Background

We have a good sociological understanding of how present-day health and medicine is experienced from the point of view of patients and lay people. There is now a substantial body of research which has explored how contemporary social changes have influenced people's experiences and understandings of both health and illness (eg Monaghan, 2001; Prior, 2003; Henwood *et al.,* 2003) and health care (eg Coulter and Fitzpatrick, 2000). By contrast, although there is a well-known literature on the medical profession (which we will discuss below) there have not been any more rounded sociologically informed empirical studies of what it means to be a doctor within contemporary society (an exception, in an Australian context, is Lupton (1997)). The studies which do exist - and from which we will of course draw some inspiration - tend to be focussed on more specific issues: views of particular policy initiatives (e.g. Armstrong *et al*, 1996; Douglas *et al* 1997; Berrow *et al* 1997; Humphrey and Berrow, 2000; Harrison and Dowswell 2002); problematic clinical issues (e.g. Stokes, 2000); training and socialisation (Becker *et al.,* 1961; Atkinson, 1981; Fox,1989); or the construction of, or means of dealing with, the uncertainty of medical knowledge (Atkinson, 1995; Fox, 1992).

Although there has been little sociological consideration of the everyday experiences and world views of doctors this topic is something that has been troubling the upper echelons of the medical profession for some time now. In a number of lectures, seminars and in a range of publications, members of the medical establishment have asked, *inter alia*: What does it mean to be a doctor? Do we still need doctors? What, if anything, makes doctors special? Why are doctors so unhappy? Has the medical profession lost control? Is there any consensus about what a doctor actually does? (Weatherall, 1995; Lantos, 1997; Turnberg, 2002; Smith, 2003; Horton, 2003; Black, 2003; Madhok, 2003; NHS Confederation, 2002). These concerns have been driven by a number of factors not least: crises of recruitment and retention (BMA, 2002a); the pages of the medical press replete with discussions about unhappy doctors (e.g. Edwards *et al.,* 2002); the impact of high profile 'scandals' such as the Shipman murders, the 'Bristol Case', Alder Hey and the consequent Inquiries; changing patterns of media attention - with twice as many negative stories about the profession as opposed to positive ones now being published (Thoebe *et al.,* 2001); and medical error - hitherto a largely taboo topic - now becoming a legitimate area of investigation (BMA, 2002b).

In his book *The Doctors' Tale: professionalism and public trust* the former president of the General Medical Council (GMC) Donald Irvine (2003) provides a detailed and personal account of the fundamental changes in the regulation of the profession. He states, 'this cultural revolution' is still ongoing and outlines the need for what he calls a 'new professionalism' - a term he credits to the medical sociologist Meg Stacey (p9). For him this 'new professionalism' must embrace:

> 'evidence based medicine rather than clinical pragmatism, the recognition of the importance of attitudes and behaviour, partnership with patients, and accountability rather than personal autonomy ...[it] is about teamwork rather than individualism, collective as well as personal responsibility, transparency rather than secrecy, empathetic communication and above all respect for others. An unreserved

> commitment to quality improvement through clinical governance is fundamental' (p. 206).

But what do doctors who work day in and day out are delivering patient care in hospitals, health centres and clinics make of all this? Are they aware of these calls for changes to their practice? Does it affect how they feel about themselves? Their experiences at work? Have their their relationships with colleagues altered at all? Are they affected by these changing expectations from the professional bodies and the public at large?

Theoretical Context

Interestingly these questions are being explored more in fiction - most notably by Jed Merucrio (a medically trained practitioner himself) in his 'best seller' *Bodies* (also recently serialised by the BBC) - than they are by social scientists. However, there is clearly a demand for social scientific conceptualisations of contemporary social change within the medical profession itself. The editors of the two most widely read medical journals in the UK, Richard Horton - who edits the *The Lancet* - and Richard Smith - who edits the *British Medical Journal,* both extensively cite sociological literatures in their attempts to make sense of their concerns (Horton, 2003; Smith, 2003). Their discourse is brimful with sociological literatures on globalization, consumerism, the changing nature of expert systems, the proliferation of information and communication technologies (ICTs) and so on, with the work of Giddens, Beck and Castells being particularly foregrounded. For instance, '[T]he most fundamental change between past and present medicine' writes Horton,

> 'is access to information. There used to be a steep inequality between doctor and patient. No longer. As people understand the risks as well as the benefits of modern medicine, we increasingly desire more information before we are willing to rely on trust to see us through. This need to be transparent about what doctors know (and what they do not), to engage in a consultation on closer to equal terms with patients, has changed the way medicine is practiced' (2003: 40).

Richard Smith conceptualises these changes as a move from what he calls 'industrial age medicine' to 'information age health care'. Within the context of the latter, old working practices have to give way to the new. For example: doctors have to recognise that their patients may be 'smarter' than they are; they have to work in networked organisations rather than hierarchical ones; they must acknowledge that their clinical knowledge can be patchy; and they must make use of information tools and systematic reviews of evidence rather than just relying on their clinical experience. These views echo that of Blumenthal (2002: 526), a North American analyst, who writes:

> 'A decade ago it would have been unimaginable to suggest that the medical profession might be headed, if not for extinction, at least toward a profoundly diminished role and status in ministering to society's ills. Yet the information revolution, coupled with other recent developments like the rise of alternative types of health care personnel and the new health care consumerism, has made such changes seem not only imaginable but even a plausible extension of prevailing trends'.

In concert with such transformations have come a whole series of policy initiatives which have direct implications for the everyday life of doctors: new forms of management and audit; the rise of evidence-based medicine; the rearticulation of the division of labour within health care; and so on. All have the potential to curtail clinical autonomy and increase clinical accountability (Harrison, 2002).These are but some of the issues which Davies (2003: 182) suggests, in combination, constitute a 'threat to classic professional identity and medical dominance'. Furthermore, she continues, this

> 'is all the greater given the climate of unprecedented doubt and distrust. It is not just that organisational arrangements that are starting to be put in place no longer support the institution of the profession, they are in some senses in flat contradiction to it. And the old props to medical authority of class, gender and race, though still there are crumbling as recruitment starts to broaden, and practice begins to be questioned from within.'

Davies' analysis taps in to the long tradition of work on the sociology of the medical profession. Following the seminal work of Freidson in the 1970s, an orthodoxy coalesced that the medical profession was too powerful and that this was detrimental for public health and health care (Freidson, 1970). Although some academics have suggested that the profession has undergone processes of de-professionalisation (Haug, 1988) or even proletarianisation (McKinlay and Stoeckle, 1988), medical dominance is still widely presumed to be intact, if increasingly precarious (Harrison and Ahmad, 2000). Certainly it is the case that as in all professions (Kruase, 1996) medicine has been subject to a profound structural fracturing in relation to its division of labour. As Horton (2003: 25-26) notes:

> 'In no country is there now a single association that includes all doctors. Separate associations exist for surgeons, physicians, psychiatrists, obstetricians, and so on. Within these tribes, sub-associations have formed cardiologists, neurologists, gastroenterologists, and oncologists.[...]. Professional success has become a source of professional weakness. Unity has been lost, interests clash and conflict is fostered'.

Freidson - perhaps recognising the fragmentation and thus the weakening of the profession overall - changed his views somewhat towards the end of his life, and suggested that society is no longer at risk from an overly powerful profession but, '[W]hat *is* at risk today, and likely to be at greater risk tomorrow, is the independence of professions to choose the direction of the development of their knowledge and the uses to which it is put' (Freidson, 2001: 14).

The extent to which doctors themselves would concur with his views however remains to be seen, because the existing literature has focussed upon the structural dimensions of doctors' roles, rather than examining the views of the 'occupants' of these roles. The medical profession does survey the attitudes of its own members, by means of self-completion questionnaires (e.g. BMA, 2003), and this provides valuable contextual data, but it fails to adequately capture the complex and naunced perspectives that form the contemporary gestalt of doctors - only good qualitative sociological or anthropological research can do that.

Social theorists have long been concerned to construct periodisations of medicine - a tradition drawn upon by Smith (see above) in his distinction between 'industrial age medicine' and 'information age health care'. In particular they have sought to understand how different socio-technological forms mesh with medical knowledge and how these configurations structure and shape the work of medical practitioners. Although there are variations in their approaches, Pickstone (1993; 2000), Jewson (1976) and Armstrong (1995) all identify shifts between what can be termed 'bedside medicine', 'hospital medicine', 'laboratory medicine', 'surveillance medicine' and 'consumerist medicine'. What these writers share is an appreciation that the organisation of medical practice is contingent upon the broader social context, and that the relative status of, and the relationships between, doctors and patients alters accordingly, as does the content of medical knowledge and medical practice.

We have suggested elsewhere that it is becoming possible to discern the parameters of a new configuration - what we have termed 'e-scaped medicine' (Nettleton and Burrows, 2003; Nettleton, 2004). We have argued that ICTs are accelerating the transformation of 'consumerist' medicine. For example, medical knowledge is no longer exclusive to the medical academy it has 'escaped' into the networked 'e-scapes' of the Internet where it can be accessed, assessed and re-appropriated by anyone. Webster (2002: 450) - Director of the ESRC Innovative Health Technologies Programme - has even gone so far as to suggest that 'the contemporary medical portfolio is becoming increasingly "informaticised"' and this manifests in a growing emphasis on consumer health informatics (Department of Health, 2003). Other elements of this new configuration include: new approaches to medical education - such as problem-based learning (Fraser and Greenhalgh, 2001); changes in doctor-patient relationships, which now should aspire to 'concordance' rather than compliance (Mullen, 1997); and the drive towards evidence-based medicine to ensure practice is rooted in systematically obtained information (Harrison, 2002). Our concern in the research proposed here will thus be to develop a better sociological understanding of the everyday life of doctors within the context of the emergence of e-scaped medicine.

Research Design

The study will be carried out by an experienced researchers with backgrounds in sociology, social policy, health service research and medicine and will be structured as follows.

Stage 1: By way of context we will undertake a literature review of the major socio-political transformations in the medical profession in the UK over the last twenty-five years accompanied by a collation of statistical and other data on the changing socio-demographics of the profession.

Stage 2: In order to capture a diverse and broadly representative range of experiences and perspectives, doctors from a number of different health care settings will be recruited. The different cultures and work practices of primary and secondary care have long been recognised, as have differences between medical specialisms.

There are also likely to be differences in perspectives relating to factors such as: age; gender; seniority; social background; and ethnicity. With these various factors in mind a sample of doctors will be selected to include: men and women; a range of ethnic groups; those trained both within and outside the UK; junior doctors, registrars and consultants; those working in relatively affluent and relatively deprived localities; those working in both primary and secondary care; and those working in local district hospitals and in teaching hospitals with specialist status and high prestige.

The sample will also be designed so as to include a range of medical specialisms. The details of the specialisms recruited will be decided in the light of the work undertaken within *Stage 1* but will certainly include those who have specialised in areas of general medicine and surgery such as neurology, dermatology, cardiology, and orthopaedics and representatives from other specialists groups such as pathology and anaesthetics. In total, 40 interviews with doctors will be required to cover the range of dimensions of difference within the profession. Because study participants will be recruited from a number of different health care settings both Multi-Centre Research Ethics Committee and Local Research Ethics Committee approval is being sought and will be secured before the interviews are carried out.

Stage 3: Qualitative semi-structured interviews will be undertaken with those doctors who agree to participate in the study. Doctors will be able to choose whether they are interviewed at work, home or some other suitable location. The aim of the interview will be to explore their work experiences and their perceptions of contemporary medical care.

It is likely that the interview will be in three main sections:

1. Education and career - this will include questions on their motives for entering the profession, experiences of education, training and career progression.
2. Views on their current work - this will include: questions about the nature and content of their own day-to-day work; their relationships with other doctors and whether or not they feel supported by their colleagues and other health professionals; aspects of their work that they find rewarding or frustrating; whether they feel their have been any changes to their day-to-day interactions with patients; and whether they have any sense of collegiality and solidarity within the profession; and, where appropriate, their feelings and reflections on how their work has changed since they entered the profession.

3. More general views on the medical profession and society will be elicited - respondents will be asked: how they think doctors (both they themselves and the profession more generally) are perceived by patients, the media, the public; and, how they think doctors now perceive themselves, what they think the role of doctors - as individuals and as a profession - should be in the 21st century.

The schedule will be piloted with the help of medical colleagues at the Hull-York Medical School (HYMS) and elsewhere, but given the exploratory nature of this study it is likely that the schedules will be refined and adapted as the study progresses.

Contacting doctors, obtaining their agreement to participate and fixing interviews is a complex process which requires tact and persistence and a carefully managed approach. In a recent study Humphrey and Russell (2004) found that the support of a secretary who was experienced and administratively skilled at negotiating with doctors was crucial to achieving a high response rate. When asked why they agreed to participate, many of the respondents also observed that the status of the researchers as senior academics based in respected medical schools had been a key consideration. The experience of conducting the interviews in that study confirmed the value of the researchers' relevant background knowledge of medicine and health care (Humphrey, 2004). This helped to minimise the 'social distance' between interviewer and interviewee, which has been noted as a potential difficulty with interviewing elites (Richard, 1996).

In the proposed study the interviews will be carried out by the Principal Applicant (Dr Sarah Nettleton). She has considerable experience of interviewing 'elite' health professionals such as GPs, dentists, pharmacists and public health specialists and has recently worked alongside doctors developing an innovative medical curriculum in HYMS. She has also taught in a number of medical schools (see CV). We anticipate that both this particular experience and her status as an established academic will be important in gaining access to the doctors, securing their agreement to participate in the study and achieving successful interviews. It is for this reason that Dr Nettleton is requesting funding for teaching relief to undertake the primary data collection, rather than delegating this work to a more junior researcher.

Stage 4: The analysis of the interview data will be guided by the central questions posed in the study. The analysis will be both descriptive and analytic (Mason, 2002; Silverman 2000). The descriptive aspect will ascertain the nature and content of medical work described by the practitioners and summarise their views on the topics explored in the interviews. Particular attention will be paid to any patterns or differences that emerge with regard to the participants' perceptions about their work, their relationships with colleagues and their perceived social status. Analytic work will be carried out to identify themes which transcend the interviews with a view to developing explanatory concepts and this will be developed in conjunction with the theoretical developments outlined above. The analysis of the qualitative data will be managed using Atlas.ti - a package successfully utilised by the applicants on a number of previous projects. As experienced qualitative researchers we are aware that the analysis of qualitative data can be time consuming. After the data has been collected the bulk of the analysis will be undertaken by Nettleton over 18 months as part of her normal duties.

Stage 5: The findings from the empirical analysis will be written up in relation to the theoretical considerations which have informed the proposal, exploring the extent to which the theoretical claims of sociologists are evidenced in the doctors' own accounts. Thus the study will contribute to and extend ongoing debates within medical sociology, medicine and social theory.

Dissemination

The are three main audiences for this research: the academic community; professional bodies; and the public. For the first the research will yield articles in journals such as *Sociology of Health and Illness*, *Social Science and Medicine* and *Work, Employment and Society*. For the second papers will be submitted to professional journals such as the *British Medical Journal*. Dissemination will also involve engagement with professional bodies such as the Royal Colleges, the BMA and Patients Associations - bodies whom, as discussed above, have been considering these issues. For the third, we will write more 'popular' pieces for the quality press and -such is the public interest in the topic - we are also confident of gaining access to Radio 4 programmes with a substantive interests in these topics. One of the proposers (Watt) has considerable experience in appropriate research dissemination because for a number of years he managed the dissemination programme of the NHS Centre for Reviews and Dissemination (see CV).

The proposers work with the newly established HYMS and, as such, are in contact with practitioners and professional bodies. They are involved with national groups who are developing innovations in the medical curriculum. Nettleton also makes presentations to medical audiences; for example she has recently given talks on her ESRC funded work on the internet and health and also on the sociology of living with an undiagnosed illness at medical 'study days' in hospital settings throughout the England.

A final but not insignificant raison d'etre for the research is that it will complement other ESRC funded studies already undertaken by the proposers (Nettleton and Watt). First, as part of the IHT Programme they investigated peoples use of on-line health information (e.g. Nettleton and Burrows, 2003; Nettleton *et al* 2004). Second, they undertook an investigation into patients' experiences of living with undiagnosed illness (Nettleton et al 2004a 2004b). Whilst carrying out this work it has become apparent that was missing was the perspective of doctors. Once the study is completed Nettleton will write a book which brings these studies together and, in particular, examines the extent to which the changing domains of health and medicine permeates the lives of doctors, patients and the public alike. Currently updating her textbook on the *Sociology of Health and Illness* (Polity Press, 1995) she is well placed to undertake such a broad venture.

[3409]

References

Armstrong, D. (1995) 'The Rise of Surveillance Medicine' *Sociology of Health and Illness* 17, 3 393-404

Armstrong, D. (2002) *A New History of Identity: a sociology of medical knowledge* Basingstoke, Palgrave

Armstrong, D. Reyburn, H. and Jones, RH. (1996) A study of general practitioners'' reasons for changing their prescribing behaviour. *British Medical Journal* 312: 949-952.

Atkinson, P. (1981) *The Clinical Experience* Aldershot, Gower

Atkinson, P. (1995) *Medical Talk and Medical Work: the liturgy of the clinic* London, Sage

Beck, U. (1992) *Risk Society* London, Sage

Beck, U., Giddens, A. And Lash, S (1994) *Reflexive Modernisation* Cambridge, Polity Press

Becker, H., Geer, B., Hughes, E. and Strauss, A. (1961) *Boys in White* University of Chicago Press

Berrow, D. Humphery, C. and Hayward, J. (1997) Understanding the relationship between research and clinical policy: a study of clinicians views *Quality in Health Care* 6 181-6

Black, C. (2003) 'Ways in which doctors are special' paper presented at seminar *Do we still need doctors?* Drugs and Therapeutics Bulletin, Portland Place, London 11th June

Blumenthal, D. (2002) 'Doctors in a wired world: can professionalism survive connectivity?' The Milbank Quarterly 80 (3) 525-546

BMA (2002a) *The Future health care workforce: Discussion Paper 9* London BMA Health Policy and Economic Research Unit

BMA(2002b) *Patient Safety and Clinical Risk* London BMA Health Policy and Economic Research Unit

BMA (2003) *BMA Cohort Study of 1995 Medical Graduates: 8th Report* London, BMA Health Policy and Economic Research Unit

Castells, M. (1996) *The Rise of the Network Society* vol 1 of *The Information Age: Economy, Society, Culture* Oxford, Blackwell

Coulter, A. and Fitzpatrick, R. (2000) The patients perspective regarding appropriate health care in G. Albrect, R. Fitzpatrick, and S. Scrimshaw (eds) *The handbook of social studies in health and medicine* London, Sage

Davies, C. (2003) Some of our concepts are missing: reflections on the absence of a sociology of organisations in *Sociology of Health and Illness Sociology of Health and Illness* 25 172-190

Department of Health (2003) Building on the Best: choice, representativeness and equity in the NHS London, HMSO cm 6079

Douglas, H.R., Humphrey, C., Lloyd, M., Prescott, K. Haines, A., Rosenthal, J., Watt, I. (1997) Promoting clinically effective practice: attitudes of fundholding general practioners to the role of commissioning *Journal of Management in Medicine* 11 (1) 26-34

Edwards, N. Kronacki, M and Silversin, J. (2002) Unhappy doctors: what are the causes and what can be done *BMJ* 324 835-8

Fox, N. (1992) *The Social Meaning of Surgery* Buckingham: Open University Press.

Fox, R. C. (1989) *The Sociology of Medicine: A Participant Observers View* Englewood Cliffes, NJ: Prentice-Hall

Fox, S. *et al* (2002) *Vital Decisions*, Washington DC Pew Internet and American Life Project

Fraser, S. and Greenhalgh, T. (2001) ‘Coping with complexity: educating for capability *BMJ*

323 799-803

Freidson, E.(1970) *Professional Dominance* New York, Atherton

Freidson, E. (2001) *Professionalism: the third logic* Cambridge, Polity Press

Hanlon, G. (2003) NHS Direct: patient empowerment or dependency? Final Report to the ESRC Project no: L218252022

Harrison, S. (2002) New Labour, modernisation and the medical labour process *Journal of social policy* 31 (3) 465-85

Harrison, S. and Ahmad W. (2000) Medical Autonomy in the UK State 1975-2025 *Sociology* 34 (1) 129-46

Harrison, S and Dowswell, G. (2002) Autonomy and bureaucratic accountability in primary care: what English general practitioners say *Sociology of health and illness* 24 2 208-26

Haug, M.. (1988) A reexamination of the hypothesis of deprofessionalization *Milbank Quarterly* Supplement 2 48-56

Heaton, J, (2004) *Reworking Qualitative Data* London, Sage

Henwood, F., Wyatt, S. Hart, A. and Smith, J. (2003) Ignorance is bliss sometimes: constraints on the emergence of the informed patient in the changing landscapes of health information *Sociology of Health and Illness* 25 (6) 589-607

Horton, R. (2003) *Second opinion: doctors, diseases and decisions in modern medicine* London, Granta Books

Humphrey, C. and Berrow, D (2000) In the eye of the beholder: problems of perception in designing a strategy to promote evidence-based clinical policy *Journal of Evaluation in Clinical Practice* 6 (2) 165-76

Humphrey, C. and Russell, J. (2004) Motivations and values of hospital consultants in south east of England who work in the NHS and do private practice *Social Science and Medicine* (forthcoming)

Humphrey, C. (2004) Personal communication.

Irvine, D. (2003) *The Doctors' Tale: professionalism and public trust* Oxford, Radcliffe Medical Press

Jewson, N. (1976) 'The disappearance of the sick man from medical cosmology 1770-1870' *Sociology* 10 (2) 225-44

Krause, E. A. (1996) *Death of Guilds: professions, states and the advance of capitalism 1930 to the present* New Haven, Yale University Press.

Lantos, J. (1997) *Do we still need doctors?* London, Routledge

Larson, M. (1977) *The Rise of Professionalism* Berkeley, University of California Press

Lupton, D. (1997) 'Doctors on the medical profession' *Sociology of health and illness* 19 (4) 480-497

Madhok, R. (2003) ' Doctors in the new millenium: hypocrates of Hippocrites? Royal College of Physicians, Milroy Lecture September, London.

Mason, J. (2002) *Qualitative Researching* London Sage (2nd edition)

Mercurio, J. (2002) *Bodies* London, Jonathan Cape

McKinlay. D. and Stoeckle, J. (1988) Corporatization and the social transformation of doctoring *Int. Jr. of Hlth Sers*. 18 191-205

Monaghan, L. (2001) Looking good, feeling good: the embodied pleasures of vibrant physicality *Sociology of health and illness* 23 3 330-356

Mullen, P. (1997) Compliance becomes concordance *BMJ* 314- 691

NHS Confederation (2002) *The problem of unhappy doctors: what causes it and what can we do?* London, NHS Confederation

Nettleton, S. and Burrows, R.(2003) 'E-scaped medicine? Information, reflexivity and health' *Critical Social Policy*, 23, 2,165-185.

Nettleton, S (2004) 'The emergence of e-scaped medicine' *Sociology* 38 4 661-679

Nettleton, S., O'Malley, L. Watt, I. And Duffey, P. (2004a) Enigmatic Illness: narratives of patients who live with Medically Unexplained Symptoms *Social Theory and Health* 2 (1) 47-66

Nettleton, S.,. Watt, I., O'Malley, L., and Duffey, P. (2004b) Understanding the narratives of people who live with medically unexplained illness *Patient Education and Counselling* in press

Prior, L. (2003) Belief, knowledge and expertise: the emergence of the lay expert in medical sociology *Sociology of Health and Illness* 25 41-57

Pickstone, J. (1993) Ways of knowing: towards a historical sociology of science, technology and medicine *BJHS* 26 433-58

Pickstone, J. (2000) Production, community and consumption: the political economy of twentieth century medicine in R. Cooter and J. Pcikstone (eds) *Medicine in the Twentieth Century* Amsterdam, Harwood Academic Publishers

Richard, D. (1996) Elite Interviewing approaches and pitfalls *Politics* 16 (3) 199-204

Silverman, D. (2000) *Doing Qualitative Research: a practice guide* London, Sage

Smith, R. (2003) 'The future of medical education: speculation and possible implications' www.bmj.com/talks

Thoebe N. Lo, S., Auvache, V. and White, P. (2001) Bad press for doctors: 21 year survey of 3 national newspapers *BMJ* 323 782-3

Turnberg, (2002) 'Science, Society and the Perplexed Physician' The Harveian Oration, Royal Collage of Physicians, London. October.

Weatherall, D.(1995) *Science and the quiet art* Oxford University Press

Webster, A. (2002) Innovative health technologies and the social: redefining health medicine and the social *Current Sociology* 50 (3) 443-57.

THE UNIVERSITY of York

RESEARCH PARTICIPANT INFORMATION SHEET

'On Being a Doctor': A study examining the views of medical clinicians in the 21st century

What is the background to the study?

- Amongst members of the medical profession there has been much discussion in recent years about the nature and content of medical work and the appropriate role that doctors should play in contemporary health and social care. There has even been a suggestion that there needs to be a 'cultural revolution' in medicine. High profile public inquiries, media attention and a more consumer orientated culture are some of the factors that have contributed to this. But what do doctors who work day in and day out delivering patient care in hospitals and general practices make of all this? What are their views? Is their work actually affected by these contemporary developments?

What is the purpose of the study?

- To investigate the views and day to day experiences of medical clinicians and to examine how they are being shaped by ongoing social, policy, organisational and technological transformations.

Who is funding the study?

- The research is funded by the Economic and Social Research Council (ESRC) www.esrc.ac.uk. The ESRC is one of the main funders of research on social and economic issues in the UK. Although it is government funded it is an independent agency and it has no connection with the NHS, the Department of Health or any other government department.
- The ESRC require that data collected is offered to the Economic and Social Data Service (ESDS) led by the UK Data Archive. (See leaflet enclosed). If the ESDS wish to accept the interview data there are strict legal and ethical regulations which pertain to confidentiality and the storage and use of the data. The interview data offered will not include your name, place of work or any other details that could allow you to be identified. You may opt **not** to give permission for this, if so this is fine. Further information can be found at http://www.esds.ac.uk/introduction.asp

How will the research be conducted?

- The study will be carried out in both hospital and primary care settings.

- Information and data will be collected by interviews, lasting 40–60 minutes, with doctors who agree to take part in the project. The interviews will take place at a mutually convenient time and place.

- The aim of the interviews is to gain an appreciation of how clinician's perceive their own roles and how these may be affected by developments and changes to their working lives.

- The interviews will be carried out by Dr Sarah Nettleton who is a Senior Lecturer in the Department of Social Policy at the University of York between June and December 2005.

Do I have to take part?

- It is not compulsory and you will be given the chance to 'opt out' of the study if you so wish without giving any reason. The more people who take part, the broader and more in-depth understandings we will generate.

What about confidentiality?

- What you say in your interview will be confidential. The only person apart from Dr Nettleton who will have access to the tape of your interview will be the transcriber who will be given a numbered (rather than named) cassette and will not be able to identify you. Any quotes from interviews that are included in the final report will be anonymised.

What will happen to the findings?

- The findings will be written up in a final report, copies of which will be made available to all those who want to receive one.

- Papers will be submitted for publication in peer reviewed journals

Who is undertaking the work?

- The research team all work at the University of York. Dr **Sarah Nettleton** is a Senior Lecturer in the Department of Social Policy; Dr **Ian Watt** is Professor of Primary and Community Care in the Department of Health Sciences and HYMS, and a GP; and **Roger Burrows** is Professor of Sociology in the Department of Sociology. Sarah Nettleton is the Chief Investigator on the project and can be contacted at sjn2@york.ac.uk

Thank you for taking the time to read this.

Wednesday, 22 June 2005 version 2
Friday, 06 May 2005 (Version 1)

DOCTORS CONSENT FORM TO BE INTERVIEWED

The study: 'On Being a Doctor': a sociological analysis.
Researchers: Dr Sarah Nettleton, Professors Ian Watt and Roger Burrows
Address: Department of Social Policy, University of York, York, Heslington, York Y010 5DD. Tel: 01904 321248

This form is to check that you are happy with the information you have received about the study and are aware of your rights as an interviewee.

1. Have you read the information sheet?	Yes/No
2. Have you had the opportunity to discuss further questions with one of the researchers?	Yes/No
3. Have you received enough information about the study to take part in the interview?	Yes/No
4. Do you understand that you may withdraw from the study at any time without giving your reasons	Yes/No
5. Do you understand that members of the study team will treat all information as confidential?	Yes/No
6. Do you agree to be interviewed?	Yes/No
7. Do you give consent for the interview to be tape recorded?	Yes/No
8. Are you willing to give consent for the transcript of this interview to be preserved in the UK Data Archive at the University of Essex.? It will be kept confidentially. The material will be preserved as a permanent research resource for use in research and publication under a set of terms and conditions agreed by this research team.	Yes/No

Signature(s)... Date............................

Name(s) in block letters..

I confirm that the purpose and nature of the study have been fully explained
Signature of researcher .... Date.............................

Name in block letters..

Friday, 06 May 2005

On Being a Doctor: a sociological analysis
Semi structured, qualitative Interview Schedule (Draft)

Introduction

Thank you for agreeing to be interviewed.
Statement of confidentiality. Permission to tape record. Signed interview constent form.

The interview will cover three main areas. First some background information about your education and training to put your views in context; second, to explore your views and opinions on your current work and finally your more general observations and thoughts on the medical profession and doctors role in society.

Section 1: Education and career

1.1 Can we begin with your route into medicine?

- Where did you train?
- Why medicine? Motives, aspirations etc
- Brief resume of career path – and why particular choices made?

1.2 To what extent did/has your training equipped you for your current work?

- Views on non-going training

1.3 Do you think the skills, qualities and knowledge needed by doctors today are any different to what they were when you were an undergraduate?

Section 2: Current work

2.1 What is your current job title?

- Length of time in present job

2.2 Can you describe your present job and your main aspects and responsibilities?

- Clinical work
- Role within a care team
- Management of junior staff
- Training / education (both of self or others)
- Research

2.3 Over the last decade (or less if appropriate) what, if any, changes have there been to your work within the health service?

- Interactions with patients
- Expectations – from patients, from management, colleagues
- Teamworking
- Organisational
- Innovations in drugs/treatments
- Innovations in technologies e.g. diagnostic techniques, equipment
- To what extent are these changes/if any due to social changes or the fact that you are working in a different type of organisational context or geographical area

2.4 Do you think that patients have changed or still fundamentally have the same concerns and issues?

2.5 Have policy initiatives such as the emphasis on Evidence Based Medicine, NSFs, NICE guidelines, targets etc had any impact on your day to day work?

- Reactions to them?
- Helpful/unhelpful
- Any tensions between needs of individual patients and epidemiological based guidelines?

2.6 To what extent –if any- has the internet affected your work?

- Use by patients to access information
- Use by yourself to e.g. to access information

2.7 How would you describe your relationships with other doctors?

- Same specialty/ different specialty
- Supported, collegiality?
- Isolated
- Any examples of conflict or tension
- Have these relationships changed in recent years?

2.8 How would you describe your relationships with doctors in primary/secondary (as appropriate) care?

- Good/Bad/Variable
- Any changes

2.9 Do you socialise with other doctors?

- During work hours (lunch times etc)
- Out of working hours

2.10 How would you describe your relationship with other health professionals (will vary with speciality) that you routinely work with on a day to day basis?

- Nurses /Pharmacists/ phsyios
- Managers/admin
- Have these relationships changed in recent years?

2.11 What are the main sources of satisfaction in your work?

- Examples

2.12 What are the main sources of frustration?
- Examples

2.13 There's a growing body of research that shows that doctors are becoming more unhappy – reflecting on your own observations and experiences have you any thoughts on why this might be?

Section 3: General Views on the Medical Profession

3.1 Are you a member of any professional associations?
- Which?
- Why?
- Degree of political involvement and activity?

3.2 In general terms how do how you think the medical profession are viewed by:
- The public
- The media
- Patients
- Doctors

3.3 Its often commented that professionals in general don't have the social status that they had in the past?
- Do you agree?
- Is it a myth?
- Does / how does it matter

3.4 Professor Joe Collier – editor of the Drug and Therapeutic Bulletin has said that 'doctor's need to ask themselves serious questions about what they do and what there special qualities are'
- What is your response to that?
- Special qualities
- What are the main tasks
- What is makes for a good 'clinician'?

3.5 Professor Ian Watt and I am involved with teaching at HYMS – what advice would you give to a medical student today?

3.6 Do you think being a doctor might be different in 5 / 10 years time?

3.7 The 'any thing else question' that is you would like to add that we haven't covered.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Non-Technical Summary (Research Summary). ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

REFERENCE No.

ACTIVITIES AND ACHIEVEMENTS QUESTIONNAIRE

1. Non-Technical Summary

A 1000 word (maximum) summary of the main research results, in non-technical language, should be provided below. The summary might be used by ESRC to publicise the research. It should cover the aims and objectives of the project, main research results and significant academic achievements, dissemination activities and potential or actual impacts on policy and practice.

In recent decades the working lives of doctors in the UK have attracted considerable attention from the media, the government, and the public. Such interest was fuelled by a series of high profile 'scandals' such as: the Shipman murders, the 'Bristol Case', the Alder Hey scandal; reforms to medical training; and, more recently, the apparent 'chaos' brought about by changes to the recruitment of junior doctors. Perhaps not surprisingly representatives of the profession have been reflecting on their 'public face' and on what their role should be. In a number of lectures, seminars and publications, members of the medical establishment have being asking questions such as: What does it mean to be a doctor? What, if anything, makes doctors special? Why are doctors so unhappy? From doctors and policy makers alike there has been a call for a cultural change within the institution of medicine and for a rethinking of medical professionalism. To contribute to these and other more academic debates on the sociology of professions more generally, the study 'On Being a Doctor: a sociological analysis' explored the views of doctors about their routine working lives. The extant sociological literatures have tended to focus upon the structural dimensions of doctors' roles, rather than examining the views of the 'occupants' therein. By contrast the current study sought to achieve an empathetic understanding of the everyday experiences of doctors by listening to their accounts of their routines, activities and views in relation to their work.

The aim of this exploratory study was to develop a rounded sociological understanding of the views and experiences of doctors working within the UK National Health Service (NHS). The research questions that guided the study were: What do doctors who work day in and day out delivering patient care in hospitals, health centres and clinics make of changes to health care? Are they aware of these calls for changes to their practice and values? Do contemporary developments affect how they feel about themselves? Have their relationships with colleagues altered at all? Are they affected by these changing expectations from the professional bodies and the public at large?

In order to answer these questions we undertook to do the following. Review the pertinent existing literature on social transformations as they pertain to contemporary medical work. Elicit 40 qualitative interviews with doctors from NHS health care settings who vary in terms of medial specialities, age, gender, ethnicity, seniority, and locality. Undertake analysis of the interview data informed by a range of theoretical and policy orientated questions with a view to contributing to debates in social theory and health policy. Disseminate findings to academic, professional and lay audiences. Insert the findings alongside other recent studies carried out by applicants in order to contribute to sociological understanding of transformations in health and health care.

Qualitative methods were employed. In the end fifty-two interviews were undertaking with doctors from NHS health care settings who varied in terms of medial specialities, age, gender, ethnicity, seniority, and locality. Analysis of the interview data informed by a

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Non-Technical Summary (Research Summary). ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

range of theoretical and policy orientated questions with a view to contributing to debates in social theory and health policy.

Forty-seven doctors (28 men and 19 women) working in hospital settings in the North of England and 5 (4 men and 1 woman) working in general practice were interviewed. Twenty of the 47 worked in a large teaching hospital serving an ethnically heterogeneous and predominantly socially disadvantaged area and 27 worked in a smaller (formally district) hospital serving a more affluent predominately white population.

The qualitative interviews generated a significant body of 'rich' data which cast novel insights on 'being' a doctor in contemporary Britain. The accounts and descriptions of the doctors training, careers, day-to-day working, and their reflections on a series of 'topical' health care issues were much fuller and more candid than had been anticipated at the outset of the project.

Certainly when listening to and analysing the doctor's talk one could not help but be struck by the participants' emotional responses to their work. Interestingly the emotions, feelings and experiences of doctors seem to be a topic of endless fascination in popular culture, a fascination that has not been reflected in the academic sociological literature. Thus the feelings doctors have in relation to their working lives comprised an aspect of the data were explored in detail and a degree of ambivalence was evident. We suggest that this is generated by a contextual tension which presumes that the medical profession are required to reproduce medicine as an abstract system - an objective, trustworthy, reliable, effective, competent and fair mode of healing - and yet individual practitioners are also required to be caring, emotionally intelligent, intuitive, and sensitive.

The observation that the 'hands on', experiential and practical content of medical practice is crucial to good practice was reiterated throughout the data. Medical practice is what sociologists of the body would call 'embodied' activity – activity which relies on tacit knowledge. The rise of new forms of governance, techniques of audit and regulation appear to be affecting upon the cultivation of embodied activity and the associated cultivation of tacit knowledge. From our data it would seem that doctors feel they are changing their working practices in the face of the modes of governance – and this is may have consequences that were unintended and unanticipated by policy makers.

Two academic papers have been written – one forthcoming in *Sociology of Health and Illness* in 2008 and one is under submission to *Social Theory and Health*. Conference and seminar presentations have been given on the findings. Further papers for both professional and academic audiences are in preparation. The findings of the research are being used for the teaching of medical students.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

REFERENCE No.

ESRC End of Award Report
RES-000-22-1158

On Being a Doctor: a Sociological Analysis

Sarah Nettleton, Ian Watt and Roger Burrows

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

BACKGROUND

In recent decades the working lives of doctors in the UK have attracted considerable attention from the media, the government, and the public. Such interest was fuelled by a series of high profile 'scandals' such as: the Shipman murders, the 'Bristol Case', the Alder Hey scandal and the consequent Inquiries; reforms to medical training; and, more recently, the apparent 'chaos' brought about by changes to the recruitment of junior doctors. Perhaps not surprisingly representatives of the profession have been reflecting on their 'public face' and on what their role should be. In a number of lectures, seminars and publications, members of the medical establishment have being asking questions such as: What does it mean to be a doctor? Do we still need doctors? What, if anything, makes doctors special? Why are doctors so unhappy? Has the medical profession lost control? Is there any consensus about what a doctor actually does? (Turnberg, 2002; Smith, 2003; Horton, 2003; Black, 2003). In 2005 a Working Party set up by the Royal Collage of Physicians reported on their extensive exploration which had set out to 'define the nature and the role of medical professionalism' in the light of significant social, cultural and organisational change (Royal Collage of Physicians, 2005: 11). Having canvassed the views of doctors and a wide range of expert advisers they concluded that medical professionalism should be defined in terms of values, behaviours and relationships which foster trust from patients and the public. This was a finding that echoes the call from the former president of the General Medical Council (GMC) Donald Irvine (2003) who advocated the need for a 'cultural revolution' in medicine - the need for what he called a 'new professionalism' - a term he credits to the medical sociologist Meg Stacey. For him this 'new professionalism' must embrace:

> 'evidence based medicine rather than clinical pragmatism, the recognition of the importance of attitudes and behaviour, partnership with patients, and accountability rather than personal autonomy ...[it] is about teamwork rather than individualism, collective as well as personal responsibility, transparency rather than secrecy, empathetic communication and above all respect for others. An unreserved commitment to quality improvement through clinical governance is fundamental' (p. 206).

The purpose of the research reported on here was to undertake a sociologically informed study of the impact of these (and other related) developments for the day-to-day working lives and experiences of doctors informed by two related theoretical literatures.

- First *the sociology of professions* - most notable here was Freidson's (1970) thesis that the medical profession was too powerful and that this was detrimental for public health and health care (Freidson, 1970). Some have suggested that the profession has undergone processes of de-professionalisation (Haug, 1988) or even proletarianisation (McKinlay and Stoeckle, 1988; McKinlay and Marceau, 2002). Freidson too observed the weakening of the profession, and in his later work suggested that society is no longer at risk from an overly powerful profession but rather '[W]hat is at risk today, and likely to be at greater risk tomorrow, is the independence of professions to choose the direction of the development of their knowledge and the uses to which it is put' (Freidson, 2001: 14).

- Second, analyses which have constructed *periodisations of medicine* which reveal how socio-technological forms mesh with medical knowledge and how these configurations structure and shape the work of medical practitioners. For instance, Pickstone (1993; 2000), Jewson (1976) and Armstrong (1995) all identify shifts

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

between what can be termed 'bedside medicine', 'hospital medicine', 'laboratory medicine', 'surveillance medicine' and 'consumerist medicine'. Related to this we have suggested elsewhere, it is possible to discern the parameters of a new configuration - what we have termed *'e-scaped medicine'* (Nettleton and Burrows, 2003; Nettleton, 2004; Nettleton *et al* 2004). We have argued that ICTs are accelerating the transformation of 'consumerist' medicine. For example, medical knowledge is no longer exclusive to the medical academy it has 'escaped' into the networked 'e-scapes' of the Internet where it can be accessed, assessed and re-appropriated by anyone. This clearly has implications for the democratisation of knowledge and the surveillance of medical practice.

These sociological literatures have tended to focus upon the structural dimensions of doctors' roles, rather than examining the views of the 'occupants' of these roles. By contrast the current study sought to achieve an empathetic understanding of the everyday experiences of doctors by listening to their accounts of their routines, activities and views in relation to their work. It aimed to examine questions such as: What do doctors who work day in and day out delivering patient care in hospitals, health centres and clinics make of changes to health care? Are they aware of these calls for changes to their practice and values? Does it affect how they feel about themselves? Have their relationships with colleagues altered at all? Are they affected by these changing expectations from the professional bodies and the public at large? The focus on the everyday life and perception of doctors also gave rise to an engagement with theoretical orientations that had not been anticipated at the outset of the project, in particular issues relating to: the sociology audit and regulation; the sociology of embodiment; and the sociology of feelings.

OBJECTIVES

The aim of this exploratory study was to develop a rounded sociological understanding of the views and experiences of doctors working within the UK National Health Service (NHS). The stated objectives of the project were to:

- Review the pertinent existing literature on social transformations as they pertain to contemporary medical work.
- Elicit 40 qualitative interviews with doctors from NHS health care settings who vary in terms of medial specialities, age, gender, ethnicity, seniority, and locality.
- Undertake analysis of the interview data informed by a range of theoretical and policy orientated questions with a view to contributing to debates in social theory and health policy.
- Disseminate findings to academic, professional and lay audiences.
- Insert the findings alongside other recent studies carried out by applicants in order to contribute to sociological understanding of transformations in health and health care.

All of the above objectives have been achieved and in some cases exceeded. For instance, 52 interviews were undertaken rather than 40. However, we also encountered some difficulties in securing participation from doctors with the full range of characteristics we were seeking, especially those from ethnic minority backgrounds.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

Methods

The research design was a simple one and comprised in-depth qualitative interviews with a purposefully selected sample of doctors. The sampling procedure was informed by a prior statistical analysis of the population of doctors working in the NHS in England. In 2006 – the most recent years for which we have figures – there were a total of 125,612 (119,096 FTE) doctors working in the UK NHS. Of these 35,369 (33,121 FTE) were GPs (28.2%) and 93,320 (85,975 FTE) were working in Hospital and Community Health Services (HCHS). Although we were keen to include a small number of GPs in our study for comparative purposes (we obtained 5 interviews in the end), our main focus was on doctors working in HCHS, in particular Consultants, Registrars and Senior House Officers. Of the 70,545 doctors on these grades in 2006 47 per cent were Consultants, 27 per cent were Registrars and 27 per cent were Senior House Officers. In our sample of 47 doctors in the HCHS 81 per cent were consultants, 13 per cent Registrars and just 6 per cent Senior House Officers. So our sample contained a disproportionate number of doctors on more senior grades allowing us to hear accounts of their reflections of their changing experiences of working life, whilst still allowing for inputs from younger doctors about contemporary experiences. At a national level 38 per cent of doctors are female and this is the same proportion as in our qualitative sample. Nationally it is estimated that approaching 60 per cent of doctors working in the HCHS are white British, whilst in our sample 86 per cent could be so classified. We would have liked this proportion to have been higher but despite our best efforts the recruitment of doctors from ethnic minority groups proved to be difficult. Our sample, however, contained good coverage of the various specialities within HCHS. Although we had no interviews with doctors working in A&E, dentistry, public health or psychiatry all other specialities were covered: anaesthetics; clinical oncology; general medicine; obstetrics and gynaecology; paediatrics; pathology; radiology; and surgeons.

Although negotiation of access and setting up interviews was difficult, once the doctors agreed to participate, they were very forthcoming and open. As we have stated, forty interviews were planned but 52 were completed. The aim of the interviews was to explore work experiences and perceptions of contemporary medical care. All of the interviews were carried out by the Principal Investigator (Sarah Nettleton) and all but three were undertaken in the participant's place of work. The interviews took place between mid-2005 and mid-2006. Before the data collection could commence ethical approval was secured from the Multi-site Research Ethics Committee (MREC) and from two Research and Development Departments. The PI was required to attend the MREC meeting and respond to a range of concerns and questions pertaining to the study design and proposed procedures.

In the end 47 doctors (28 men and 19 women) working in hospital settings in the North of England and 5 (4 men and 1 woman) working in general practice were interviewed. Twenty of the 47 worked in a large teaching hospital serving an ethnically heterogeneous and predominantly socially disadvantaged area (identified as A1-A20) and 27 worked in a smaller (formally district) hospital serving a more affluent predominately white population (identified as Z1-Z27). Five had trained overseas and 5 were from minority ethnic groups. The age range of the sample spanned 25 to 65 years, with the youngest consultant being 35. Senior doctors were overrepresented in our sample for both methodological and pragmatic reasons. In terms of the former we were keen to explore practitioners' experiences over time and to elicit their views on perceptions of how things

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

have changed. In practical terms it is difficult to access junior doctors because they do not have their own telephones, they are constantly 'mobile' and there are few opportunities or locations to interview them. In contrast consultants tend to have their own or shared offices and secretarial support. The salience of this is discussed in Nettleton *et al* (2008).

The interviews covered four broad areas: education and career; current work, including relationships with other doctors and other professionals; views on the current state of the medical profession, especially how they thought doctors were perceived by patients, the media and the public; and finally, what they thought the role of doctors - as individuals and as a profession - should be in the 21st century. The doctors talked candidly and in a highly engaged manner. The interviews lasted a minimum of one hour, but with the majority lasting two hours or more. All of the interviews were recorded, transcribed and entered into Atlas.ti – a qualitative data analysis software.

The transcripts were initially read carefully to ensure familiarisation and were subsequently coded to provide both descriptions of the doctor's accounts and inductively as issues emerged as being salient. Because more themes emerged towards the end of the coding process the transcripts were re-read to assess whether any issues had been overlooked in the earlier trawl. The PI carried out all of the interviews and the coding of the data and this ensured a full familiarisation with the data and facilitated the detailed analysis of the findings. As issues and themes arose they were discussed with the other two members of the research team – each of whom brought different insights and knowledge derived from their contrasting backgrounds. Ian Watt, who is both an academic and part time General Practitioner, and Roger Burrows who is a sociologist and currently Programme Coordinator of the ESRC E-society programme, therefore contributed to extending the findings in relation to contemporary developments in social theory and research.

Results

The qualitative interviews generated a significant body of 'rich' data which cast novel insights on 'being' a doctor in contemporary Britain. The accounts and descriptions of the doctors training, careers, day-to-day working, and their reflections on a series of 'topical' health care issues were much fuller and more candid than had been anticipated at the outset of the project. Indeed, many of the study participants appeared to welcome the opportunity to reflect upon their experiences and we received positive feedback from some that they found the opportunity to 'stand back' from their routines to be a useful exercise. No doubt there was an element of catharsis. Certainly when listening to and analysing the doctor's talk one could not help but be struck by the participants' emotional responses to their work. Interestingly the emotions, feelings and experiences of doctors seem to be a topic of endless fascination in popular culture, a fascination that has not been reflected in the academic sociological literature. Thus the feelings doctors have in relation to their working lives comprised an aspect of the data which we explored in further detail (Nettleton *et al.*, 2007). In addition to the evident emotional dimension of medical work was the observation that the 'hands on', experiential and practical content of medical practice is crucial. Medical practice is what sociologists of the body would call 'embodied' activity – activity which relies on tacit knowledge. The rise of new forms of governance, techniques of audit and regulation appear to be impacting upon the cultivation of embodied activity and the associated cultivation of tacit knowledge.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

Feelings in Relation to Medical Work

The dominant view of the profession within the sociological literature is of a socio-economic group the occupants of which tend to aspire to rationalist, positivist, and objective values. Hitherto there has been a tendency to portray doctors as relatively unfeeling; an elite who are inclined to make unsubstantiated claims to altruism. There is some truth to this. The training of doctors has tended to inculcate a biomedical worldview, which is said to create a professional rationality that eschews feelings, emotions and sentimentality. So, for example, in a paper exploring the 'Hidden Values of Biomedicine' Kirmayer (1988: 63) argues that doctors cultivate a rational and objective approach to the care of patients and certainly do not reflect on their own frailties. 'Physicians have exaggerated standards for rationality' he writes, 'based on distancing from bodily feeling and emotion'. More recently James and Hockey (2007: 41) comment that the dominance of the medical paradigm often means that practitioners views are likely to be at odds with the more subjective and variable responses to illness of their patients. The alignment of biomedicine with the profession of medicine exacerbates the tendency to portray doctors as relatively lacking in feeling. For example, it is has been argued that there is 'an inverse law of status and skill in emotional labour' (James, 1992: 503) with doctors orchestrating care in a rational way, while nurses and health care auxiliaries carry out the bulk of the emotional 'mopping up'.

The very notion of feelings potentially involves vulnerability since the whole edifice of biomedical science, and attendant evidence based practice, presupposes a form of expertise which - to use the terminology of Giddens (1990) - is 'disembedded', from personal relations and local situations so that the abstract system (of biomedicine in this case) is maintained across place and time. Such abstract systems have little room for feelings or emotions. However, there is a tension here, because at the same time some forms of emotion are a necessary characteristic of medical work because patients have to feel that they can provide authentic narratives of their 'troubles' to a professional in whom they can both trust and invest with 'expertise'. The negotiations of relationships and feelings are dependent on the agency of individuals in the context of particular times and places. Feelings are risky in that they may easily be conceived of as 'unprofessional' (as a threat to the abstract system of medicine). Perhaps this is why sociological studies of doctors have tended to foreground the more structural features of the role rather than offering up any sustained treatment of the emotional life of doctors?

As noted above one of the aims of the project was to de-emphasise the structural roles of medical professionals and explicitly focuses on the 'human side' of the 'occupants' of these roles. In effect we were asking the seemingly personal question: how do you feel doctor? Seemingly personal, but in fact the individual responses must also be socially contingent. In his seminal paper on mundane 'techniques of the body' Mauss (1973: 70) describes techniques such as walking, sleeping, and swimming - in order to convey the ways in which people 'know how to use their bodies'. Correspondingly what we report on here are 'techniques of feeling' which are at once personalised and social responses to a particular set of circumstances. Although doctors vary in terms of their concerns, their persona and of course their gender, age, race, and position in the medical hierarchy, the multiplicity of feelings they describe form the essential features of 'being' and 'doing' doctoring in the early 21st century in the UK NHS.

Hochschild's (1983) seminal book on emotional labour was instructive to our analysis. Not so much for her concept of emotional labour itself, because this was not our central concern, rather for her classification of emotional states in an appendix titled 'Naming

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

Feeling' (Hochschild, 1983: 233-239). In this she produced a table - a list of named feelings which included: anger; contempt; frustration; guilt; nostalgia; sadness; and shame. 'To name a feeling' she suggested, 'is to name our way of seeing something, to label our perception' (Hochschild, 1983: 233). Through our data we found examples of this full range of feelings, perhaps most notably in relation to patients, but also in relation to clinical work, to medical training, to colleagues, and to conditions of employment. Space precludes a full account, so a couple of examples will have to suffice.

A recurrent theme was that working with people, seeing them get better, supporting them through difficult times, doing something for the benefit of humankind was gratifying.

> I do perceive my job as useful, whereas I watch the news and there'll be something about bankers, and I'll think that's a complete waste of time, we could kick them all out and it would make no difference at all. Whereas if you got rid of all the dustmen, typists or doctors it would make a big difference. So I do perceive myself as socially useful and I do derive some satisfaction from that. I have a lot of patients I enjoy talking to because they are interesting and the core bit about medicine is the interest you have in the human condition. And I think I am perfectly adequately paid, I have no gripes at all about my payment (Z009, Consultant Male, 40s).

Similarly a younger SHO enthuses:

> I love it, there are frustrations, but there are frustrations in every job. Every job has boring bits. My job is so special; you can make a difference. Every day is different, so you meet some amazing people, some nasty people. I absolutely love my job and I wouldn't change it for the world (A019, SHO, Female, 20s).

Fostering 'good' relationships, learning about people's lives, their families, and their illness trajectories were repeatedly reported to be a source of satisfaction and pride. Such responses are perhaps hardly surprising as these accounts invariably draw upon a range of discourses; not least prevailing societal and professional expectations of 'good doctoring' (GMC, 2006). Even so the emotionally charged nature of exchanges with patients – the 'human' side of their work - was reflected upon during the interviews, as we hear from a radiologist who was reflecting on his career choice.

> I like the patients, I like the emotion that goes with it; you know, the tears and the happiness. Compared to a lot of the other parts of radiology it's significantly more emotionally charged. There's a good proportion of tears in that clinic and they're not all nasty tears, you know, some of them are tears of joy. But I mean it's, it's a good tiring hard work session. But I mean that wakes me up and sort of gets me started, you know it's a 'nice' tired. It's, you know, it's like climbing to the top of a mountain and sat there and thinking Christ I've done that; it's an 'achievement' sort of tired (A007, Consultant, Male, 30s)

Most doctors recalled particular patients who they felt had touched their sensibilities. Recollections of their patients were not simply of passive objects – as bodily containers of disease - as the biomedical paradigm might imply. On the contrary, they had enduring memories of their patient's lives, their families, their circumstances and how some of their patients had coped with their illness experiences. Yet retaining their 'rational self' at

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

the same time as feeling such emotions was viewed as an important aspect of being an effective doctor.

Participants often appeared diffident when expressing these views noting that it sounded rather trite – 'it sounds a bit pathetic doesn't it' - they would say, even though for some these feelings had motivated them to enter medicine. Living in a context where media culture is saturated with emotional crises, the expression of such positive feelings can appear hackneyed and distanced from authentic emotion thus making the reporting of such feelings difficult.

Within hospital settings the scope for informal support and the opportunities for dissoluteness were thought to be on the wane. Some doctors lamented the demise of the hierarchical 'firm' structure – in spite of the scope for patronage and opportunities for consultants humiliating their juniors. Relationships between consultants and juniors are now more prescribed as the former have to carry out more 'objective' assessments of their trainee's competences. Relationships may be becoming formalised and impersonal. The informal spaces where doctors could meet are also disappearing: the consultant's dining room; the doctor's mess; and the (in)formal social events. There are few 'backstage' settings (Goffman, 1961) in hospitals now with only some consultants having their own offices (others share with other consultants and/or their secretaries) and non-consultants have very few places into which they might retreat from the public gaze. This is in marked contrast to doctors working in general practice who reported having ample meetings and discussions with their colleagues and who are only 'front stage' for clearly demarcated periods.

There are numerous illustrations of 'techniques of feeling' in the data - that is the expression of emotional responses that are precipitated by and contingent upon a particular set of circumstances. The feelings articulated in relation to work are rooted within the 'habitus' (Bourdieu, 1990) of contemporary medical practice - thus they are inextricably interlinked with the assumptions, expectations and prescriptions about medicine which prevail in wider society. Being able to balance effectively between the needs of patients and ones self, between empathy and rationality, between ones frustrations and achievements, between the dictates of managerialist regulatory environments and professional integrity, and between work and home, comprises – in a colloquial parlance – 'a well balanced' professional.

Regulating Medical Bodies
The very detailed accounts of the hum drum routines of medical practice that we have perhaps rather surprisingly meshed with a number of quite conceptual contemporary theoretical debates. Indeed, a central finding of the study was the ways in which processes of modernisation and regulation of medical work are having potentially unanticipated consequences for medical knowledge and medical practice. This relates to the thesis pertaining to periodisations of medicine discussed above. Of course the observation is not a wholly original one (see for example, Harrison, 2002; Flynn, 2004), however what our study adds is empirical material to further substantiate these claims. These findings are discussed in detail in our forthcoming paper: 'Regulating Medical Bodies?' (Nettleton *et al.,* 2008) – the central thesis of which is that 'regulatory processes' are contributing to a 'disembodiment' of medical knowledge.
In the UK the modernisation agenda has involved a series of reforms intended to 'modernise' welfare provision by making practices and procedures more transparent (Department of Health, 1997). Professionals comprise a key target and they are required

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

to become more accountable, less autonomous and more carefully regulated. Medicine is no exception as is evidenced by the publication of the recent White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (Secretary of Sate for Health, 2007). Thus the language of reform has been replete with terms such as: 'audit'; 'governance'; 'accountability'; 'information'; and 'performance'. The emergence of these changes has been theorised by Power (1997) in his seminal text *The Audit Society* a work which we found to be especially instructive for making sense of our findings.

In this book he traces how techniques, which have their origins in accounting firms, are transported into virtually all areas of public service. He argues that 'the growth of auditing is the explosion of an *idea*; an idea that has become central to a certain style of controlling individuals and which has permeated organisational life' (Power, 1997: 3). Performance, measurement, cost containment, transparency of procedures are the concrete manifestations of this idea. But a commitment to audit also implies a commitment to a set of social aspirations which presume that being able to 'audit' (make visible and document) the activities of actors is, *ipso facto,* a good thing. Not surprisingly these managerial practices have been found to impact upon workers' identities. Indeed, Power suggests that the organisational systems designed to facilitate the goals of audit create: 'new motivational structures … as auditees develop strategies to cope with being audited; it is important to be seen to comply with performance measurement systems while retaining as much autonomy as possible' (Power, 1997: 12). In many respects it was these 'new motivational structures' that we tapped into during our study in that we were able to discern the ways in which dimensions of regulation impacted upon identities, practices, and responses to work.

Amongst the accounts given by the doctors the matter of clinical experience emerged as a salient theme and appeared to be to the fore in comparison to other issues. The salience of this has been well documented by medical sociologists (Atkinson, 1981; 1995; Good, 1994) and the profession's over reliance on the 'art' of medicine has been extensively critiqued (Cochrane, 1971; Freidson, 1970). More recently however some sociologists have suggested that regulatory cultures (Harrison, 2002) or new forms of bureaucracy (Flynn, 2004) are giving rise to the prioritisation of codified knowledge and undermining 'reflective' or tacit knowledge. Could it be that the regulation of working practices, training, knowledge and accountability has the potential to reduce opportunities to cultivate tacit knowledge? Certainly the policy shifts associated with regulation and audit are bringing about changes in medical training and medical practices and will therefore invariably have consequences for the mode of transmission of medical work. Thus the 'body pedagogics' (Shilling, 2007) within the hospital may be yielding different practices; 'becoming' and 'being' a doctor or 'accomplishing' medical work is thus likely to be different within an 'audit culture'.

Bourdieu (1990) claims that there is a homology between habitus and institutional context - what he refers to as the 'social field'. Within the 'field' of medical education the values and merits of managing fatigue, working long hours, intense socialising and camaraderie, deference to 'superiors', and a privileging of masculine norms over others, have inculcated a recognisable medical 'habitus' (Becker 1976; Fox 1989). However, the institutional context of medical training is changing and one might suppose this would have consequences for the associated medical habitus. Changes to working hours, the introduction of shift systems, the demise of 'the firm', the fear of litigation and associated reluctance to 'throw juniors in at the deep end' to carry out procedures that they have never done before, alter the culture of the hospital. Hospitals, alongside other formal

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

institutions are transforming; they are no longer quasi-total institutions (Goffman, 1961) where doctors 'lived in', had little separation between their work and social life and knew their place within the clearly demarcated social hierarchy. Our data has richly picked up some of the myriad embodied consequences of this.

Activities

Sarah Nettleton was an invited speaker at the *ESRC* Seminar *Regulating Medicine* 'Knowledge of Bodies, Bodies of Knowledge: the changing nature of contemporary doctoring in the UK' University of Leeds, June 2006. She also gave a paper at the *BSA Medical Sociology Group 38th Annual Conference on* 'The Human Side of Medicine: some sociological reflections on the 'realities' of contemporary doctoring' 14- 16th September 2006.

Outputs

Nettleton, S. Burrows, R. and Watt, I. (Forthcoming 2008) 'Regulating Medical Bodies? An Analysis Of Doctor's Accounts Of The Consequences Of The 'Modernisation' Of The NHS For The Disembodiment Of Clinical Knowledge' *Sociology of Health and Illness,* Forthcoming.

Nettleton, S. Burrows, R. and Watt, I. (under submission) 'How Do You Feel Doctor? An Analysis Of Emotional Aspects Of Routine Professional Medical Work' *Social Theory and Health*

Impacts

Both Nettleton and Watt are involved in the curriculum development and delivery of teaching in the Hull York Medical School (HYMS) and they have ensured that the matters dealt with in this report are covered. The findings have proved to be useful teaching material to help students reflect on the nature of professional practice.

The findings also add empirical weight to contemporary debates within professional, policy and academic arenas on the nature and role of medical work and medical professionalism within the changing social, cultural and technological environment.

Future Research Priorities

To investigate the extent to which doctors feels professionally and socially isolated in their current roles and the impact on patient care given that there seems to be a feeling amongst some doctors at least in our sample that there is less social and professional cohesion in hospitals now than in the past..
To investigate the extent to which the importance of "tacit" knowledge is recognised as important for patient care by doctors, health service mangers and policy makers" to this end studies using studies using non- participant observation methods are necessary.
To explore the work of junior doctors using both longitudinal and observation methodologies.

Ethics

The research raised no special issues of note.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

References

Armstrong, D. (1995) 'The Rise of Surveillance Medicine' *Sociology of Health and Illness* 17, 3 393-404

Atkinson, P. (1981) *The Clinical Experience* Aldershot, Gower

Atkinson, P. (1995) *Medical talk and medical work: the liturgy of the clinic* London, Sage

Becker, H. S. (1976) *Boys in White: student culture in medical school* New Brunswick, Transaction Publishers

Black, C. (2003) 'Ways in which doctors are special' paper presented at seminar Do we still need doctors? *Drugs and Therapeutics Bulletin*, Portland Place, London 11th June

Bourdieu, P. (1990) *The Logic of Practice Cambridge*, Polity Press

Cochrane, A. L. (1971), *Effectiveness and Efficiency: Random Reflections on Health Services*, Nuffield Provincial Hospital Trust.

Department of Health (1997) *The new NHS modern, dependable* White Paper London, Department of Health.

Flynn, R. (2004) 'Soft Bureaucracy' Governmentality and Clinical Governance: theoretical approaches to emergent policy' in A. Gray and S. Harrison (eds) *Governing Medicine: theory and practice* Maidenhead, Open University Press.

Fox, R. C. (1989) *The Sociology of Medicine: A Participant Observers* View Englewood Cliffes, NJ: Prentice-Hall

Freidson, E. (1970) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, New York: Harper Row.

Freidson, E. (2001) *Professionalism: the third logic* Cambridge, Polity Press

Giddens, A. (1990) *The Consequences of Modernity* Cambridge: Polity Press.

GMC (2006) *Good Medical Practice* London, General Medical Council

Goffman, E. (1961) *Asylums: essays on the social situation of mental patients and other inmates.* New York, Doubleday.

Good, B. (1994) *Medicine, rationality, and experience: an anthropological perspective* New York : Cambridge University Press.

Harrison, S. (2002) 'New Labour, Modernisation and the Medical Labour Process' *Journal of Social Policy* 31 465-485

Haug, M.. (1988) A reexamination of the hypothesis of deprofessionalization *Milbank Quarterly Supplement* 2 48-56

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

Hochschild, A. R. (1983) *The Managed Heart: commercialisation of human feeling* London, University of California Press

Horton, R. (2003) *Second opinion: doctors, diseases and decisions in modern medicine* London, Granta Books

Irvine, D. (2003) *The Doctors' Tale: professionalism and public trust* Oxford, Radcliffe Medical Press

James, A. and Hockey, J. (2007) *Embodying Health Identities* Basingstoke, Palgrave Macmillan

James, N. (1992) 'Care = organisation + physical labour + emotional labour' *Sociology of Health and Illness* 14 (4) 488- 509

Jewson, N. (1976) 'The disappearance of the sick man from medical cosmology 1770-1870' *Sociology* 10 (2) 225-44

Kimayer, L. J. (1988) 'Mind and Body as Metaphors: hidden values in biomedicine' in M. Lock and D. Gordon (eds) *Biomedicine Examined* Kluwer Academic Publishers

Mauss, M. (1973 [1934]) 'Techniques of the Body' *Economy and Society* 2 70-88

McKinlay, J. B. and Marceau, L. (2002) 'The end of the golden age of doctoring' *International Journal of Health Services* 32 , 2: 379-416.

McKinlay. D. and Stoeckle, J. (1988) Corporatization and the social transformation of doctoring *Int. Jr. of Hlth Sers.* 18 191-205

Nettleton, S (2004) 'The emergence of e-scaped medicine' *Sociology* 38 4 661-679

Nettleton, S. and Burrows, R.(2003) 'E-scaped medicine? Information, reflexivity and health' *Critical Social Policy, 23, 2,165-185.*

Nettleton, S. Burrows, R. and Watt, I. (2007, under submission) 'How Do You Feel Doctor? An Analysis Of Emotional Aspects Of Routine Professional Medical Work' *Social Theory and Health*

Nettleton, S. Burrows, R. and Watt, I. (Forthcoming 2008) 'Regulating Medical Bodies? An Analysis Of Doctor's Accounts Of The Consequences Of The 'Modernisation' Of The NHS For The Disembodiment Of Clinical Knowledge' *Sociology of Health and Illness*, Forthcoming.

Pickstone, J. (1993) Ways of knowing: towards a historical sociology of science, technology and medicine *BJHS* 26 433-58

Pickstone, J. (2000) Production, community and consumption: the political economy of twentieth century medicine in R. Cooter and J. Pcikstone (eds) *Medicine in the Twentieth Century* Amsterdam, Harwood Academic Publishers

Power, M. (1997) *The Audit Society: rituals of verification* Oxford, Oxford University Press.

To cite this output:
Nettleton, Sarah (2007). On Being A Doctor: A Sociological Analysis: Full Research Report.
ESRC End of Award Report, RES-000-22-1158. Swindon: ESRC

Royal College of Physicians (2005) *Doctors in Society: Medical professionalism in a changing world: Report on a Working Party*, London. RCP

Secretary of State for Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* Cm 7013 London HMSO

Shilling, C. (2007) Sociology and the body: classical traditions and new agendas *Sociological Review* 55 1 1-69

Smith, R. (2003) 'The future of medical education: speculation and possible implications' www.bmj.com/talks

Turnberg, (2002) 'Science, Society and the Perplexed Physician' *The Harveian Oration*, Royal Collage of Physicians, London. October.