Surgeons & the Canadian Medical Association: both define expectations, set standards, & attempt to protect the status & economic security of members

* The Medical Council of Canada is mandated by statute to license & supervise medical practitioners, as well as to prevent unqualified ones from practicing

* As such, autonomy & power are crucial characteristics of this profession

* On the job, autonomy & power vary depending on whether one works in sole practice, in colleague networks, large group practices or university clinics (surveillance varies)

* Primary sanction against practitioners is ostracism (e.g. not referring patients, denying hospital privileges). Limited in effectiveness (observability, relative dependence on referrals, how paid, status of work setting, network of medical contacts varying along class, ethnicity, & gender lines, among other things)

* Hospital committees affect doctors' hospital privileges (e.g. credentials committees, ever more hospital administrators & bureaucracy intruding on what was once solely doctors' domain). Alternative means of getting things done emerge in response to rationalization/ cost cutting (e.g. gossip)

* Over time, the medical profession has declined in power somewhat as state control has gained

The Management of Mistakes:

* Medical practice inevitably involves uncertainty: mistakes get made that can result in serious consequences.

* However, Millman (1977) notes:

- what gets counted as a mistake is variable
- some results are considered undesirable enough to investigate (despite doctors' neutralization & collective rationalization)
- hospitals have formal mechanisms for dealing with mistakes, using errors as sources of education, & investigating culpability (though these may attempt to informally keep discomfort down & come to a consensus)

* Bosk (1979): Technical ("to be expected") vs. Moral (not easily forgiven) mistakes

* Wennberg (1984): Practice norms & variations among colleague networks in different hospital service areas (e.g. % of hysterectomies). No variation by illness rates, insurance coverage, access to medical services, age distribution, per-capital hospital bed ratios, & physician/population ratios. Must be subjective variations

* Rachlis & Kushner (1994): Varying productivity & treatments by doctors from area to area, partly due to research responsibilities

* Bunker (1985): Variations due to fact medicine an art, not a science, involving much uncertainty

* Wennberg et. al (1980): rates of common surgeries vary by jurisdiction due to imperfect diagnostic/treatment procedures, norms of practice, networks, etc.

* Welch et. al (1996): economic & cultural influences on practice (e.g. invasiveness of elderly cardiovascular intervention in Canada vs. US)

* Malpractice suits growing in number, success & cost. Doctors carry expensive malpractice insurance with the Canadian Medical Protective Association