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UNIVERSITY OF ALBERTA

THE DEVELOPMENT OF A SENSE OF PROFESSIONALISM IN PHYSICIANS

BY

VICKI LYN LYALL

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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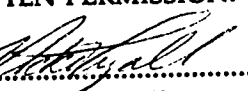

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SUBMITTED BY VICKI LYN LYALL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN EDUCATIONAL ADMINISTRATION.

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Dedication

This work is dedicated

to my children --

Dustin and Craig

Abstract

The primary purpose of this study was to generate propositions about the developmental nature of professionals' personal policies--their socialized beliefs, attitudes, values, and principles--in relation to their professional conduct. Michael Polanyi's (1966) definition of tacit knowledge was adopted as the meaning for the term *personal policies*.

A qualitative approach using a case study design was employed. Data were gathered predominantly through semi-structured interviews with 26 members of the College of Physicians and Surgeons of Alberta. Document analysis, interviews and observation techniques were used to familiarize the researcher with the discipline process implemented by the College and the system of remuneration administered through the Alberta Health Care Insurance Plan. Erickson's (1986) deliberative approach was applied to the fieldwork, data analysis and reporting.

The findings indicate that (a) professional conduct is an evolving concept that goes beyond the intellectual and the practical to a way of living, and that (b) the period of greatest influence on a doctor's personal policies in relation to professional conduct is during the introduction to professional practice phase. Factors of greatest influence on doctors' personal policies in relation to professional conduct include (a) modeling teachers and peers, (b) values learned during the formative years, (c) changing attitudes among doctors prompted by lifestyle options, (d) perceived loss of respect from the public, (e) ethical dilemmas between humanity and self interests that have

evolved from the system of remuneration, advances in medical technology, and fear of litigation, (f) changes in the doctor-patient relationship allowing patients greater rights to informed decision making, (g) edicts from the College, (h) reports of discipline of peers, and (i) service to the profession through involvement in the affairs of the College.

Oppressive strains on doctors personal policies in relation to professional conduct are causing resentment within the profession and need to be addressed. Recommendations call for a redefinition and revitalization of the service ideal and a review and revision of the remuneration system administered through the Alberta Health Care Insurance Plan. Recommendations aimed at the College urge the development of outlet mechanisms for member concerns, optimization of peer modeling to influence members' professional conduct, and appeals to the universities to integrate ethical studies into medical programs.

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CHAPTER 1
INTRODUCTION

Need for the Study

In this century professional associations have become more highly organized and are more strictly regulated through legislation (Medical Profession Act, Revised Statutes of Alberta, 1980; Occupational and Professional Associations Act,1985; Alberta Health Care Insurance Act,1969). There is a widely held perception that, traditionally, professionals were held in high esteem by the public, yet in recent years, they have been subjected to more critical public opinion (Kindred, Bagin, Gallagher, 1984; Marx, 1983; Reid, 1984). A paradox has emerged. Although there are tighter controls over the professional and the way in which the professional practices, and although most people would agree that the effectiveness of the service provided by the professional has improved with technological advances, the status of the professional has diminished and public confidence in the professions is be waning.

A decline in professional status has been identified by writers over the past few decades (Marx, 1983; Mintzberg, 1979; Reid, 1984; Scott, 1955; Seymour, 1963). In writing about the way in which "outsiders" gain a set of attitudes about a profession from communications media, Ronald Bodley Scott (1955) described medical practitioners as they were seen in contemporary literature.

> It is commonly said that the esteem in which the public holds the medical profession has fallen. If this be true, the situation is one which should cause us all concern; although we may reflect on the irony of this decline going hand in hand with an increase in our ability to control disease of which our fathers would not have dared dream. The barometer of public opinion is not easily read; and any information on this subject, however trivial its source, is of value. (p. 341)

Mintzberg (1979) asked for solutions "to a society concerned about its professional bureaucracies," and cited "financial control of professional bureaucracies" and "legislation against irresponsible professional behavior" as obvious necessities. He stated that beyond that, solutions must grow from a recognition of professional work for what it is, and that change must come "by the slow process of changing the professionals." He said:

> Where such changes are resisted, society may be best off to call on the professionals' sense of responsibility to serve the public, or, failing that, to bring pressures on the professional associations rather than on the Professional Bureaucracies. (p. 379)

How do professional associations influence the professional's sense of responsibility? An understanding of how the professional's "sense of responsibility to serve the public" and concept of professional conduct evolve is necessary if professional associations are to play an effective role, as Mintzberg has suggested, in changing the professionals, thereby enhancing the professional service to the client. It was this notion that led me in the direction of this study.

Purpose of the Study

The purpose of this study was to generate propositions about the developmental nature of *personal policies* concerning professional conduct among members of the College of Physicians and Surgeons in Alberta. I inquired into the meaning of professional conduct held by some Alberta physicians and surgeons, and endeavored to determine how these doctors' *personal policies* concerning professional conduct evolved. The influence of the College of Physicians and Surgeons of Alberta (the College) and its discipline process were variables identified prior to collecting the data. Analysis of interview data included a search for patterns in the definitions of professional conduct and in the factors that participants identified as influences on their *personal policies* in relation to professional conduct.

Personal Policies Defined

> *What I have been talking about is knowledge. Knowledge, perhaps, is not a good word for this. Perhaps one would rather say my Image of the world. Knowledge has an implication of validity, of truth. What I am talking about is what I believe to be true; my subjective knowledge. It is this Image that largely governs my behavior.* (Boulding,1956)

Personal policies are socialized beliefs and values that guide our behavior. If you ask a person to make a statement that would define that individual's personal set of beliefs, attitudes, values and principles in relation to a concept like professional conduct, chances are that the respondent will not reply immediately with a short, concise statement. Such a question would likely cause this person to think about personal experiences, past decisions and actions, relationships, and intrinsic perceptions of external phenomena. Then the individual would search for words to express the meaning arrived at, not an easy operation since much of what one is attempting to define is tacitly known. In this sense, *personal policies* are tacit theories.

Michael Polanyi (1966) defined tacit knowledge. For the purpose of this study, Polanyi's definition was adopted as the meaning for the term *personal policies*. Polanyi, a scientist-turned-philosopher, was intrigued by a realization that our "whole civilization was pervaded by the dissonance of an extreme critical lucidity and an intense moral conscience" (p. 4). He described human knowledge as the emergence of a "harmonious view of thought and existence, rooted in the universe" (p. 4).

Polanyi started his "reconsideration of human knowledge" from the basis that we can know more than we can tell (p. 4). Knowing encompasses both the intellectual "knowing what" and the practical "knowing how." Polanyi uses the terms "proximal" and "distal" to describe the first and second terms of tacit knowing. Tacit knowing, according to Polanyi, involves:

1. the *functional* relation between the two terms: "we know the first term only by relying on our awareness of it for attending to the second" (p. 10),
2. the *phenomenal* structure as in the exercise of a skill, when we are "aware of its several muscular moves in terms of the performance to which our attention is directed" (p. 11),
3. the *semantic* aspect which represents the separation of a meaning from that which has this meaning (p. 12), and
4. the *ontological* aspect which "tells us what tacit knowing is a knowledge of" (p. 13).

Polanyi offered an example of tacit knowing as the process by which we "become aware of subliminal processes inside our body in the perception of objects outside" (p. 14). He explained that physiognomies cannot be fully described in words, nor even by pictures.

> But can it not be argued, once more, that the possibility of teaching these appearances by practical exercises proves that we can tell our knowledge of them? The answer is that we can do so only by relying on the pupil's intelligent co-operation for catching the meaning of the demonstration. Indeed, and definition of a word denoting an external thing must ultimately rely on pointing at such a thing. This naming-cum-pointing is called, "an ostensive definition;" and this philosophic expression conceals a gap to be bridged by an intelligent effort on the part of the person to whom we want to tell what the word means. Our message had left something behind that we could not tell, and its reception must rely on it that the person addressed will discover that which we have not been able to communicate. (pp. 5-6)

Symbolic interactionists would say that we would "discover" that "something left behind" by interpreting the other's actions and reacting based on our own perspective.

Polanyi added another dimension to the meaning of tacit knowing as the act of indwelling moral teachings:

> We meet with another indication of the wide functions of indwelling when we find acceptance to moral teachings described as their *interiorization*. To interiorize is to identify ourselves with the teachings in question, by making them function as the proximal term of a tacit moral knowledge, as applied in practice. This establishes the tacit framework for our moral acts and judgements. (p. 17)

Polanyi's "reconsideration of human knowledge" lays a framework for studying doctors' definitions of professional conduct and the evolution of their personal policies in relation to professional conduct. Polanyi said, we can know more than we can tell. I have not been able to fully describe the participants' personal policies in relation to professional conduct, although some meaning was shared by participants through their definitions of professional conduct in Chapter 4. Nevertheless, through analysis of the data I have identified factors which participants view as having had an influence on their tacit knowledge.

Assumptions

The public image of the professions has eroded over the past twenty years, and public confidence in most public institutions has declined (Marx, 1983; Reid, 1984). With a loss in public confidence, the professions also stand to lose decision-making power along with access to public funds and other resources--a problematic situation for both the professionals and the institutions charged with the responsibility to provide a public service. This notion was reinforced by Miklos (1978), who stated,

> The image which outsiders have of an organization is crucial to its survival and to its ability to acquire resources required for effective performance. (p. 2)

A loss of resources to publicly funded professional services, and a loss of input into policy decision-making by the professionals who will implement the policy will result in lower quality professional services. This assumption and those that follow were formed after I completed a review of

literature which addressed the impact of public opinion on the policy process. The literature review is reported in Chapter 2.

Assumptions in this study include the following:

Assumption 1: The attitudes, the expressed opinions and the conduct of the professional, play a role in shaping public opinion about the profession and the service the profession provides,

Assumption 2: Public opinion about the the publicly funded service professions (i.e., the judiciary, medicine, social work, and teaching) and the services these professions provide will influence political decision making,

Assumption 3: The influence of public opinion about these professions and their services on political decision making will indirectly influence allocation of resources to these professions,

Assumption 4: Allocation of resources will have an impact on the quality of service these professions provide to their clients, and

Assumption 5: The quality of service these professions provide to their clients will influence the opinions and attitudes of the clients in relation to the individual professionals providing the service, the profession as a whole and the quality of service the profession provides to the public.

This repetitive and interdependent cycle of influence plays a role in determining the quality of service provided by the publicly funded service professions. Professional associations will benefit from a better understanding concerning the evolution of professionals' personal policies in relation to professional conduct. This information will be useful for the development of programs aimed at influencing the professional work of their members. Through such programs, professional associations may succeed in

"changing the professionals"--the solution to society's concern about professional bureaucracies that Mintzberg called for. The ultimate goal for the professional associations in this regard is to improve the quality of service provided by the publicly funded service professions.

Methodological Approach

This is a qualitative and exploratory study that was approached from the theoretical perspective of symbolic interaction. Symbolic interaction, as a theory, originated in the early part of this century with the pragmatist philosopher and educator, John Dewey. It was further developed by George Herbert Mead during the 1930s. This approach to research assumes that to understand human behavior, "we must understand definitions and the process by which they are manufactured" (Bogdan & Biklen, 1982, p. 33).

This investigation entailed a case study of the College of Physicians and Surgeons of Alberta. Semi-structured interviews were conducted with 26 arbitrarily chosen members of the College. The sample of participants included 2 members elected to the governing Council of the College and 2 administrators of the College. Basically, I was seeking answers to two questions:

1. what impact does the College have in the formation of its members' personal policies in relation to professional conduct, and
2. what other factors play a role in shaping these doctors' personal policies in relation to professional conduct?

In relation to the first question, three facets of potential influence by the College were purposefully examined during the interviews:

1. how the College communicated with members about professional conduct,
2. how members perceived the discipline process, and

3. whether or not members' thought involvement of members in the affairs of the College had an influence on their personal policies in relation to professional conduct.

The investigation related to the second general question was less structured. First, I wanted participants to define professional conduct. Erickson stated that "an explanation of cause in human action must include identification of the meaning-interpretation of the actor" (1986, p. 127). Secondly, I asked participants to identify and describe factors of influence on their personal policies in relation to professional conduct. I wanted participants to explain the conditions of meaning that they and others create leading doctors to conduct themselves in a particular manner in their professional lives. Rather than ask what behaviors of doctors are positively correlated with professional conduct, in interpretive research the researcher asks, "How are these meaning systems created and sustained in daily interaction?" (Erickson, p. 127). Participants' definitions of professional conduct are reported in Chapter 4. The influences on participants personal policies in relation to professional conduct are reported in Chapter 5.

I used document analysis and observation techniques to familiarize myself with the College's discipline process and the Alberta Health Care Insurance Plan. Documents which I reviewed included the *Medical Profession Act, Revised Statutes of Alberta* (1980), the College's annual *Reports from Council* for the past 5 years, examples of "Dear Doctor" letters from the College to its members, The Alberta Health Care Insurance Plan schedule of remuneration, The Alberta Medical Association's (AMA) INFOPAC, and various brochures outlining AMA services and current issues facing doctors. I attended one annual general meeting of the College and sat as an observer through one discipline hearing. To become familiar with the College operations and its discipline process I met with the deputy-registrar a number of times and interviewed the College's legal counsel and discipline prosecutor. I also conducted an interview with the chief administrator of the Alberta Health Care Insurance Plan.

Data were collected through taped, semi-structured interviews designed to investigate the relationship among the elements identified above and to allow for the emergence of other elements not considered previous to

the interviews. A detailed description of the methodology used in this study is reported in Chapter 3.

Research Questions

I developed a semi-structured interview questionnaire after completing the review of literature, reported in Chapter 2. The semi-structured interview questionnaire appears in Appendix A.

Data were gathered during the course of interviews with 26 doctors to provide answers to the following general questions.

1. How do doctors define professional conduct?

2. (a) What do doctors believe to be the most influential elements in the evolution of their personal policies in relation to professional conduct?
   (b) What patterns of influence are evident in the data?

3. How do doctors perceive the implementation of the discipline process by the College as an influence on their personal policies in relation to professional conduct?

4. In what other ways does the College influence members' personal policies in relation to professional conduct?

Conclusion

I examined doctors' personal policies in relation to professional conduct with an intent to discover how professional associations might influence the professional conduct of their members. My assumptions were that professional conduct indirectly influences public opinion about the profession, the allocation of resources to the publicly funded profession and the quality of service provided by the profession. I believed that knowledge about the evolution of personal policies in relation to professional conduct would shed light on how those personal policies might be reinforced and/or

changed. Conclusions and recommendations based on the findings in the study appear in Chapter 6.

The intent of this study was to describe and to generate propositions about the evolution of personal policies in relation to professional conduct among some members of the College of Physicians and Surgeons of Alberta. It is not expected that the results of the study will be generalized to other professions, or even to all doctors. It is conceivable though, given the general nature of human behavior, that many of the hypotheses generated in this study may relate to people working in other professions.

CHAPTER 2
LITERATURE REVIEW

Literature that addresses the impact of public opinion on the policy process was reviewed early in the development of this study. I wanted to know what kind of relationship, if any, existed between public opinion and policy. A causal relationship would magnify concern over the loss of public support for the professions. It could mean that public influence on policy decisions by a non-supportive public would result in policy that is detrimental to the professions.

The first section of the literature review examines the impact of public opinion on policy. This issue became part of the rationale for the study. The rationale is detailed in the Need for the Study and Assumptions discussed in Chapter 1.

Once evidence of a relationship between policy and public opinion had been established I focused on means through which public opinion about the professions could be influenced. That focus was narrowed to the specific purpose of this study through the process presented and discussed in Chapter 1. The remainder of the literature review is organized beginning with a discussion of communication with the public about professional conduct and responsibility for professional conduct. Literature concerning attitude formation, influence, and perception is then reviewed.

The findings are discussed in relation to the evolution of personal policies concerning professional conduct and the influence of professional associations on their members' personal policies concerning professional conduct. Three facets of potential influence of the professional association on its members' personal policies in relation to professional conduct are examined in the literature review:

1. communication,
2. perception, and
3. influence itself.

The chapter concludes with a list of questions that were compiled into the semi-structured interview schedule.

The literature for this study is drawn from the areas of policy analysis, professions and professionalization, organizational behavior, and communication.

Policy and Public Opinion

Three external communication variables that influence the policy process were agreed upon in the literature. They are

1. public opinion,
2. mass media, and
3. attitudes of constituent groups.

Mazmanian and Sabatier (1981) identified all three. Attitudes of constituency groups, for example, were said to influence the policy implementation process through their interaction with other variables. Mazmanian and Sabatier explained that public attitudes affect implementation through published studies that are of a critical nature, through public opinion campaigns, and through appeals communicated to authorities.

Mazmanian and Sabatier claimed that the media may affect the perceptions of the general public toward the policy, particularly when the public has little direct experience with it. The media, they maintained, can present an obstacle impeding support for the policy implementation process or, if a program receives neutral or supportive reporting by the media, it is more likely to be implemented effectively. Further, they suggested that public opinion and its interaction with the mass media can influence which policy issues will receive the attention of the legislators. As well, public opinion polls are used to support particular policy positions (pp. 10-18).

Ruth Levitt stated that the role of the news media is crucial in drawing attention to policy problems, "even though it is not fully developed and used by those groups concerned with public policy that could usefully enlist its support" (1980, p. 17). Nakamura and Smallwood referred to the news media

as powerful actors in the implementation environment which "shape the perceptions of the public, the policy makers, and the policy implementers as well" (1980, p. 52).

Mazmanian and Sabatier's (1981) views on the relationship of public opinion and policy were supported by Lasswell (1972) who provided examples of the influence of public opinion on public policy at every stage of the policy process. Lasswell proposed that the role of the media in the policy process is that of "a third voice." "At present," he stated, "the principal voices are self-serving, whether the self is a government, a political party, a business, or whatever. The role of a third, disinterested voice is to supply a competing appraisal of the images spread by self-serving sources" (p. 307). The media would carry out this function through public opinion/communications research which would probe and report "on the adequacy of the flows of information that enter into policymaking, as well as on the functioning of the policy process at all stages" (p. 301).

Devine (1970) attempted to empirically link the opinion-policy process. He found that it was extremely difficult to make a direct causal link between public opinion and specific policy action or support. However, Key (1963) found that the public reacts strongly if leaders go beyond boundaries permitted by the mass public. The true effect of public opinion may be in the policy impact area. As Strouse (1978, p. 30) noted, "one can argue that it is the absence of policy that arouses public opinion."

Thomas Dye stated that the question of whether public opinion constitutes an important independent influence over public policy is a difficult one to answer. He said we can never be sure whether "mass opinion shaped public policy or public policy shaped mass opinion" (1981, p. 341). However, Dye gave three reasons to support his contention that more often public policy shapes public opinion:

1. "few people have opinions on the great bulk of policy questions confronting the nation's decision makers. . . .One study estimates that less than 20 percent of the public holds meaningful, consistent opinions on most issues, even though two-thirds or more will respond to questions asked in a survey,"

2. public opinion is very unstable and can change in a matter of a few weeks in response to news events, and
3. "leaders do not have a clear perception of mass opinion." (p. 342)

Although there is support in the communications literature for Dye's reasons (Cutlip, Center and Broom, 1985, pp. 151-183), his rationale does not provide evidence for his contention. Dye admitted that decision makers "may act in response to news stories or to the opinions of influential news makers in the mistaken belief that they are responding to public opinion," and that "public opinion polls frequently create opinions by asking questions that respondents never thought about until they were asked." (1981, pp. 342-343)

Regardless of whether public opinion shaped public policy or public policy shaped public opinion, it appears that there is agreement among Dye, Sabatier and Mazmanian, Levitt, and Cutlip, Center and Broom that public opinion and the policy process are interrelated and that each is affected by the news media. Public policies shape and are shaped by public opinion.

Professional Conduct

The literature on professional conduct suggests factors that may be integral to the formation of a professional's personal policies in relation to professional conduct. Open communication about misconduct by the profession may be an important factor in encouraging individual members of the profession to discuss mistakes and failures with their colleagues and clients, and in keeping sensational rumors at bay.

Misconduct of a professional, rather than professional conduct, is more likely to be a topic of public discussion. Professional conduct, however defined by the public, is expected--it is viewed as an ordinary, day-to-day practice of those trusted and licensed to carry out professional service. Misconduct is an anomaly, and draws the interest of an otherwise disinterested public. That interest can be heightened by misunderstandings and rumors that evolve and grow in sensationalism as they spread. Professionals, who feel that they have been "burned" by misinterpretation are

reluctant to share information when the public interest has been aroused. Everett C. Hughes (1951), in his discussion of errors within a professional colleague-group, noted,

> when some incident makes an alleged failure or mistake a matter of public discussion, it is perhaps the feeling that outsiders will never understand the full context of risk and contingency that makes colleagues so tight-lipped. (p. 149)

Hughes explained further,

> if matters have gone to such a point that mistakes and failures are not freely discussed even within the trusted in-group, public discussion may be doubly feared. (p. 149)

Sensationalized rumors are less likely to spread among an informed public (Cutlip, Center & Broom, 1985). If Hughes is correct, an important first step to an informed public is open discussion of misconduct within the professional group. Reports of misconduct and ensuing penalties administered by the professional association are one means of encouraging discussion among colleagues about mistakes and failures.

What is, or is not, communicated from the profession about a mistake or failure has an impact on public opinion. Understanding the definition of what constitutes a mistake or failure should be an important goal of that communication. Hughes stated that such a definition leads to still another concern which is a significant one for the professional:

> Who has the right to say what a mistake or failure is? The findings on this point are fairly clear; a colleague-group will stubbornly defend its own right to define mistakes, and to say in the given case whether one has been made. (p. 148)

Hughes' conclusion has been reinforced in a recent discipline case in which a professional, found to be not guilty on a criminal charge in the courts, was judged by his colleagues to be guilty of unprofessional conduct based on the same evidence heard by the court (Lyall, 1988). Hughes pointed out that the contrary may also occur:

> a man may be considered by his colleagues to have done a piece of work properly and without error, even when the client may accuse him of error, mistake, or failure. (p. 148)

Writers agree that the service ideal, the right to determine mistakes, set standards of performance and ethics, and enforce those standards are characteristics that distinguish a profession from other individuals or groups in society. The professional occupations place great emphasis on individual responsibility for professional conduct. Each has its own code of conduct that determines what is considered right and wrong within the occupation. These professional "codes of ethics" have been around a long time. For example, Jeffrey (1962) stated that:

> Civil legal codes governing the conduct of occupational affairs are known to have existed at least 4,000 years ago, and professional codes developed by medical practitioners were recorded about 2,500 years ago. The principles expressed in the Oath of Hippocrates deal with many of the same matters as do present-day medical codes. These were, and are, codifications of basic ideals, among them significantly the ideal of devotion to a calling to be of service. (p. 345)

In 1922 Clyde King, editor of The Annals of the American Academy of Political and Social Science, explained:

> Codes of ethics are important agencies for social control. The complexities and the specializations of modern industrial life leave many individuals unable to judge whether or not a member of any profession has performed his services with due regard to the interests of all, as well as with due regard to the interests of his client. In all but the crassest and most obvious defaults in service standards the work of the physician must be judged by physicians and that of the lawyer, by lawyers. And so with each of the professions. The higher the skill, the greater the need for organized group effort toward maintaining a fine sense of obligations, not primarily to others in the same profession, but chiefly to the general well-being of all. (p. vii)

The public must trust the standards set by the profession and believe that such standards are strictly enforced. Straightforward communication to the public about these standards and their enforcement is vital in developing public trust (Cutlip, Center, and Broom, 1985).

Responsibility for professional conduct is what sets the professions apart in society. Emile Durkheim (1933) said that a professional group is a moral authority which dominates the life of its members. Robert MacIver (1955) differentiated between professionals and business managers in that business managers do not have associations that enforce standards of ethics. He said that the autonomy established by a professional group and its collective self-control over standards of performance and behavior are key characteristics of a profession. To feel acceptance within the professional colleague-group an individual must exhibit worthy behavior as defined by the group. Durkheim (1958) stated:

> There is no form of social activity which can do without the appropriate moral discipline....It is this discipline that curbs him [the professional], that marks the boundaries, that tells him what he must pay in current dues towards the maintenance of the community. Since the precise function of this discipline is to confront the individual with aims that are not his own, that are beyond his grasp and exterior to him, the discipline seems to him--and in some ways is so in reality--as something exterior to himself and also dominating him. (pp. 14-15)

The professional has responsibilities which go beyond those expected of the ordinary citizen. The professional is expected to accept a responsibility to serve the public interest, even at the expense of serving one's own interests. Leake stated that professionals have "more specific moral issues confronting them than the mass experience of humanity has evolved rules to cover" (1927, p. 4). He pointed out a conflict for the professional who must daily make choices between the interests of humanity and his or her self-interests.

In considering professional codes of conduct, Vollmer and Mills questioned the actual behavioral effectiveness of these kinds of formal statements:

> The contention is made that codes of conduct are effective operational directives. However, little, if any, systematic study has been done to demonstrate the actual changes caused by the introduction of formal codes of occupational conduct. Are these codes mere formalistic window dressing for outsiders which, in actuality, often fail to control behavior to any significant extent? A related aspect of this question is whether or not formal and informal conduct norms tend to coincide more often in the highly professionalized occupations and the extent to which this hypothesized coincidence is a consequence of the existence of formal codes of ethics. (p. 151)

Becker and Geer (1958), in their study of idealism and cynicism in medical students, stated that it makes a difference in a professional's performance whether or not the professional believes wholeheartedly in what he or she is doing and is convinced that it is a good thing. Seymour (1963) contended that attitudinal factors are extremely important in bringing about desirable behavioral changes within a profession. "Professionalism," he explained, "is a state of mind" (p. 129). Information about how attitudes are formed may provide some insight into how attitudinal factors concerning professional conduct might be influenced.

Attitudinal Factors

Personal attitudes play a primary role in guiding an individual's behavior. A professional's personal policies concerning professional conduct may be influenced by attitudes previously held by the professional. The theory of cognitive dissonance, advanced by Leon Festinger (1963), suggests that people demonstrate a desire for consistency in their attitudes. People avoid information that is adverse to their views and their way of doing things because they find conflict between what they know and what they do discomforting. It is difficult to change attitudes when people seek out only information pertaining to attitudes they already hold.

How one apprehends by means of the senses or cognition is the key to how one's attitudes are influenced. The way an individual perceives a

situation is the way it is with that individual. "One person's fact is another person's fiction. . . . People act on the basis of the pictures in their heads rather than in accordance with the reality of the world outside" (Cutlip, Center, and Broom, p. 164).

One may conclude then, that if attempts to influence attitudes of professionals are to be successful, those exerting the influence must be cognizant of the attitudes that are presently held by the professionals. Each person will perceive external influences on the basis of their own personal view of the world.

Influence

In the former section it was suggested that attitudinal factors are important in bringing about desirable behavioral changes within a profession. This section of the review defines influence and looks at the role that influence can play in changing attitudes and behavior.

Cartwright (1965) claimed that there is no single body of literature on influence. He said, instead there is

> a collection of discrete and more or less independent literatures concerned with various aspects of influence, such as leadership, attitude change, conformity, persuasion, communication, social learning, and socialization. (p. 3)

Cartwright identified three major aspects of the influence process:

1. the agent exerting influence,
2. the method of exerting influence, and
3. the agent subjected to influence.

A purpose of this review is to gain insight into the formation of personal policies and into ways by which a professional association may be able to influence the personal policies in relation to professional conduct of its members. Greater emphasis will be placed on Cartwright's second aspect of influence: the method of exerting influence.

March (1955) and Simon (1957) maintained that influence is a special instance of causality--changing one person's responses by the actions of another. Dahl (1957) defined the means of influence as "a mediating activity by A between A's base and B's response" (p. 203). Russell (1938) identified three principal ways in which an agent may exert influence over a person:

1. by direct physical power over the body,
2. by rewards and punishment, and
3. by influence on opinion.

He gave the examples of education or propaganda as influences on opinion. Gilman (1962) identified four methods of influence:

1. coercion,
2. manipulation,
3. authority, and
3. persuasion.

Cartwright (p. 21) attempted to "impose some order on the literature" by identifying four broad classes of methods of influencing:

1. an agent exerts physical control over another's body,
2. an agent exerts control over the gains and costs experienced by the other,
3. an agent exerts control over the information available to the other, and
4. an agent uses another's attitudes toward being influenced by the agent.

Communication from a professional association about standards and enforcement of professional conduct was discussed above in relation to public opinion about the profession. Communication concerning professional conduct may also play a role in influencing attitudes and behavior of professionals. A number of writers described the means of influence in relation to communication (Cartwright, 1965; Dahl, 1984; Fisher, 1981). Dahl identified seven means of influence through communication, including: trained control, persuasion, inducement, power, coercion, physical force, and unilateral and reciprocal control. He distinguished among four of the means of influence with the following explanation.

> Influence through communication that consists of a cue or signal might be called *control by training*. Influence by means of communications that provide information (correct or misleading) about the advantages and disadvantages of alternative courses of action can be called *persuasion*. Influence by means that bring about a change in the nature of the alternatives can be called *inducement*. . . . when compliance is attained by creating the prospect of severe sanctions for noncompliance, [it] is often called *power*. (1984, pp. 38-42)

Dahl provided a further distinction between two forms of persuasion:

1. *rational persuasion*, which is humane and desirable and takes place by means of rational communication aimed at leading another to come to an "understanding of the true situation by means of truthful information," and
2. *manipulative persuasion*, which exists "when A influences B by communication that intentionally distorts, falsifies, or omits aspects of truth known to A that if made known to B would significantly affect B's decision" (pp. 39-40).

He provided examples of rational persuasion drawn from relations between professionals and clients because,

> a professional code of conduct requires that in relationships with the client, professionals transmit only information that is, to the best of their knowledge, truthful. (p. 40)

Dahl stated that most advertising is a form of manipulative persuasion.

Rational persuasion is a fitting description of the communications relationship between professional and client. In addition to rational persuasion, the professional association would exercise power in its relationships with members. Through the enforcement of professional standards (the discipline process) the professional association gains compliance by its members by "creating the prospect of severe sanctions for noncompliance" that were described by Dahl. This form of influence through power is more appropriate for professional relations than power exerted through the political use of communication in organizations which Morgan wrote about.

Morgan (1986), in his discussion of control of knowledge and information as a source of power in organizations, stated,

> By controlling these key resources a person can systematically influence the definition of organizational situations and can create patterns of dependency. (p. 167)

He explained that a skillful organizational politician can influence individuals' perceptions of situations and the ways they behave in relation to those situations by controlling both the knowledge that is available and the flow of information. Stemming from a similar rationale, Mehler (1988, p. A-7) lauded the chief information officer as the hot executive for the 1990s because "he can ration the powerful tools of technology and control the flow of information through the organization."

To exert influence on members' conduct the professional association and its staff must be viewed as credible by its members. The esteem in which an individual is held by his or her co-workers is a variable in determining an individual's level of influence. Cartwright (1965), in his discussion of influence, stated that, from the research,

> it is clear that the apparent nature of the source of communications is also an important feature of persuasion. . . . [Also,] prestige or credibility, seem to be specific to persuasive influence. . . (p. 21-22)

These findings are consistent with the evidence presented from the perception literature that follows the review of Etzioni's theory of compliance.

Using Dahl's terms, it appears that *rational* communication is the most effective means through which attitudes and behavior can be influenced. Acts of power result in influence over people's attitudes and behavior only when those people comply with the desires of the actor exercising the power. Three decades ago, Amitai Etzioni proposed a theory of compliance that has since received broad acceptance as a result of organizational research. Etzioni's theory is outlined below.

Etzioni's Theory of Compliance

Etzioni (1975) based his comparative study of organizations on the premise that compliance is a "central element of organizational structure" (p. 3). He defined compliance as,

> both a relation in which an actor behaves in accordance with a directive supported by another actor's power, and to the orientation of the subordinated actor to the power applied. (p. 3)

Etzioni stated that organizations are especially concerned with performance, and thus require some means of controlling the behavior of their members. He identified two aspects, or bases of compliance:

1. the formal, control structure which exerts power and authority through hierarchical job descriptions and procedures, and
2. the motivational aspect which refers to the level of commitment of members to organizational goals.

Etzioni argued that where there is more of the second aspect of compliance less formal control mechanisms are needed.

The two bases of compliance were used to produce a typology of organizations. Etzioni identified three classifications of power as a means to ensure compliance:

1. coercive power which results from either the threat or implementation of physical sanctions,
2. remunerative power which is based on control of material resources like wages, salaries, and fringe benefits, and
3. normative power that rests on the allocation of symbolic rewards such as prestige and acceptance.

Etzioni claimed that most organizations emphasize one of these types of power, and that within an organization, a different type of power may be used at different hierarchical levels; i.e., coercive power is used more at the lower levels, and normative more at the higher levels.

Etzioni suggested three kinds of involvement, ranging from low to high:

1. Alienative involvement, or an intense negative orientation toward the organization characterized by feelings of disassociation;
2. calculative involvement, or a mildly negative, or mildly positive orientation characterized by calculative attitudes toward those in power; and
3. moral involvement, or highly positive orientation characterized by feelings of commitment and loyalty.

Together, the power and involvement elements constitute nine types of compliance relationships in organizations, as shown in Table 1.

STYLES OF POWER	STYLES OF INVOLVEMENT		
	Alienative	Calculative	Moral
Coercive	1	2	3
Remunerative	4	5	6
Normative	7	8	9

Table 2.1: A Summary of Etzioni's Typology of Compliance Relations (Etzioni, 1975, p. 12)

Three of these types constitute congruent relationships which are found more frequently in organizations. The three most common types are 1, 5, and 9--coercive power and alienative involvement, remunerative power and calculative involvement, and normative power and moral involvement. The other six combinations are incongruent, and will strain the system, resulting in a shift in one of the bases of compliance. Etzioni suggests that congruent compliance structures will be found in more effective organizations that are not suffering tension from incongruent systems.

Numerous studies have been reported which support the basic thesis of Etzioni's compliance theory (Bigelow & Driscoll, 1973; Randell, 1968; Franklin, 1972a, 1972b, 1972c; Julian, 1966, 1968; Smith & Brown, 1964; Gouldner, 1955; and Guest, 1960).

Etzioni's framework can be applied to the professional association and its potential for influence on the conduct of its members. The discipline process may be viewed as the *formal control structure.* The members' commitment to association goals, and their involvement in association programs would fall within the *motivational aspect* of Etzioni's theory. According to Etzioni, the greater the motivational aspect, the lower the need for control mechanisms. It is easier to encourage behavior and attitudes of organizational members that conform to the goals, policies, and rules of the organization (Fisher, 1981, p. 370). Thus, the professional association may be expected to have greater influence on the personal policies of members who are more directly involved in the association's affairs than on their colleagues. One might also hypothesize that the motivational aspect of compliance, represented in Etzioni's typology of compliance relations as the *normative power-moral involvement* relationship, will be greater among those members who take an active role in the administration of association affairs.

A professional association would fall predominantly into Etzioni's ninth compliance relationship which he claims is a congruent combination of *normative power* and *moral involvement.* Members who do not comply with high moral involvement are controlled with either *remunerative power* or *coercive power.* The association would control members who comply with *calculative involvement* by exerting remunerative power through control over licensing and other resources vital to the member's professional practice. Coercive power is exercised on *alienative* members through the discipline process. It would appear then, that the structure of a professional association provides congruent compliance relations, and, according to Etzioni, should therefore be a more effective organization than if it were suffering tension from incongruent systems. The professional association should be in a good position to influence personal policies of members with an aim toward enhancing the image of the profession's commitment to public service.

The Communication-Perception Process

Johns (1988) described person perception as an important aspect of organizational behavior. He stated,

> Some of the most important perceptions that influence organizational behavior are the perceptions that organizational members have of each other. (p. 81)

Perception, though, is not exclusively an interpersonal phenomenon. As Massarik and Wechsler explained,

> Perceivers and perceived need not be single individuals. Entire *social groupings* may do the "looking" or may be "looked at." We can, for example, conceive of the social perceptions existing between two rival departments of a corporation, with each department viewing the other with possible hostility or competitive jealousy. Similarly, we may distinguish social perceptions among small work groups, among large companies, and even among nations. (1959, p. 199)

Massarik and Wechsler would have us believe that we may distinguish the social perceptions of doctors as a group, and thus it may be possible to influence those perceptions that can be attributed to the group as a whole.

Perceptions have been highlighted as the critical determinants of behavior in organizational settings (Blake & Ramsey, 1951; Kelly, 1980; Litterer, 1973). If interpersonal perception plays a major role in influencing organizational behavior, the communication-perception relationship between the professional association and its members may have considerable influence on the personal policies of the professional members. Insight into this relationship may be gained through an examination of personal perception and communication.

Perception has been defined as "the process of interpreting the messages of our senses to provide order and meaning to the environment" (Johns, 1988, P. 81), and as "the process whereby people become aware of the outside world and themselves" (Kelly, 1980, p. 139). In his examination of leading developments in perception theory and research, Johnson (1987)

stated, "Research on perception highlights the powerful, unavoidable impact of personal perspectives on all activities" (p. 218). He specified seven generalizations which highlight central aspects of that impact:

1. The perception process comprises a number of stages: stimulus, sensation, comparison with an implicit theory of personality and existing perceptual knowledge, attribution of cause for personal behavior, and impression formation/amendment.
2. Perceptions, rather than objective reality, at least partially shape individual attitudes and behavior.
3. Perceptions are frequently no more than approximations of reality.
4. Individuals are incapable of recognizing and verbalizing some perceptions.
5. Perceptions tend to develop as internally consistent and temporally stable structures.
6. Perceptions are affected substantially by an extensive but recurring array of factors arising out of social and cultural experiences, organizational attributes, and personality characteristics.
7. Additional factors, such as first and recent impressions, impose on perceptions of persons. (p. 218)

Administrators may use their knowledge of perception to predict human behavior, and to influence the perceptions and behavior of others (Hochberg, 1978; Johnson, 1987), particularly if the administrators are viewed as credible. An administrator's credibility depends on his or her interpersonal communication style. The communication credibility of the association administrator influences the extent to which he or she will be able to bring about intended changes in the personal policies of members. Klauss and Bass (1982) explained the relationship of perception to communication credibility:

> the communication behavior of a person shapes the image of perception others have of that person, and this perception in turn mediates the extent to which other persons will respond to the communication behavior and message content conveyed by a focal person. (p. 40)

In a series of studies Deutsch (1958) linked interpersonal communication style to credibility as a result of finding communication to be a central variable in the development of trust. According to Argyris (1962) and Likert (1967), organizational effectiveness is enhanced through open communication which forms the basis of credibility, or trust.

The literature on the communication-perception process suggests that there is considerable potential for the professional association to influence personal policies of its members. Elements that may determine the extent to which the association is influential include: other elements of influence in the professional member's environment, life experience, clarity of the message communicated, accuracy of the perceptions, ability to recognize and verbalize the perception, personality characteristics, first and recent impressions, credibility of the source of communication, and interpersonal communication style of the source. For the individual administrator communicating on behalf of a professional association the literature revealed that

1. an open communication style enhances the administrator's credibility, and
2. the provision of accurate information means more accurate perceptions, which ultimately lead to more appropriate behavior.

Conclusion

Findings in this review of literature that were relevant to the purpose of the study were consolidated and revised to form eight questions. These questions formed the basis of the semi-structured interviews to determine what participants perceived as factors of influence on doctors' personal policies in relation to professional conduct.

Question 1: How do the participants define professional conduct?

Question 2: What factors are perceived as influences on doctors' personal policies in relation to professional conduct?

Question 3: Which elements have had the greatest influence on doctors' personal policies in relation to professional conduct?

Question 4: Do participants perceive that the traditional commitment to "service before self" has fallen from favor in doctors' concepts of professional conduct?

Question 5: Who do participants believe should set the standards for their profession? Is this right as closely guarded as Hughes would lead us to believe?

Question 6: What, and how, does the College communicate about professional conduct to doctors? Do participants think the College influences doctors' personal policies in relation to professional conduct?

Question 7: How do participants view the discipline process? Do they perceive it to be an influence on doctors' personal policies in relation to professional conduct?

Question 8: Do participants perceive involvement in College affairs as an influence on a doctors' personal policies in relation to professional conduct? If any participants do, is it viewed as a positive or negative influence?

The interview format used in this study appears in Appendix A.

CHAPTER 3
METHODOLOGY

Design of the Study

The case study was the design selected for this qualitative study because it lends itself well to an intimate analysis of the variables interacting within their natural environment. The case study is well suited for research in the interpretive paradigm, the perspective chosen for this study. The interpretive paradigm applies a subjective approach to the social world (Burrell and Morgan, 1979). The case study allows for a holistic consideration of the subject, a technique that is congruent with a subjective approach.

The case study design has been the target of considerable criticism by researchers who pointed out its inherent disadvantages (see Campbell & Stanley, 1963). The case study design cannot be used to test hypotheses. Stone (1978) noted, however, that it can be used to generate hypotheses. The case study design provided an opportunity to gain insights and develop hypotheses related to the elements in this study.

Campbell and Stanley (1963) criticized the case study for its lack of comparative ability. In defining what they appeared to have viewed as acceptable research design, they made the following statement:

> Basic to scientific evidence is the process of comparison, of recording differences, or of contrast. Any appearance of absolute knowledge, or intrinsic knowledge about singular isolated objects, is found to be illusory upon analysis. Securing scientific evidence involves making at least one comparison. For such a comparison to be useful, both sides of the comparison should be made with similar care and precision.
>
> In the case studies of Design 1, a carefully studied single instance is implicitly compared with other events casually observed and remembered. (p. 6)

Campbell and Stanley made these comments at a time when interpretive, or qualitative research, was not widely accepted among credible researchers. Since then interpretive research has earned respect within the research community.

Other criticism often aimed at the case study design by some researchers relates to a perceived lack of external validity, or generalizability. In its favor, the case study carried out in a natural setting allows "full congruence between the situation being explored and the real world about which generalizations are to be made" (Guba & Lincoln, 1981, p. 116). This study employed qualitative methods that stand up to tests of rigor, and although, as Guba and Lincoln stated, "generalization in the traditional sense is not possible, . . . the idea of *generalizability* should be replaced by the idea of *fittingness*" (p. 118). The concept of fittingness involves thinking in "terms of working hypotheses that fit more or less well into a context other than the one in which they were derived" (p. 118). Working hypotheses cannot be transferred to another context without a good understanding of the original context. For this reason Guba and Lincoln recommend Gilbert Ryle's notion of "thick description" as it was adapted to anthropology by Geertz (1973).

> Thick description involves literal description of the entity being evaluated, the circumstances under which it is used, the characteristics of the people involved in it, the nature of the community in which it is located, and the like. . . . thick description also involves interpreting the meaning of such demographic and descriptive data in terms of cultural norms and mores, community values, deep seated attitudes and motives, and the like. (Guba and Lincoln, 1981, p. 119)

Thick description is a component within this study. I combined document analysis and observation techniques with personal interviews in an attempt to understand the professional association context within which participants operate. This allowed a greater understanding of the meanings of professional conduct described by the participants.

The advantages of a case study design have been identified in the literature. Although the advantages or disadvantages are dependent on the

methodology employed, Stone (1978, p. 137) specified five advantages that a case study can offer:

1. It allows for flexibility in data collection;
2. It allows for data to be collected in a natural setting;
3. It permits the full complexity of the unit under study to be taken into consideration;
4. It is well suited to the generation of hypotheses and insights; and
5. It is generally less expensive than other research designs.

In the expression of some concluding thoughts in *The Mass Media, Public Opinion, And Public Policy Analysis: Linkage Explorations,* James C. Strouse (1978) recommended the case study as "an important area for opinion-policy research" (p. 272). He also suggested that in-depth interviewing should be used for special areas of interest.

Methodological Framework

The general methods used and the kinds of data produced should be determined by the goals of the study (Douglas, 1976). To generate propositions about the elements of influence on doctors' personal policies in relation to professional conduct two complementary methodological approaches were employed:

1. symbolic interactionism (Mead, 1977; Blumer, 1969; Becker, Geer, Hughes & Strausse, 1961), and
2. Erickson's (1986) deliberative approach to fieldwork and his generating and testing assertions approach to data analysis.

Symbolic Interaction

The symbolic interaction theory influenced the methods used to collect data. George Herbert Mead is credited with originating symbolic interactionism while a professor at the University of Chicago during the first

two decades of this century. His students, Blumer, Hughes, Becker and Geer, did much to expand on the fundamental concepts he presented. At the basis of Mead's theory is the concept of "self" as a micro-social system. The self has an inner perspective where one is able to act toward oneself (Meltzer, 1967).

At the root of symbolic interactionism is the concept that people derive meaning about things from their social interaction, that individuals interpret one another's actions and react based on their own perspective (Blumer, 1969; Becker et al, 1961). Symbolic interaction is viewed as a process in which symbols and interpretation mediate between a stimulus and the resulting human behavior (Blumer, 1978).

Although symbolic interaction has been adopted by quantitative researchers (Bogdan & Biklen, 1982), it has been most widely applied to qualitative research. It is particularly well-suited to this study because of its assertion: to understand behavior one must first understand "definitions and the process by which they are manufactured" (Bogdan & Biklen, 1982, p. 33).

Erickson's Approaches

There are many approaches to what has become most well known as qualitative research. Erickson (1986) preferred to use the term *interpretive* to refer to the whole family of approaches. He provided three reasons for adopting this term:

> It is more inclusive than many of the others (e.g., ethnography, case study); (b) it avoids the connotation of defining these approaches as essentially nonquantitative (a connotation that is carried by the term *qualitative*), since quantification of particular sorts can often be employed in the work; and (c) it points to the key feature of family resemblance among the various approaches--central research interest in human meaning in social life and in its elucidation and exposition by the researcher. (p. 119)

Erickson's approach was selected for the study for two reasons. First, and foremost, it is consistent with the goals of the study in that it employs a philosophical base conducive to interpreting meaning. Secondly, the

approach is one that the investigator worked with comfortably, a recommendation made by Bogdan and Biklen (1982). Erickson described the aspects of theory and method most salient in his work as follows:

> In substance, my work is an attempt to combine close analysis of fine details of behavior and meaning in everyday social interaction with analysis of the wider societal context--the field of broader social influences--within which the face-to-face interaction takes place. (p. 120)

Erickson's Deliberative Approach to Fieldwork

In a recent review of qualitative methods in research on teaching, Erickson dispelled the "romantic conception of fieldwork, in which the fieldworker arrives in the setting with a *tabula rasa* mind, carrying only a toothbrush and hunting knife" (p. 140). Instead he advocated a deliberative approach.

> When we consider fieldwork as a process of deliberate inquiry in a setting (cf. Pelto & Pelto, 1977: Levine, Gallimore, Weisner, & Turner, 1980) we can see the participant observer's conduct of data collection as progressive problem solving, in which issues of sampling, hypothesis generation, and hypothesis testing go hand in hand. Fieldworkers' daily presence in the setting is guided by deliberate decisions about sampling and by intuitive reactions as well. . . . From the point of view of a more deliberative conception of fieldwork, however, the central issue of method is to bring research questions and data collection into a consistent relationship, albeit an evolving one. This is possible, we argue here, without placing shackles on intuition and serendipity. Framing research questions explicitly and seeking relevant data deliberately enable and empower intuition, rather than stifle it. (p. 140)

Erickson claimed that without a deliberative approach to fieldwork "problems of inadequate evidence emerge at the stage of data analysis after leaving the field" (p. 140). He said there are "five major types of evidentiary inadequacy:

1. Inadequate amounts of evidence.
2. Inadequate variety in kinds of evidence to warrant key assertions through triangulation.
3. Faulty interpretive status of evidence.
4. Inadequate disconfirming evidence.
5. Inadequate discrepant case analysis. (pp. 140-141)

Erickson's process of fieldwork as deliberate inquiry bears some resemblance to Glaser and Strauss's (1967) grounded theory approach. The similarity lies in the recommendation that data analyzing activities be engaged in early in the research process. Glaser and Strauss used the term theoretical sampling to refer to this process. Erickson advised beginning observation and interviewing "in the most comprehensive fashion possible," then moving in "successive stages to more restricted observational focus," then periodically returning to "more comprehensive sampling, to restore breadth of perspective, and in order to collect more instances of events across the full range of events that occurred in the setting" (p. 143). As the researcher focuses on "a more restrictive range of events within the setting, the researcher also begins to look for possible connections of influence between the setting and its surrounding environments" (p. 143). When the researcher moves "out again to investigate (the) surrounding environments," the analytic task is "to follow lines of influence" into the surrounding environments (p. 143). Erickson noted that cues to these lines of influence come from participants, and from site documents:

> With time, the fieldworker's notions of the phenomena that are most relevant to the study become clearer and clearer. In the final stages of fieldwork research, the focus may be very restricted indeed, as research questions and working hypotheses become more and more specific. (p. 143)

Erickson's Classic Analysis

Erickson described two basic tasks of data analysis:

1. to generate assertions, largely through induction, and

2. to establish an evidentiary warrant for the assertions one wishes to make.

Assertions are generated during the course of fieldwork or by searching the data corpus--the fieldnotes, interview notes, audiotapes, and site documents. The assertions are then tested and retested against the data base. He outlined the process as follows:

> To test the evidentiary warrant for an assertion the researcher conducts a systematic search of the entire data corpus, looking for disconfirming and confirming evidence, keeping in mind the need to reframe the assertions as the analysis proceeds. . . . Any discrepant cases . . . would be identified. If the discrepant cases outnumbered those that fitted the assertion, the assertion would not be warranted by the data. Even if most of the cases fitted the assertion, the discrepant instance would be noted for subsequent analysis. (pp. 146-147)

Erickson labeled these functions *classic analysis,* which is referred to in the literature on fieldwork methods as analytic induction. "Much of this induction takes place during fieldwork, but much of it remains to be discovered after leaving the field" (p. 147). He suggested a good rule of thumb is to ensure that an equal amount of time to that spent in the field is planned for analysis and write-up afterwards.

The data analysis method which Erickson (pp. 145-153) described can be summed up as follows:

1. Begin with multiple readings of the fieldnotes.
2. Generate assertions.
3. Establish evidentiary warrants for assertions by seeking both confirming and disconfirming evidence, and report *particular description* (instances of social action or of interview comments quoted in the interpretive commentary).
4. Look for *key linkages* (those things that connect many items of data as analogous instances of the same phenomenon), and report *general description* (more synoptic surveys of patterns in the basic units of analysis).
5. Using *interpretive commentary* (commentary "interpolated between particular and general description") make "connections

between the details that are being reported and the more abstract argument being made in the set of key assertions" (p. 149).

6. Revise assertions.

Research Procedures

Research methodology does not necessarily imply specific research techniques. Content, rather than procedure, is of primary significance in qualitative, or interpretive, approaches to research (Erickson, 1986). Research strategies outlined in this section accentuate the methodological framework described in the previous section. Erickson's emphasis in relation to theory and method was adopted for the study. He described it as follows:

> In method, my work is an attempt to be empirical without being positivistic; to be rigorous and systematic in investigating the slippery phenomena of everyday interaction and its connections, through the medium of subjective meaning, with the wider social world. (p. 120)

Gaining Access

The case study was conducted with the College of Physicians and Surgeons of Alberta. A field study was carried out in January and February of 1988 to investigate the appropriateness of a setting for the study and to make some predictions about the potential for gaining access to the setting. In order to obtain preliminary information about the organization presumed to be most suitable, the investigator collected data concerned with both the formal and informal systems within the organization. Interview and document analysis methods were used for the investigation. Following the field study, I decided to make a formal request to the College for access to conduct the study. Approval was subsequently granted.

Ethical Considerations

Prior to undertaking the research, I communicated to the administration of the College that the study would be conducted in an ethical manner, consistent with the University of Alberta "Research Ethics Review Policies and Procedures" (1988). The research procedures in the study did not pose any physical harm for the participants. Any potential mental harm was avoided by carefully planning steps to guarantee anonymity of participants and by obtaining fully informed and voluntary consent from each participant. The responses were treated confidentially. I informed the College administration that permission would be sought if data were to be used in any way other than that explained at the outset. Any secondary use of data, not anticipated at the time of the study's development, was to comply with the university's guidelines. Names of participants and locations of professional practice have not been revealed in the reporting of data.

I ensured that I was sufficiently knowledgeable about relevant literature and methodology, the potential for risk and the uses to which the results were likely to be put. Responsible decisions were made at each step by consulting with informed colleagues whenever a question concerning the most appropriate way to proceed arose.

Selection of Participants

In January, 1989 forty-three doctors were contacted by the researcher via a personal letter, which briefly described the study and requested their participation (see Appendix B). The 43 doctors contacted were identified through three sources:

1. 26 were recommended by the College deputy-registrar who made a concerted attempt to provide a "non-biased sample,"
2. 8 were recommended by the communications director of the Alberta Medical Association, and

3. 10 were individuals known personally to the researcher. In addition, the deputy-registrar arranged interviews with the president and vice-president of the College.

A large majority of the doctors who were invited to participate in the study responded by telephone within two weeks of receiving the letter of request. The remainder were either telephoned or contacted by letter. Three doctors declined the invitation to be interviewed. Seven, who I was unable to contact by telephone, were sent letters informing them that enough participants had been identified for the study and that an interview was no longer requested. Five doctors who volunteered to be interviewed were also told that enough participants had already been identified. These doctors agreed to participate in a second round of interviews if such interviews were necessary.

I received a more positive response to my requests for participants than I had anticipated. I had thought initially that I would interview approximately 20 doctors. Due to the positive response, a larger number of participants was included in the study.

Appointments for interviews were made with thirty doctors from Edmonton, St. Albert, Sherwood Park, and two rural Alberta communities. Twenty-seven doctors were subsequently interviewed. Three doctors had to cancel appointments due to unforseen circumstances. One of the audio-tapes used in an interview was faulty and thus the interview was not recorded. Data from interviews with a total of 26 participants were analyzed.

Data Collection

To permit triangulation during analysis, data collection involved participant interviews, both participant and non-participant observation, and document analysis. Semi-structured interviews with Alberta doctors are the primary source of data. The interviews were of one to two hours in duration and took place during the period of January 16 through to March 20, 1989. Participants were interviewed in their natural work setting, either an office or

a hospital. The interviews were tape recorded and I took note of the surroundings, particularly if the interview took place in the personal office of the participant. An overt approach (Bogdan & Biklen, 1982, p. 120) to data collection was taken. I made my interests known to the participants and disclosed any additional information related to the study which was requested by participants.

I observed the discipline process at the College through my attendance at a discipline hearing. I also attended the 1988 annual meeting of the College. The president and one vice president of the College were interviewed in the Council Chambers at the office of the College. The registrar and the deputy-registrar were each interviewed in their respective offices. In addition to one formal interview, I met a number of times with the deputy-registrar who provided additional information.

Numerous documents were perused, including legislation, annual reports, promotional materials, and correspondence. I had permission to access discipline and other files of the College.

Tentative arrangements were made with doctors who were willing to participate in a second round of interviews, if analysis of the data had warranted them.

Data Analysis

After each interview, I made brief notes about the physical setting in which the interview took place and other items of special interest, and listened to the audio tape. During the period when the interviews took place I recorded insights and tentative assertions which were revised as the data collection progressed. I then listened to each of the audio tapes again and made summary notations of the responses under headings identified by the content of the interview. In addition to the summaries, many direct quotations were recorded. New headings were created for topics that arose in the interviews which were not structured into the general interview format. This summary notation process involved listening to the interviews a

number of times. As notations were made, their location on the tape were recorded for easy retrieval later. The data was not transcribed word for word. This decision was made as a result of a previous data analysis experience in which I worked from transcripts. There I experienced difficulty understanding many of the respondents' comments. This study focused on meanings and perceptions of the participants. A truer description of participants' responses was made possible by leaving the data in the audio format whereby intonation, pauses, and other verbal signals provided a more trustworthy source than would have been possible using transcriptions. Maintaining the audio recordings was even more important when one considers that the visual communication was already lost (except for what remains in the memory of the researcher and was noted during or following the interview).

During and following the summary notation process I generated propositions from the data. Responses were recorded in tables which made it easier to identify patterns in the data. Frequencies of responses were noted. The propositions were then revised. The data corpus was reviewed again to identify evidentiary warrants for the propositions by seeking both confirming and disconfirming evidence. At this point, what Erickson termed *particular description* (instances of social action or of interview comments quoted in the interpretive commentary) were reported. This process of reviewing the summary notations, quotations and audio tapes continued while I looked for and identified key linkages. Both general descriptions and interpretive commentary were recorded as I worked through the data. Propositions were then revised until I was satisfied that I had extracted credible findings.

Meeting Tests of Rigor

Guba and Lincoln (1981) used the term *credibility* to refer to internal validity--the establishment of confidence in the truth value of the findings. They cited Speizman's (1969) suggestions of invalidating factors, which were applied to data from the study as outlined below.

When employing the interview method for data collection one expects high reactive effects. Distortions may result from reactive responses in subjects as a result of the researcher's presence. Attempts were made to minimize these effects by establishing an adequate level of rapport with the subjects prior to the data collection. I found this came with ease in almost all interviews, and where it did not, a longer period of time was taken to develop rapport. Without exception, the participants expressed interest in contributing to the study and very few appeared guarded in their responses, even at the outset. In addition, I employed interviewing techniques which promoted thick data filled with words that revealed the subjects' perspectives.

Investigator sensitivity was used as a valid check on distortions arising from bias on the part of either the researcher or the subjects. Distortions arising from the manner in which data-gathering techniques are employed was reduced by careful scrutiny of the data for internal and external consistency and by cross-checking responses with documents, participant observation fieldnotes, and with comments from other participants. This triangulation of the data during analysis increased the credibility of the findings by establishing a degree of structural corroboration. "As statistical means are more stable than single scores, so triangulated conclusions are more stable than any of the individual vantage points from which they were triangulated" (Guba & Lincoln, 1981, p. 107).

Cross examination was not used in this study, as it might have jeopardized the level of trust between the researcher and the participant. Guba and Lincoln stated that "credibility checks are the only possibility of establishing the truth value of information obtained naturalistically" (p. 111). Two of the audio tapes and the recorded notations that I had made were returned to the interviewees for credibility checks. Each was asked to listen to the tape and peruse the notes, and to comment on the accuracy of the written notes. The responses received from the interviewees affirmed the accuracy of the written notes. Guba and Lincoln recommend such "member checks" which involve "taking data and interpretations to the sources from which they were drawn and asking directly whether they believe--find plausible--the results" (p. 110).

The term analogous to external validity or generalizability, as proposed by Guba and Lincoln, is *fittingness* which answers the question of applicability. Two conceptual elements applied to this study in the collection and analysis of data, i.e., propositions, or assertions which is the term used by Erickson, and thick description, serve to test "the degree of *fit* between the context in which the working hypotheses were generated and the context in which they were applied" (p. 120). In addition to member checks on the raw data, I took copies of the written dissertation to two doctors who had participated in the study and asked each of them to comment on how well they thought the propositions and evidence fit the situations reported on. Comments from these doctors confirmed the propositions and conclusions reached in the study.

As a "qualitative research" substitute for the term reliability which is used within the context of the empirical paradigm, Guba and Lincoln suggest *auditability* which is concerned with consistency and replicability of findings. They explain that "it is impossible to have internal validity without reliability" and "a demonstration of internal validity amounts to a simultaneous demonstration of reliability." Triangulation of the data, as reported above, is a form of the overlap method which demonstrates *consistency,* the concept Guba and Lincoln use to replace the empirical research term objectivity.

Conclusion

This study was developed to examine the developmental nature of doctors' personal policies in relation to professional conduct and to generate propositions in that regard. The examination entailed a consideration of the meaning that members of the College ascribed to the concept of professional conduct. A case study design using qualitative methods in an interpretative framework was selected as the methodology most appropriate to achieve the purpose of the study. The symbolic interaction theory and Erickson's deliberative approach to fieldwork were applied to the data collection.

Erickson's classic analysis method was used in the analysis of the data. A field study was carried out in the winter of 1988 and data for this study was collected during the winter and spring of 1989. According to methods recommended by Erickson, data was analyzed during the data collection period and the process of analysis continued to evolve through the final writing of this dissertation. Guba and Lincoln's strategy for meeting tests of rigor were applied to the methods employed in this study.

CHAPTER 4
PRESENTATION OF THE DATA: DEFINITION OF PROFESSIONAL CONDUCT

For Polanyi (1966) *knowing* encompassed the intellectual "knowing what" and the practical "knowing how." For the participants in this study "knowing what" meant a definition of the concept of professional conduct. This definition was prerequisite to the identification of factors that influenced the participant's personal policies in relation to professional conduct (the basis of the data analysed in Chapter 6). Agreement with this notion was explicit in Erickson's statement: "An explanation of cause in human action must include identification of the meaning-interpretation of the actor." (1986, p. 127)

In this chapter the data related to the definition of professional conduct are classified, conjoined, and then consolidated in the form of 11 propositions.

Findings

The data did not imply a commonly held definition of professional conduct among the participants in the study. Fifty descriptors were identified in the 26 definitions of professional conduct. In Appendix C, the descriptors used by the participants in the study to define the concept of professional conduct are listed. The descriptors are organized into three functional categories: (1) cognitive, (2) affective, and (3) behavioral. In this context the meanings of these 3 terms are as follows:

1. *cognitive descriptors*: definitional statements that describe thinking based on one's knowledge and beliefs,
2. *affective descriptors*: definitional statements that describe and arise from feelings and emotions, and
3. *behavioral descriptorss*: definitional statements that describe how an individual conducts or should conduct oneself.

The descriptors in Appendix C are listed under categories that define the participant's approximate years of practice and whether the participant was trained in Canada or Britain, the locations of medical training for those interviewed.

The categories were created after the data were collected. One definitional category, described as *professional conduct extends beyond a doctor's practice of medicine,* was developed from the answers to a specific question posed during the interviews. The other definitional categories were drawn from participants' responses to the open-ended questions: "How do you define professional conduct? What does that concept mean to you?"

Through a process of analytic induction descriptors with similar meanings were grouped into broader definitional categories than the units identified initially and reported in Appendix C. The descriptors were reorganized into revised categories continuously as confirming and disconfirming evidence was identified in the interview data. The resulting definitional categories reported in this chapter exhibit some blurring. Some descriptors have been included in more than one of the definitional categories.

The non-verbal cues, observed and evident in the tone of the speakers' voices while defining professional conduct, demonstrated little emotion relative to the participants' discussions of influences on their personal policies in relation to professional conduct (reported in Chapter 5). Thus, the analysis in this chapter relies more heavily upon frequency measures than does the analysis in Chapter 5 where greater meaning is derived from the tonality of the participants' voices.

None of the participants were new to the profession. One had been in practice for 5 years, seven for 9 or 10 years, twelve for 11 to 20 years, and six for 21 or more years.

Eight of the participants were trained in Britain, the remaining 18 were trained in Canada, most of whom attended the University of Alberta. The distinction was made between countries of training because initial analysis of the data suggested a perception among some of the British trained doctors that in Britain, doctors received *more formal and strict ethical training* than the Canadian trained doctors did. One of the more senior doctors commented:

> My teachers at medical school were trained at the turn of the century. They had a very formal, stiff collar, Victorian-traditional way of looking at professionalism. . . . Our training was very formal. Dress and title were important. . . . You were told to get permission from the College before talking to another doctor's patient. You were taught to practice professional courtesies.

Upon further analysis, it was noted that the majority of the British trained doctors were in the most experienced category, whereas only one of the Canadian trained doctors fell into that category. Thus, it was not possible to distinguish with any confidence, between the 21 or more years experience category and the British trained category and to which category to attribute the *more formal and strict ethical training*. Five of the 8 British doctors who participated in the study had been in practice for 21 years or more, 3 of those

for over 30 years. Only one of the Canadian trained doctors interviewed had been in practice for more than 20 years.

The distinction between countries of training and years of experience is reported only in instances where one or both of these variables made a difference.

The data demonstrated a higher frequency among the British trained doctors in reference to *responsibility that comes with privilege or social status* in their definitions of professional conduct. Four of the 8 British trained doctors and 1 of the 18 Canadian trained doctors used this descriptor. Three of these doctors were in the 11-20 years experience category, thus the synonymous relationship of *British trained* and *21 or more years experience* does not appear to skew this assertion.

Three aspects of meaning in the definitions of professional conduct were agreed upon by majorities of the participants in the study:

1. professional conduct is expressed in one's behavior,
2. professional conduct is primarily focused upon the doctor's patients, and
3. professional conduct is maintained through both internal and external controls.

Sixteen or 66% stated that professional conduct referred to the *behavior, involvement or conduct* of the professional. One of the more senior doctors who had been practicing for over 30 years said, "Professional conduct is a way of behaving. If people know you as a doctor you should behave like a doctor because that is what people have a right to expect." A younger participant commented:

> It's your manner, how you conduct yourself, how you present yourself to the public, to your colleagues. It's your image--you establish some sort of a persona viewed by the public and your colleagues about the type of physician you are.

Another doctor who had been in practice for over 30 years said that professional conduct is simply a part of social conduct requiring that one behave responsibly.

A doctor who had been practicing for 10 years related a definition of professional conduct to behavior in the following way:

> Professional conduct is the difference between behaving in a professional and moralistic, caring fashion towards other individuals as opposed to having a laissez-faire or noncommital approach to daily life and interpersonal communication. I think it is a way of life--something that you do minute to minute, hour to hour, day to day. It's not something that you put on and take off. I think it is something you either have or don't have. I think it is a skill that you learn, and it's better if you grow up with it because then it is much more ingrained. I come from a very dedicated, professional family. Professional conduct is just part of everyday life--respect of each other's rights and freedoms, the preservation of an individual's own self, empathy, the ability to communicate, and to listen. Professional conduct is a group of behavior patterns that become your way of life.

One participant began a discussion of the concept by stating that "Professional conduct is principally conduct toward patients, colleagues and Alberta Health Care." The latter grantee adds a distinctive dimension to the definition of professional conduct. In total, 6 participants made reference to following government restrictions or guidelines in their definitions. Another doctor included specific reference to government controls on billing by the Alberta Health Care Insurance Plan in the doctor's definition of professional conduct:

> Big brother is watching you all the time. You should keep a low profile, don't bring the eyes of the public on you, be average, be within two standard deviations above the mean, don't be too apparent.

In the next chapter the health care system is discussed further in relation to *influences* on the doctors' personal policies in relation to professional conduct.

It was interesting to note that although the majority of participants referred to *behavior of the professional* in their definitions, the concept of professional conduct was described in *cognitive* terms more frequently (88) than in *behavioral* (63) or *affective* (12) terms. One participant explained that, "It is a philosophical concept." Perhaps participants viewed the concept more

as an inherent part of an individual's character than as a list of do's and don'ts.

When the participants used *behavioral* terms they described what professional conduct is or what a doctor should do, and what professional conduct is not or what a doctor should not do. Seven of the participants made reference to the importance of keeping information about their patients confidential. One doctor noted that "there is a tendency to think of misconduct. It is easier to define what is wrong." On the participants' lists of "should nots" or misconduct were "no sex with patients" and "no criminal behavior", each identified by 4 participants. One participant noted that it is "unethical to steal a colleague's patients." Another expressed the behavioral aspect of professional conduct as follows:

> I can talk about professional conduct in different ways. One way is my [illegible] be sure that I am not trying to have sex with my pa[illegible]vealing confidential information, or selling drugs il[illegible]rough the practice, or going out and being a croo[illegible] have double jeopardy in our profession.

Patient-centred comments were made by 18 participants (69%). Seven of the participants identified the patient as "the central concern" or "doing what is best for the patient" in their definitions of professional conduct. One doctor commented,

> Professional conduct links very closely with the service you are providing. The first thing is that you have to establish some rapport with patients. . . . You are their advocate. . . . You should be helping them make decisions. You should have the patient's best interest as your primary objective.

Five participants emphasized relationships with patients and two of the participants commented on provision of the best or highest level of service. Three participants identified listening and including patients in decision making and one participant referred to an unstated or stated contract with patients.

A number of participants referred to *relationships with others* in their definitions. Nine of the doctors interviewed included references to

relationships with patients, colleagues and/or other health care workers. One of the doctors expressed it as follows:

> Professional conduct is the way an individual relates to those he is responsible to and for--to his peers, his patients, those other members or authorities in a hospital or to the College or government bodies.

Another doctor said it this way:

> Professional conduct includes everything but personal relationships. You must be professional in your conduct outside your practice to gain respect for your advice given in your conduct with patients. There are three areas of concern here?: (1) Patients should be treated with dignity. Doctors must be willing to listen and let their patients in on decision making. There has been a change in this area and I am concerned about the dignity with which the physician adapts to changes concerning more participation with patients. (2) Other health care workers and professionals should be treated with dignity and allowed to have their input. Doctors have to realize that they are not "kings" anymore! (3) The third area is the public.

Just under one third of the participants (8 or 31%) included a *code of ethics or standards* in their definitions. Seven participants made some reference to a moral or ethical component. Generally, the participants who described the meaning of professional conduct in ethical terms related it to issues of right or wrong and good or bad. There was, however, one comment that stood out among the rest.

> The reason a number of doctors keep up their professional conduct is to keep stress at a minimum, for example, if one stretches conduct to the limit to make more money that would be stressful.

The doctor was referring to stress from worrying about whether he or she would be audited and/or disciplined by the College. When asked: Where do you draw the line between what is and what is not professional conduct? The reply was, "If there is fraud." This participant expressed the power of an external control over conduct of the doctor--avoiding misconduct because of the possibility of punishment rather than being guided by the internal controls of one's value system. Although 15 (58%) of the participants noted

external controls in their definitions of professional conduct (see Figure 1), they also made some reference to one's values, attitudes, conscience or some form of service to others. One doctor expressed both internal and external controls as follows:

> Professional conduct is an extrapolation of the phrase "being a good boy or being a good girl," and you have to try and define what they mean. First of all it means you must follow the *Ten Commandments,* then the *Hippocratic Oath.* I still believe in it. It is more and more difficult with government intervention to be a physician and follow the government constraints that say you can't do a certain test because it is too difficult. Every physician is torn between the litigious kind of atmosphere that we are now being forced to practice in (and his or her own definition of professional conduct). Now not only must one follow professional conduct but you also must follow what the government says you have to.

There was a higher frequency of responses concerning *external controls* in the definitions of professional conduct among the doctors who had been in practice for 21 years or more than among the doctors with 20 or fewer years experience. The doctors in practice for 21 years or more had a 267% frequency rate compared to a 75% frequency rate among the doctors in practice for less than 21 years.

code of ethics
public expectations
dictated by the organization you belong to
following government restrictions
avoiding stress by stretching conduct to the limit
no criminal behavior
double jeopardy

Table 4.1: External Controls in Doctors' Definitions of Professional Conduct

One third of the participants expressed *difficulty in defining professional conduct.* A doctor with over 30 years experience stated, "I don't think that professional conduct is something that is defined by being written down." A younger doctor responded to the question "How do you define professional conduct?" by commenting: "It's difficult to answer. I haven't ever thought about this," and then went on to give quite a lengthy definition. One doctor's comments summed up what was expressed by a number of participants by stating: "Professional conduct is a difficult term to put an exact definition on. It encompasses a lot of things."

A doctor who was serving a term of office on the College Council explained the difficulty doctors have in defining professional conduct:

> not sure that a lot of them go through an objective process, I think that they learn a pattern of behavior which they perceive to be ethical. It is a learned phenomena which develops to a certain extent through their medical education, and to a certain extent they bring it to their medical education with them. I don't think that they consciously think about what their ethical behavior should be. I think they practice it. That doesn't mean that it can't be codified, or structured. I think it is learned but not consciously written down, or thought about each day.

In a similar vein, another doctor said:

> It is not something that you verbalize or discuss at meetings. It's just something that you intuitively know--that you develop by osmosis. You develop it by seeing other people, you develop it by hearing others being crucified for having made a mistake and you learn that this is something for you to avoid.

These comments express what Polanyi (1966) described in his definition of tacit knowledge, the theory which was adopted in this study as the meaning attributed to the term *personal policies.* Polanyi said that we know more than we can tell, and that our "knowing" encompasses both the intellectual function of "knowing what" and the practical function of "knowing how" (p. 7). Eight of the participants made particular reference to professional conduct as something that goes *beyond the intellectual and the*

practical to a way of existing, expressed in comments like, "a way of life," "a pattern of professional practice," and "a culture distinct to the profession."

> Professional conduct is a pattern of professional practice and a general way of life. The two go together, you can't show misconduct in your personal life and show true professional conduct in a medical practice.

Leggatt (1970) used Wilensky's interpretation of Polanyi's *Tacit Knowing* to support his thesis that the core characteristics of professions are their "foundation upon systematic, technical knowledge and their devotion to the service ideal:"

> Wilensky argues that high status professions have a knowledge base founded both in theory and the long practice that gives 'tacit knowledge', that residual element identified by Polanyi that remains when all knowledge that can be has been communicated. The acquisition of both open and tacit knowledge necessitates long training and impresses the public with the feelings of awe and inferiority that secure a mandate for the wide exercise of professional discretion. (p. 158)

Legatt's concept of the "*service ideal*" received considerable attention among the doctors interviewed. Some expressed it as an expected standard that goes beyond what people in other occupations might determine is a normal day's work. Other participants talked about the service ideal in terms of "service before self" and conveyed the impact this concept has on them personally and on the profession as a whole.

Four participants stated that the medical profession requires a stricter level of standards than that expected of other people. One doctor said:

> Professional conduct is self imposed. What goes beyond one's day to day action for other working people in other spheres of work would not be unprofessional conduct. What may be acceptable in other spheres of work would not be appropriate in medicine.

Another reference to higher standards was voiced as follows:

> I don't think doctors are ordinary. I don't think they should be. Do you send your family to an ordinary doctor?

This kind of thinking is expressed in the literature that attempts to define professionalism (Corwin, 1970; Jackson 1970; Vollmer & Mills, 1966). Jeffrey (1962) stated,

> One of the marks of a profession is a code of ethics. A profession involves a sense of service and responsibility to the community, and the conduct required of a professional man is above that required of other men. (p. 345)

Barber (1963, p. 4) sums up the general themes throughout the literature by distinguishing four essential attributes that define one's practice as professional:

1. generalized knowledge,
2. primary orientation to the community interest,
3. internalized code of ethics, and
4. rewards which primarily symbolize work achievement.

Leggatt (1970, p. 158) argues that his moderate definition of a profession, "systematic, technical knowledge and devotion to the service ideal," is what is agreed upon in the literature that defines the core characteristics of professions. In the opinions of 5 of the participants, it is this concept of *the service ideal* that makes a doctor more than just "ordinary."

> You have higher expectations of your own behavior. Most doctors have a strong work ethic. They are usually self-sacrificing.

> I am responsible to do what is best for a patient. Service before self doesn't strike me appropriately because when we serve others we serve ourselves. So I don't find it to be a mutually exclusive thing. I like to do things for other people, and I like what I do. It benefits me to do the best for other people.

> You exist for patients, rather than patients exist for you.

Jackson (1970, p.6) stated that "the service ideal of the professional is usually taken to be one of the key characteristics of the profession." He added, though, that,

> There is no reason to assume that professionals are either more charitable or more interested in their fellow men than others. What, rather, is significant, is that their occupational niche is defined around problems of universal, or at least widely experienced, social concern. In each case they encompass specialized areas of knowledge which affect all individuals but where only a few can become expert.

One of the doctors interviewed questioned the service ideal. This doctor expressed concern with the expectation of "service before self" and noted that it has become a big issue in the profession. It is important how doctors deal with the stress it creates and how they set their priorities.

> All throughout training altruism is expected. You are viewed as selfish--you must not be a dedicated physician--if you look after yourself. . . . Many doctors show an inability to prioritize, resulting in alcoholism and substance abuse and an eventual indifference to professional conduct. Standards fall because they can't deal with it all. I have to keep catching myself. I'm a workaholic. In the past the doctor was just expected to do it all. With the information explosion they can't do it all, but it is still considered bad to be selfish. The public and the physicians must recognize that doctors can't be that dedicated. Physicians can't always be altruistic. This is acceptable in the United States but not here.

There were some surprises in the data. Professional conduct was defined using *affective* terms or phrases least often. Overall there were 12 descriptors that fell within the affective domain, somewhat fewer than one might expect from professionals who deal with people, perhaps in their most vulnerable states, on a daily basis. Only one of the 6 participants who had been practicing over 21 years used an affective term to define professional conduct. Only two doctors identified *honesty* in their definitions of professional conduct, although another two made reference to fair billing practices. Likewise, the other affective descriptors, each identified twice in the data, were *kindness and caring, conduct dictated by a clear conscience* and *empathy*. Trust was a more commonly held attribute among the affective terms used. Four of those interviewed identified *trust* as an element in the concept of professional conduct, and 7 regarded the related concept of confidentiality as a behavior expected of doctors. A related descriptor among

the cognitive phrases was *respect/concern for patients rights/dignity,* which was identified by 6 participants. The related behavioral and cognitive descriptors demonstrate a higher level of affective domain description than the functional categories suggest.

Professional competence was linked with professional conduct by only one of the doctors interviewed. This was surprising since the College controls licensing and disciplines members for incompetency as *conduct unbecoming.* There were other low-frequency descriptors that are more relevant to competency than to ethics, e.g., *provision of best/highest level of service, listen, include patients in decision making,* and *self-educating,* however the majority of participants did not define professional conduct in terms of *competence.*

One definitional category resulted from asking most of the doctors interviewed if professional conduct *extends beyond a doctor's practice of medicine.* Twenty-two, or 92% of those asked, said yes; two said no. The topic was not discussed with the other 2 participants. The doctors had much to say about professional conduct influencing their lives beyond their professional practice.

> Professional conduct most definitely goes beyond practice. You cannot isolate good conduct as a professional and yet be a louse somewhere else.
>
> Doctors are isolated in their social life.
>
> To a certain extent you are constrained to be a physician on your own time. You have an ethical mandate at that time that is different because you are not dealing with patients, but you are being perceived as a physician by other people. You can't turn off the switch.
>
> Our business or social activities could be considered inappropriate behavior. We are subject to our own discipline regulations for misdemeanors outside our medical practices.
>
> If people know you as a doctor you should behave like a doctor because that is what people have a right to expect. I don't think it really matters if you are practicing medicine or not.

There are limitations on my private life. All the time I am "on tap," I can be called away, I can't "party it up."

I'd like to see my family more, it severely restricts what we do. We need to take two cars to our band practice. I can't take the children in my car in case I get called. I don't think that because I have an MD after my name that I act any differently though, I try just to be myself.

If you have privilege, you have responsibility.

I often carry my frustrations, anxieties, home. It affects my marriage. . . . I went in to Medical school with my eyes open--I was prepared for long hours. I don't think my wife was though.

Friends tend to treat you differently. There tends to be a "thing" that surrounds physicians, you must bite your tongue sometimes. You tend to have a certain status.

You can't walk out of the doctor's office and shed your profession. I don't think it places limitations, but instead it opens doors, it is a very positive thing.

It especially affects one's personal life in a small town. I am often approached for service in the drug store!

There is a tremendous feeling that big brother is watching all the time. I think that being a doctor now is an experience in paranoia. The government can get a complete profile off the computer on you at any time. . . . Professional conduct takes a tremendous amount of trust. A lot of us feel that nobody trusts us. The patients should be our judges. Some of the peers who review us are far removed from practice.

It encompasses everything about one's life. In the city it is reasonably limiting, but not like in a small town. Every time I go to a public place I meet someone I know as a patient or otherwise. There is a general feeling that the community keeps its eyes on professional people, be they doctors or teachers. In the community everyone is expected to perform within certain guidelines which aren't clearly defined, but nevertheless are in good taste. One doesn't get drunk and rowdy and get into fights, or chase after other people's wives.

Conclusion

The findings from participants' definitions of professional conduct are conjoined and consolidated below in the form of 11 propositions:

Proposition 1: Professional conduct is an elusive concept that means many things to doctors.

Proposition 2: There is some congruence between Polanyi's (1966) tacit theory of knowledge and the way doctors define professional conduct. Many view it as an *evolving concept* that goes beyond the intellectual and the practical to a way of living one's life.

Proposition 3: Professional conduct extends beyond a doctor's practice of medicine.

Proposition 4: Doctors agree upon three aspects of meaning in the definition of professional conduct: (1) professional conduct is expressed in one's behavior, (2) professional conduct is primarily focused upon the doctor's patients, and (3) professional conduct is maintained through both internal and external controls.

Proposition 5: Doctors identify a *behavioral* component in the definition of professional conduct, yet they predominantly use *cognitive* phrases to describe the concept. Dominant behavioral aspects of the concept of professional conduct are *confidentiality, following government restrictions,* and *relationships with patients, colleagues and other health care workers. Afective* terms or phrases are seldom used in doctors' definitions of professional conduct. *Trust* is the most commonly held attribute among the affective descriptors. Trust is congruent with the most common behavioral descriptor: *confidentiality.*

Proposition 6: For doctors with more than 20 years experience *external controls* are more instrumental in the definition of professional conduct than for doctors with less experience. Doctors in the higher experience category focus less upon patients in their definitions of professional conduct than doctors in the less experience category.

Proposition 7: The *service ideal* is a commonly held concept in doctors' definitions of professional conduct. It may be expressed in terms of a *stricter level of standards,* as *service before self,* or as *altruism.* These descriptors are consistent with the literature that defines professionalism.

Proposition 8: *Relationships with patients, colleagues, and/or others* is a commonly held concept in doctors' definitions of professional conduct, albeit less commonly held than the *service ideal.*

Proposition 9: The meaning of professional conduct is often explained in relation to issues of *right or wrong* and *good or bad.*

Proposition 10: *Responsibility that comes with privilege or social status* is a concept inherent in the definition of professional conduct more common to doctors who receive their training in Britian than to doctors trained in Canada.

Proposition 11: *Competency* is rarely thought of by doctors as a concept inherent in the definition of professional conduct.

CHAPTER 5
PRESENTATION OF THE DATA: FACTORS OF INFLUENCE ON PERSONAL POLICIES IN RELATION TO PROFESSIONAL CONDUCT

The major focus of the study was to examine factors of influence on personal policies in relation to professional conduct as perceived by the participants. I wanted to know what meaning the doctors gave to factors perceived as having influenced their views, attitudes, principles and beliefs related to professional conduct. Influences within the context of the professional organization were emphasized. An attempt was made during the interviews to direct participants' attention to their social interaction as members of the medical profession--how they viewed themselves as individuals operating within the collective.

The socialization of values and attitudes prior to professional training was relevant to this study in so far as it was viewed by participants as an ethical basis upon which their personal policies in relation to professional conduct were developed. Personalistic and formative factors of influence were identified by participants. Influencing factors encountered after participants had entered their professional training, however, were emphasized during data collection and analysis.

Factors of influence that are most salient in the participants' interview comments are reported and discussed in this chapter. I made judgements concerning how strongly the views expressed by a participant were held. These judgements were based on what the participant said and how the participant expressed what he or she said. Gestures made by the participants as they spoke, and elements within the environment where the interview took place were noted when they appeared to amplify the meaning being expressed by the participant. The non-verbal cue primarily used to recognize

the salience of a participant's phraseology was the intensity of emotion expressed in the participant's voice. This was why the raw data were left in an auditory format for analysis.

Patterns were identified from multiple descriptions of similar phenomena encountered in the data. These patterns are reported in general descriptions accompanied by reports of particular instances taken from the interview comments.

I identified a number of classifications of influencing factors on personal policies in relation to professional conduct before the interviews were carried out. These included:

1. personalistic factors: the inherent character and personality of the individual,
2. formative factors, pre-medical training: family, church, teachers, the educational system, and the community,
3. sociological factors related to the profession: public expectations, professional training, legislation, and the code of ethics, and
4. the College: the enforcement through the discipline process of the code of ethics, legislation and other rules and regulations, members' involvement with the administration of the College, and communication from the College to its members.

The dominant categories that were drawn from the data during analysis within classification 3. above were different from those identified before data collection. The sociological factors of influence were more appropriately recategorized as follows:

1. teacher and peer role models,
2. relationships with patients,
3. lifestyle,
4. remuneration and the role of government,
5. litigation, and
6. advances in technology.

The size of the sample varied slightly among the categories for analysis. In a few interviews time was limited to one hour because the doctor was scheduled for surgery or had other commitments. One of the interviews was

cut short when the participant was called away to assist in the delivery of a baby. As a result, in a few cases some sections of the interview were either discussed very quickly or were missed. Where this had an impact on reporting during analysis the sample size has been noted.

In analyzing and reporting the data I have presented the necessary information in a way that is easily discernable for the reader.

1. I began by listening to the interview tapes a number of times and noting reoccurring themes.
2. From these notations and from field analysis during data collection propositions were generated.
3. I listened again to the tapes and perused my notes seeking confirming and disconfirming evidence for the propositions and identifying particular description from the interview comments. This is the stage of analysis where Erickson (1986, p. 149) establishes evidentiary warrants for assertions. At this stage too, I looked for key linkages connecting items of data that appeared to be analogous.
4. Patterns drawn from this analysis were developed into categories of factors of influence on participants' personal policies in relation to professional conduct.
5. Using interpretive commentary I reported my findings making connections between the data and the key assertions.
6. Following the reporting process the presentation of data was summarized.
7. Finally, revised propositions were framed.

I chose to present my process of interpretation rather than present only the final summary and discussion with revised assertions. This presentation allows the reader to critique the analysis as well as review the findings. The reader's experience may lead to different conclusions.

Generally, participants expressed a much higher level of emotion when they talked about influences on their personal policies in relation to professional conduct than they did when defining professional conduct. In the presentation of the data that follows I have attempted to let the participants "tell their story" as much as possible. The data have been

organized as described above, nevertheless, as much as possible, the data are presented in the words of the participants.

Findings

Factors of influence on personal policies in relation to professional conduct that were identified by participants were classified into the four categories that appear in this section:

1. personality,
2. the formative years,
3. socialization into the profession, and
4. the College.

Personality

During their interviews, six of the 26 participants (23%) made reference to personality as an influence on personal policies in relation to professional conduct. Two of the six agreed that role models during medical training had some influence on how they practiced, however their own characters had more bearing on their professional conduct. One of these doctors stated emphatically:

> Professional conduct is the result of something you have in your genes which is modified by your upbringing and your home environment. Once you get to medical school it is improved upon. There are some characteristics that one is born with that makes that person a good person.

For three of the doctors interviewed, personality was an issue that was not receiving enough attention in the selection process for medical school. At the conclusion of the interview a doctor commented:

> Formative experiences and personalistic factors--subconsciously I avoided these influences. There was no reason to. I didn't touch on the personalistic factors because there isn't any selection process which takes this into consideration. The only consideration is highly superior grades. This is of concern to me--that we are choosing people based on things that don't tie in with what we think makes a good doctor. By choosing only on the basis of academic standards the focus is on a very narrow area of their personalities. Doctors deal with the public. We aren't screening for ability to deal with people and to communicate. We will have to pay the price for that. Perhaps the medical association should be looking at how we choose these people. Being personable with patients is an important factor in getting good results from patients.

The University of Calgary's medical school was applauded by a participant because it tried to "get people with a particular frame of mind. It didn't always get the people with the highest academic ability." The concern over selection was expressed with considerable fervor by one of the more senior doctors:

> We are now seeing a different type of medical student let into the faculty. Selection is primarily based on academic achievement. There used to be other factors considered, and we will be going back to that. As a result we are getting a different type of person into the health care system.

> Many of those disciplined by the College should not have been accepted into the profession in the first place. The selection process is very important. The *Charter* has made it difficult. The College needs hard data. How do you demonstrate that someone's character is not right? How do you measure attitude? Who should judge? The *Charter* is the worse damn piece of legislation that ever hit this country. It doesn't protect good people, it protects the bad! The College has (several) cases in the Supreme Court that are *Charter* cases when (many) of these individuals should be behind bars!

Summary

Just less than one quarter of the participants perceived personality to be a variable that influences doctors' personal policies in relation to professional conduct. A few of the participants thought that greater attention should be paid to a person's personality characteristics when selections of candidates for medical school are made.

In their definitions of professional conduct (Chapter 4) many participants expressed that doctors deal with more than the physiology of their patients--that emotional, psychological and, for some, spiritual characteristics play an important role in the diagnosis and treatment process. There was considerable evidence in the definitional data that demonstrated a need perceived by doctors for empathy, trustworthiness, confidentiality, socially moral behavior, responsibility and ability to communicate effectively with patients in a doctor's professional practice.

Judging from the comments made by participants in relation to their definitions of professional conduct, the doctors interviewed in this study perceive personality factors to be more relevant to the practice of medicine than the responses reported in this chapter may lead one to believe.

Propositions

1. Personality has some influence on personal policies in relation to professional conduct.

2. There is some concern among doctors that not enough attention is paid to an individual's personality characteristics when selecting candidates for medical school.

The Formative Years

The formative influence of one's family and upbringing on the individual's attitudes and basic principles related to professional conduct was expressed by almost three quarters of the participants. Many of the doctors alluded to the formation of their *values* while growing up and explained that these values formed the basis of their professional ethics. In listening to their comments one can detect a fairly consistent mood of respect and indebtedness. Eight of the doctors interviewed specified values, general ethics--knowing right from wrong--or spiritual beliefs as influencing factors from their formative years.

> The greatest influence on my professional conduct was my upbringing which was based on self respect and consideration and caring for others. I think I would conduct myself the same in my personal life if I wasn't a professional.

> My formative years still seem appropriate--it still holds. Nothing has happened in the past 40 or 50 years to change my basic values, my behavior or conduct, my honesty, loyalty, decency, and responsibility that became a part of my thinking as a child--my value system.

> The way I was brought up was a big influence. My mother was a health professional--a nurse. I observed her--she showed much compassion and that has had an influence on me. My spiritual values guide my professional conduct. I'm a Christian.

Two of the participants talked about developing a sense of commitment to serve others as a result of their family experiences. One doctor expressed the influence with a great deal of sentiment:

> My family was the greatest influence by far. My father had a pharmacy. I knew about making your life part of a service commitment to humanity. We often held dinner for Dad while he served others. My family was very committed to service.

Another referred to the service attitude learned while working in the family store:

> While growing up I had to work in the store every day. My father said, "Be nice to the customers. They're not here for you." I try to come into the office with a smile and say, "I'm sorry I'm late." I try to show my patients respect for their time. My father said, "Have respect for others."

Living up to the standards and expectations of one's parents was an influence on professional conduct expressed by one of the participants.

> My parents influenced my views, attitudes, principles and beliefs in relation to professional conduct. Starting in this field was an attempt to please them. Once I got involved in it I wanted to conduct myself in a manner that wouldn't be embarrassing to them.

Two of the more senior doctors who had emigrated from Britain referred to the influence of their strict Victorian upbringing which stressed high morals.

> The greatest influence was my growing up. My parents were very Victorian, they had strong morals. I grew up during World War II.

Early in the interview a participant had described the experience of being influenced by teacher role models during medical training. While contemplating the greatest influence on a doctor's personal policies in relation to professional conduct later in the interview, the doctor referred back to those statements. The tone was subdued, the expression sincere.

> The most important influence on one's professional conduct is the mother's knee. I'm only impressed by the two role models that I spoke of earlier because I also know my mother would have said the same thing--only because they agreed with my mother! Even at my age I sometimes wish I could sit down and write to my mother or talk to her about decisions I must make.

Summary

One's family and upbringing were believed to be powerful influences on personal policies in relation to professional conduct for almost three

quarters of the participants. Parents were perceived to have influenced basic values and to have modelled behaviors that participants viewed as integral to their concepts of professional conduct.

Generally, the tone of participants' voices as they related formative experiences during the interview suggested a high level of respect and indebtedness, primarily toward their parents, but also toward other significant adults, for example a small town doctor and a teacher.

Propositions

1. The formative years exert a powerful influence on personal policies in relation to professional conduct for doctors. Basic values that lead one to practice professional conduct are implanted during these years.

Socialization in the Profession

Sociological factors of influence on participants' personal policies in relation to professional conduct encountered after participants had entered their professional training are reported in this section. Six categories of sociological factors of influence were drawn from the data (see page 61). They are presented here in descending order based on the frequency with which they were encountered in the raw data.

Modeling

A strong pattern that developed from the data was the powerful influence of the doctors' teachers on the formation of their personal policies in relation to professional conduct. This influence had the highest frequency (21 of the 26 interviewed or 81%) among all the factors of influence identified by the participants. Role models were perceived as having had a considerable effect during the period of training when the doctors were in residence. The

experienced doctors who taught were held in high esteem by the unseasoned residents.

> When I was going through my training I learned what ethical behavior was. I saw it in action. You obviously watch those who have the most to give--the ones you would like to emulate. . . . Teaching ethics in a course is not a particularly reasonable way to do it. You really have to see it in action. The people in those role models are the most significant influence.

> It is something that is constantly reinforced by the teachers and colleagues that you are exposed to during the practice of medicine. They are a stimulus--to try to do the most you can. There is more influence during the training phase--during the residency training period where you are exposed to the same clinicians for a period of time.

One doctor who had been practicing for over 35 years remarked:

> The most important influence for me was the men I admired intensely when I was a young physician.

Many of the participants talked about how the behavioral component of their personal policies in relation to professional conduct crystalized for them as a result of observing the conduct of their senior doctors. An insightful comment was made by one of the participants.

> I had good teachers, but they taught by example. Teachers teaching by example were really what brought it all together for me.

Role models taught some of the young doctors what not to do.

> There is no one dramatic influence, however the influence on young interns exerted by their senior doctors who are teaching is one of the major influences. For example, how they see their seniors interact and work with other doctors, how they see them deciding whether people will get treatment, the backstabbing--they learn how they don't want to be. They observe their seniors in practice and watch how they behave. Are they kind? How do they work with other colleagues? Sometimes we learn as much from seeing it done wrong as we do from observing the right conduct.

> There are a number of influences. First--what I've seen in other people in practice during my training. There were those that I would like to emulate and those that I would like to stay away from. . . . How you view things depends on your own interpretation. There was no one idol. There were many different styles and individuals. You pick and choose accordingly to determine how you will behave yourself.

Although the participants were almost consistent in pointing to role models in the profession as a factor of influence, one doctor who had been in practice for 9 years de-emphasized the influence of teacher role models in relation to the formative factors of influence.

> During my first year of medical school I was already looking for role models and examples. I was trying to anticipate how I would do things on my own. Guidance for my professional conduct came from what was in me prior to medical school. What is demonstrated doesn't have a long term effect on doctors.

Conversely, another doctor, also with 9 years of practice, believed that doctors do not have their basic views, attitudes, principles and beliefs in relation to professional conduct before medical school.

> It comes from watching other people. Most of it during medical training, particularly the residence training. You tend to learn from other individuals, so you pick up their traits. You learn by example. You pick and choose what you like--learn what is right and wrong. You don't have it before medical school. Most of us learn it as we go along. There was no course that was taught in this stuff. Along the way there are certain ethical issues that come up. You see how people approach them, then, particularly when you are involved directly with patient care you see these things and you determine in your own mind what is right and what is wrong and how you will handle it. It is taught, but not formally.

It was not the conduct of teachers only that was modeled. Relationships with peers provided another arena where participants observed and imitated behavior.

> We have a major impact on one another. You can read a book on ethics but when you see it in practice it has a more profound influence.
>
> Obviously peer pressure is a big influence too. You pick up consciously and subconsciously conduct, mores, attitudes and acceptable conduct from peers--the people who you work with.
>
> Other doctors are a major component of influence, particularly eminent professionals that I had a great deal of respect for.
>
> The greatest impact on doctors comes from the peer aspect through role models. Personal growth and development come from discussions on ethics with colleagues.

Summary

Modeling had the highest frequency among participants (81%) as an influence on personal policies in relation to professional conduct. Doctors believed that the period of greatest influence was during internship, although current peer influence was also presumed to be a major influence.

The influence of the teaching doctors on the young residents can be explained by a social learning theory known as modeling. Modeling is based on the premise that we learn to behave in certain ways by identifying with others--by observing and imitating their behavior--rather than through our own experiences. Johns (1988, p. 52) stated that the kinds of models who are likely to provoke the greatest degree of imitation are, "attractive, credible, competent, high-status persons." He elaborated by saying that "it helps if the model's behavior is vivid and memorable--bores do not make good models." Evidence from the data that participants viewed their models in a fashion similar to that described by Johns was reported in this chapter. The data also suggested that people observed by others who are not viewed as credible or competent in certain instances teach behavior as well as the credible models, albeit the result is not to imitate but rather to learn that one does not do things the way the teacher has demonstrated.

Previous experiences of participants allowed them to be more highly influenced through observation of their peers than they might have been prior to the experiences. For some of the participants the formative factors that influenced behavior in their youth were crystalized into specific practices of professional conduct through role modeling of the doctors under whom they interned.

Doctors continued to learn from observing their peers throughout their careers. As they became more experienced they were able to extrapolate greater meaning from observing the behavior of others.

The modeling theory may also help to explain the influence on participants' personal policies in relation to professional conduct as a result of involvement in the work of the College--on committees, review panels, or the governing council. This premise is pursued further in the summary following the fourth section in this chapter titled *The College*.

Propositions

1. The greatest influence on doctors' personal polices in relation to professional conduct stems from doctors modeling other doctors in practice.

2. The period of greatest influence for modeling is during the doctor's internship.

3. Current peer modeling is also a major influence.

4. As a doctor's experience grows the ability to extrapolate greater meaning from the behavior of others increases.

5. Positive role models are generally held in high esteem by doctors during the period of greatest influence.

6. Learning what is not professional conduct from behavior of others which a doctor judges to be unacceptable, is also part of the modeling process.

7. Professional conduct is learned more through example than as a result of classroom teaching.

Lifestyle

Of the 26 doctors interviewed 19 (74%) alluded to lifestyle factors as having an influence on doctors' personal policies in relation to professional conduct. Thirteen of the participants expressed concern over changing attitudes within the profession, particularly among the younger doctors.

> We are in the middle of a transition now from a service oriented attitude toward thinking about the practice as a business or a job. This new attitude is more prevalent among the younger doctors who have graduated since 1970. The public has more information and attitudes toward physicians have changed. Doctors feel that they are given less public respect so they feel that they have less responsibility. You can't be a good doctor with that attitude. Your job is to look after the patient.

Four of the 13 participants wondered what impact this different way of thinking would have on medical service. Comments from two of those doctors follow.

> Traditionally doctors defined professional conduct as a lifetime commitment. This is the belief among those retiring now. Young doctors are leading a more balanced lifestyle. They are not willing to give up as much. There is a lack of commitment. A good physician must have a life outside of medicine. The young doctor desires to be a person who happens to be a physician rather than the other way round. Maybe in the end a balance will be struck and it will be better for all concerned.

> Young doctors are worried about whether they will have jobs, they worry about government regulations and financial remuneration, and whether their futures are secure. For us and those that came before us there was no concern about the future. They are also concerned about what we are doing overall in society and to our own environment. There is a greater willingness to work on issues outside of science. Young people are moving away from the medical field and I think we are facing future shortages.

There was a dichotomy in the perceptions that were voiced by the remainder of the 13 participants who had expressed concern over changing attitudes within the profession. Approximately half believed that the new attitudes were positive or at least had some positive aspects to them.

> The younger physicians are more conscious of the pitfalls of the workaholics and the resulting effects on some doctors. They are not less committed, but rather desire to live more balanced lives for the benefit of themselves, their families and their patients.

> The older doctors had high professional ethics The younger people are more adjusted to reality--perhaps they are smart. They realize that selflessness is not the only way and they are quite willing to work in (walk-in clinics) where they have no responsibilities beyond treating a specific symptom. There are low stress levels. The income is the same or higher. I can't relate to their lifestyle.

A more demeaning evaluation of the "new attitudes" within the profession was presented by the other half. An air of disillusionment enveloped the comment made by a specialist who had been in practice for 10 years.

> The attitudes of interns now are very different from the attitudes of most of my classmates. My classmates were very work oriented, they knew what they were getting into. Now it is ridiculous for me to say don't come in on Saturday because they had no intention of coming in on Saturday. That kind of attitude is a result of socialized medicine.

Those comments were echoed by another specialist.

> Interns now say no or consider not coming in to the hospital on a Sunday. Ten years ago I wouldn't have even considered--it wouldn't have entered my mind--not to go in. Your attitudes toward professional conduct depend on your age . The older doctors are more committed because they had to be then. If you weren't you didn't get taught. There are less demands now.

A pessimistic portrait of the future of the profession was the outlook for another one of the participants.

> I am concerned with the younger doctors who are shedding it (professional conduct) at their office doors. They see themselves more as employees and when they go home they no longer see themselves as doctors. It is going to adversely affect service. Physicians in the future are going to be less available. We are becoming more unionistic in our approach to things. Doctors in training and internship negotiate contracts. They get into the mindset of time off for night work and will only work a certain number of days per year. They are going to set up a practice that will meet those expectations. We may see a profession where shift work is being done by different physicians. I don't think that the lack of continuity will provide good service. Just look at the Swedish model, or at the United States. Optimum care is not letting someone else take over in the middle of treatment.

I responded to this participant, "Then it's lifestyle first and professionalism second?" The doctor continued:

> Yes. I worry that we aren't preparing great medical leaders who lead by example and by dedication to patients at great personal sacrifice.

Many of the participants had something to say about this whole area of personal sacrifice. The concept of *service before self* was one of the topics of discussion during the interviews that drew a great deal of emotional response from participants.

> There is a broad spectrum concerning the general commitment to professionalism and service before self. It is slipping. Some doctors don't care except for salary. We're going through a period of time the past 10 to 20 years when everybody has become more mobile and more concerned with themselves. If this continues medicine will suffer.

"There has been more change in the past 10 years than in the former 80," declared a family physician who had been in practice for 17 years. This participant told a story about a physician who had given high levels of selfless care over a period of more than 30 years. The physician felt that all that was given back was a "kick in the teeth." The physician said it was not worth it. The physician's patients were told they could call but they might not find anyone in. "Patients expect it," stated the participant. "This is happening a lot to doctors who have been selfless. They say, 'No more!"

The difficulties encountered in attempts to balance one's dedication to work and to family were expressed with frustration and compassion in the comment that follows.

> In relation to priorities my family comes first, or it should--often it comes last. It is difficult to develop an attitude to look after yourself. Throughout training altruism is expected. If you do look out for yourself you are viewed as selfish--you must not be a dedicated physician. Yet you must have some steadfastness inside of yourself and in your family--you have to have some kind of soul. The inability to prioritize has resulted in alcoholism and substance abuse which results in an indifference to professional conduct. Standards fall because physicians can't deal with it all. I have to keep watching myself. I'm a workaholic. In the past doctors were expected to do it all. With the information explosion and new technology doctors can't do it all. . . . The public and physicians must recognize that physicians can't be that dedicated.

Another participant who left an impression of one battling dedication declared with conviction:

> My family comes first. I'm married to my wife, not my practice. I do not want to lose my wife and family as I saw many of my teachers do. This is a very seductive profession, mainly because the patients show you so much love and respect. You can get seduced into trying to help everyone.

This participant continued to illustrate why the concept of *service before self* is changing.

> In order to do what we are supposed to, we had better take care of ourselves. Some see that as selfish. . . . People are realizing that you are no good if you are dead, or addicted, or stressed out.

Another participant shared this view.

> Some people are so committed to their medical practices that they work at the expense of their personal lives. They accordingly are less able to serve themselves and their patients because if you neglect your personal life you detract from yourself as a person. On the other end of the spectrum there are the people who see it as a nine to five job. The vast majority that I know are very committed to do the best that they can for their patients.

Some opposition to the *service before self* concept grew out of a loss of status for the profession in the view of one participant.

> The commitment to service before self certainly still exists. For many physicians the job comes first and the family comes second. There is objection to that by physicians who believe we are being treated like civil servants and yet we are expected to give so much.

A doctor who had been practicing for more than 30 years displayed a tone of bitterness while voicing similar sentiments.

> I don't think that the commitment to service before self is gone entirely. People my age are disillusioned about what is happening. I left Britain because of the destruction of professional self-esteem. Patients have no loyalty. Hospitals used to be hospitals, now they are corporations!

The growing number of women in the profession was another lifestyle factor identified by participants. A male participant explained that within the retiring age group there are approximately 10 percent women, within the middle-age group (40s) there are approximately 25 percent, whereas now the physicians entering the profession are about 50 percent women. These women "tend to seek out a practice where they can partition off the demands of the practice and their family demands." Another male participant commented about the young interning doctors in a tone that exhibited

acumen and then reflected on the lifestyle of many of his female colleagues:

> These attitudes (time off for night work and only work a certain number days per year) reflect society as a whole. There are demands for more leisure time, more convenience. Now there are up to 50 percent females in medical school. They come into the profession with different ideas about what lifestyle is all about. Other doctors are looking at that and saying, "I would like to spend more time with my family too."

A female specialist who had graduated from medical school in the mid 1970s victoriously pronounced:

> Women in my age group were trail blazers. We had a passion and a mission. The new students don't know what they are in for. They are just there to make money. It is easier for the young women entering medicine now. Their attitudes are different--they expect to have it all. We did this for our younger sisters, and we have won.

Another lifestyle-related factor that was raised by participants during the discussions about changing attitudes in the medical profession was walk-in clinics. This was a highly charged emotional topic for many of the participants. Comments ranged from acknowledgement that walk-in clinics are meeting a need to furious opposition. Overall, the attitudes toward walk-in clinics among participants were more negative than positive. Some of the remarks on the more positive side follow.

> (Walk-in clinics) grew up because traditional family physicians were unable or unwilling to adapt to changes in society, principally working women. People got fed up with waiting in an emergency room for 5 hours with a sick child. (Walk-in clinics) have become successful because they are efficient and convenient. They will continue and will be successful. . . . There is a loss in this kind of practice in the cases where there are emotional problems couched in, "I have a stomach ache," or "I'm having trouble sleeping," but there is not much lost because there are not many urban physicians running that kind of practice.

> There may be a shift in physicians' desires to have more control over their own lives. (Walk-in clinics) started not only because of business reasons but also in response to the needs and wants of the public.
>
> I have no personal animosity toward (walk-in clinics). They wouldn't be here if they weren't needed. People do not need to have one doctor there all the time to give good care. Patients have to take responsibility for themselves too.

On the other side of the issue, some very skeptical comments were made.

> (Walk-in clinics) do not provide optimal care. There is no continuity, no access to the hospital. Comprehensiveness of care is not there. They are not responsible for follow-up. One third of payments from Alberta Health Care go to walk-in clinics.
>
> There is nothing wrong with extended hours of service as long as those providing the service have the right motives. Walk-in clinics lack continuity and basic primary service. They can provide emergency care. It is a user problem rather than a clinic problem. People think that they are getting adequate care. They are very costly to the system. They are a threat to family practices. Our clinics here in town have opened evenings in response to the (walk-in clinics).
>
> Views toward professional conduct are very different from what they were 15 years ago. There was more of a climate of commitment then. We didn't have walk-in clinics then.

Another doctor who had been practicing for over 30 years was disillusioned with walk-in clinics and the level of commitment of some peers.

> The young doctors in (walk-in clinics) work when they want to. There is no commitment. The (walk-in clinics) miss long term illnesses. They go against tradition. I think a lot of doctors are unhappy. If the government wanted to put physicians on salary, it could do it now.

An expression of animosity toward walk-in clinics accompanied some of the participants' comments. They expressed concern that the doctors working in walk-in clinics were earning as much or more than the traditional

family physicians and were experiencing less stress and shorter hours. One participant said, "They are not involved in the blood and guts of the whole thing. They don't see the patient break down and cry in front of you." Others commented as follows:

> The fee schedule allows doctors working in (walk-in clinics) to get paid well on off hours to deal with trivial matters. They basically view it as a job. There are no worries about follow-up. . . . People would not pay for the service they get at a (walk-in clinic) if the government were not paying for it. They are divorced from having to consider the economic aspects of it. If patients had to pay the (walk-in clinics) would disappear. People are not getting the service there like they do from a family physician.

> Turnstyle medicine makes me very angry--it's assembly line medicine. It is an inevitable reaction to socialized medicine.

A participant who didn't have a particularly polarized view on the topic observed:

> There has been a shift in attitudes within the profession, with medicine going to the malls and doctors working shifts. There still are, however, many traditional family practices, especially in rural areas. Probably there is more self before service, even among the rest of us. It's probably because it is easier to get away now than it was in the horse and buggy days.

Some of the participants stated that walk-in clinics are a convenience for the public and therefore should be an option. This comment was expanded on by one of the participants with an analogy: "I don't have time to cook dinner tonight so let's go grab a hamburger."

One of the participants who had completed medical training in England during the early 1960s told the researcher a story that took place during training to illustrate how maintaining a steady family practice can sometimes greatly benefit the patient. This participant was out on a house call with a senior physician. A lady had fallen downstairs in her home. After talking for a while the senior doctor told the lady that she was going to the hospital. The junior doctor was confused, because no symptoms were observable to lead to such a conclusion. The woman had a brain hemorrhage.

After this was discovered the junior doctor asked the senior doctor how the diagnosis was made back at the woman's home. It was quite simple, the senior doctor replied. The lady had not made a cup of tea for the doctor. She always made tea when the doctor was on a house call.

The forgoing illustration is not a picture of a common family practice today. The participant who told the story pointed out that very few family physicians today know their patients as well as the senior physician in the story knew the female patient.

One of the participants who was a clinical professor working in a hospital said that over 50 percent of doctors in the United States are employees. "There will be a shift in Canada to more group practice. More communication will be required if we go to nine to five care," the doctor said.

Summary

One of the most often cited socialization factors to influence doctors' personal policies in relation to professional conduct was lifestyle (second only to modeling). Lifestyle was identified by three quarters of the participants, the same number of respondents that was reported for the influencing factor, *the formative years.*

Participants believed that doctors' attitudes toward professional conduct were changing as a result of a number of lifestyle factors. Participants agreed that the direction of attitude change was toward less commitment and less dedication to the practice of medicine, sometimes expressed as a dissolution of the *service before self* notion. The participants were not, however, consistent in their reasons for the loss of commitment. Nor did they agree whether or not the change was a good thing.

One third of the 13 participants who commented on the value of this attitude change thought it was a positive move that would benefit both doctors and their patients. Another third thought that changing attitudes were resulting in lower quality service. The final third identified both benefits

and losses and did not conclude that the change in attitude was either positive or negative.

Generally, four reasons were identified as having caused the changed attitudes among doctors that were reflected in decreased commitment and dedication.

1. Health reasons, particularly mental and emotional health, were often cited. Doctors believed that many of the personal problems experienced by colleagues (i.e., family break-down and alcohol and substance abuse) resulted from a colleague's extreme dedication to the practice of medicine at the expense of time and energy for personal and family activities.
2. A greater concern for personal lifestyle with time for leisure activities was identified as a reason for changing attitudes. Participants thought that lifestyle concerns were most prevalent among the younger generation of doctors.
3. A desire to spend more time with one's family was included in participants' rationales for changing attitudes. Having more women in the profession was viewed to be the impetus for this desire.
4. Participants felt that doctors were getting less in return for their services than in the past--less respect, less money and less autonomy. They thought that these losses were also creating a drop in professional self esteem. Some doctors expressed a desire to live a more balanced lifestyle that they believed would benefit themselves, their families and their patients. For the most part, the doctors who were interviewed had not achieved this desire. They were struggling with a new attitude, that for some made a lot of sense, yet none reported that they were able to integrate this attitude change into their individual lifestyles.

This study did not include young doctors beginning their professional practice. With the exception of one participant all those interviewed had more than 9 years experience. The one participant with 5 years was a specialist and had been in the profession prior to speciality practice for at least the length of time required to complete speciality training. Thus, it was not

possible to check the perceptions of many of the participants that this younger generation of doctors was conducting its practice of medicine as part of a more evenly balanced lifestyle.

The emergence of walk-in clinics was discussed by participants in the context of changing attitudes in the medical profession. Whether changing attitudes contributed to the emergence of walk-in clinics or walk-in clinics created an environment conducive to attitude change was not clearly distinguished by the doctors interviewed. Generally, participants thought that doctors working in the walk-in clinics subscribed to the "new" less committed and less dedicated attitudes toward professional conduct.

Walk-in clinics were a highly-charged emotional issue for many of the doctors in the study. There was more negative than positive reaction among the participants toward walk-in clinics. There were participants who believed that there is a lack of continuity in patient care in walk-in clinics. Most saw this as a detriment to good medical practice.

Walk in clinics were viewed as costly to the system. The Alberta Health Care Insurance Plan fee schedule lists a a higher fee to be paid to a doctor for a first time visit by a patient. Return, follow-up visits are are paid at a lower fee level. Participants explained that family physicians tend to see the long term illnesses whereas the physicians in walk-in clinics are treating mostly symptomatic illnesses that require only a one time visit. According to a number of participants the doctor in a walk-in clinic is making more money in the same amount of time worked by the traditional family physician. Many of the traditional family physicians are feeling resentful toward the walk-in clinics because, in their views, the doctors in walk-in clinics are making more money and are not practicing good medicine.

Propositions

1. Lifestyle factors, which include,
   (a) attempting to balance professional, family, and leisure obligations, and
   (b) striving for a healthy level of job related stress,

are powerful influences on doctors' personal policies in relation to professional conduct.

2. Experienced doctors believe that professional service commitment among doctors is waning as concerns for personal lifestyle increase. Experienced doctors attribute this transition more to the younger generation of doctors than to their own generation.

3. Doctors are bewildered about where the "new attitudes" toward professional conduct are taking the profession and the kind of impact these attitudes will have on the practice of medicine. Some doctors are frustrated and disappointed by the impact this is having on professional conduct, some see it as a positive move toward a more balanced and healthy lifestyle and some are not sure what the ultimate effects might be.

4. Doctors think they are getting less respect and reward for their high levels of dedication and service than in the past and as a result feel less responsible and less committed to the traditional "service before self" definition of professional conduct.

5. An increase from approximately 10% to 50% female practitioners within the space of one generation has influenced personal policies in relation to professional conduct.

6. The lifestyles of doctors working in walk-in clinics verses doctors in traditional family practices has become a contentious issue for doctors and has an impact on their personal policies in relation to professional conduct.

Remuneration and the Role of Government

The factors of influence identified as remuneration and the role of government were combined in this section. These two factors are inextricably bound together in the minds of the majority of participants who were involved in the study. Seventeen of the 26 participants (65%) identified the government's system of remuneration for their services as a factor that

influenced their personal policies in relation to professional conduct. Overall, the level of emotion detected in the voices of the participants was greater during their discussion of these factors of influence than at any other time during the interviews.

In a resentful voice, one of the more senior doctors summed up what other participants had to say in relation to these factors of influence.

> What influences a physicians behavior is who is paying. It is the politicians who influence behavior.

In a similar vein, another participant's discouragement was evident in the tone of the statement,

> The fee schedule influences the professional conduct of doctors. You can change behavior by changing monetary rewards.

There were four issues that were referred to repeatedly by the participants who recognized remuneration and the role of government as factors that influenced their personal policies in relation to professional conduct. These four issues are distinguished in this analysis as follows:

1. doctors on salary,
2. the health care insurance plan,
3. the amount of earnings, and
4. the perceived intrusion of government.

Doctors on Salary

The issue of whether or not the government will put doctors on salary, and whether or not it would be a good thing, was raised by some of the participants. One of the participants who raised this issue did not see doctors on salary as a potentially negative influence on professional conduct.

> Being on salary wouldn't be bad. The benefits and overhead would be paid. Doctors would have set holidays. They would have a more regulated life with coverage when they're away. Doctors would be more relaxed. They would sleep better. The level of service would not go down. That is the concept of professionalism whether we are paid on salary or not. As long

> as lay people aren't determining whether or not we can order a test I don't think that we would lack any autonomy.

This participant was alone with these views. The others who raised this issue expressed concern about attitudes toward professional conduct of doctors on salary and the resulting quality of service doctors on salary might provide. Comments from four participants follow.

> My prediction is that eventually we will all be on salary which will be a bad thing. In Britain doctors became thick skinned. They were perceived as not having adequate remuneration and as having lost individual concern for patients. The image of family doctors is bad there. You hear stories of the same patient coming in a number of times, seeing a different doctor each time and being put through the same tests over and over again.

> When doctors are put on salary their attitudes change. They can no longer work more to increase their salaries. A fee for service means that the physician will extend himself.

> Where physicians are on salary the level of commitment is less by a particular physician. I saw it when I was in Scotland. When I am on salary I don't have a personal commitment to you. Canada's health care system used to be the best, but it is deteriorating because the economy cannot support optimal care for everyone. The answer is that the patient pays some of the costs. A user fee would cut back on the utilization and make the system affordable.

> Lack of commitment and insular behavior is a direct effect of government economic pressures. If the next step is to put doctors on salary then their commitment will be to their employer and not to the patient. I think that may result in poorer medical care where there is a tendency to look at the disease and not at the person.

The Alberta Health Care Insurance Plan

There was very little evidence of support for the present health care system in Alberta among the doctors interviewed. A doctor who had been in practice for 9 years was one of the few who expressed a preference for an

insurance scheme over a direct exchange of fees from the patient to the doctor.

> The insurance scheme makes it better for doctors because they will be viewed well by their patients. There doesn't have to be an exchange of money and it is more pleasant. It is an easier way to conduct a practice.

Another doctor had favorable comments about socialized medicine relative to an experience working in the United States. A great deal of sorrowful emotion accompanied the following statement:

> I can remember being very upset about seeing patients being turned away from emergency at the hospital because they would cost the hospital money. For me this experience formulated some strong attitudes in relation to professional conduct.

A third doctor stated,

> The present system is not so bad if the government would get off our backs. We have the best system to universally serve the public. The government has to quit blaming the doctors for increased medical costs.

Most of the participants presented views of the health care system that contradicted the views expressed above.

> Some of our professionalism has been altered by the present remuneration system resulting in a loss of morale. . . . In the system that we had previously there was a reward for the kind of service that doctors had given. If a patient couldn't pay for the service it was given freely. Charity is a bad word now. We can't give charity any more. The government has taken that away from us.

This participant told of a friend who had moved to Arizona in 1976. The friend said,

> that he had fallen in love with medicine again because he set up his contracts with his patients and felt more accountable again. He was reading more, attending more conferences, and making more money for the same hours of work and seeing fewer patients.

Later in the interview this participant expressed considerable frustration in the following comments:

> The only way in family medicine to make a living is to see a lot of patients. We're not working for the patients, we're working for the government with none of the benefits. In 1972 my overhead factor was 6 to 7 patients per day. Now it is 9 to 13 patients per day.

A middle-aged member of the governing council of the College of Physicians and Surgeons revealed a sense of wonder and disillusionment as he expressed the following:

> My view of (professional conduct among doctors) has been tempered by my experience on Council. I am distressed by the number of unethical practices out there. I was sheltered in my environment.

This doctor attributed much of the unethical practice to the health care system.

> It's getting harder to be ethical--harder to find the ethical giants like the Oslers of 90 years ago. It's tough to be both entrepreneurial and ethical. We're driven by the health care system which has tremendous impact on ethical behavior from the remuneration format. The better job you do as a physician the less money you make. We should have a system that drives you toward ethical behavior and at the same time puts a lid on costs.

This participant commented later in the interview that doctors "see themselves as guardians over the health care system." Another participant stated similarly, "We have become gate keepers to the utilization of the health system."

An administrator from the College said that there has been a tremendous change in doctors' views in relation to professional conduct over this century, the change being attributed to third party paying.

> It is simpler to be a mediocre doctor and make more money than a hard working doctor. In the old days a practice took you in and molded you. The user pay principle helped the physician-patient relationship. There was more responsibility. Doctors would deal with patients' problems because they wanted the patients back. . . . Money is driving doctors to work quickly. They are losing that relationship.

A few of the participants conveyed a certain impression of having been defamed. One doctor described the health care insurance system as a "fee for income, not a fee for service." Another commented that, "the doctor has almost been brought down to the level of a civil servant with medicare." In a tone marked by indignation, another participant declared:

> It is no longer a privilege to have health care. People think that it is their right. They pay less for their health care insurance than for their car insurance.

When asked what the optimum remuneration system would be, this participant replied that it would be based on a relative value scale according to how long it takes to do the various procedures. "The relative value index should be higher for the specialist," the doctor stated.

A clinical professor who participated in the study saw other problems with the present health care system. The professor tells students that physicians are privileged.

> In what other profession can you earn a living in the 6 figure income bracket whether you are needed or not? The system is set up that way. Medicine has been overprotected. Most doctors work in urban areas where they are not needed. There are too many urban family physicians and there are not enough specialists in some areas.

Amount of Earnings

Doctors should be encouraged to maintain high standards or lose their privileges was the view of one participant who had been in practice for 17 years. "Nobody cares if there is a conference on ethics," the doctor declared.

> It costs them too much! My overhead is $5500 a month. . . . If I practiced like I did when I first went into practice I could not make a living now. Economic factors have driven the level of commitment down.

A doctor in practice for 9 years said pensively that financial remuneration presents some ethical dilemmas for doctors where patients' needs may conflict with the doctor's needs. The doctor provided an example of a situation where a surgeon is advising a patient who has two low-risk options. "The operation is worth more to the doctor than the advice to go home and come back when the pain gets worse," the doctor said.

Another doctor explained that,

> There is a limit to what a doctor can make unless the doctor is running a (walk-in clinic) or is practicing bad medicine.

This doctor did not see free enterprise and competition working in the practice of medicine. The doctor did not think that physicians and surgeons would provide better service, or that there would be a public perception of better service if one doctor could charge more than another doctor for higher quality service.

Perceived Intrusion of Government

A senior doctor and member of the College Council stated with extreme conviction: "The single greatest factor influencing the professional conduct of physicians is the intrusion of the state." The doctor went on to explain:

> The factor that has changed attitudes in relation to *service before self* is the intrusion of the state. Now that the physician is no longer directly responsible to the patient but rather to the state, the number of complaints about physicians not being available or being rude to patients has increased--since the advent of medicare.

The doctor compared what is happening to physicians in Alberta with the sequence of events following state intervention into health care in

Britain. The final comment spoken by this participant was optimistic and denoted an element of faith in the profession.

> Money and ethics and attitudes are very much akin. The proof of what I'm trying to say is in the 40 years of state intervention in medicine in Britain. Physicians were well paid for the first while so they were quiet. Then they became very disgruntled for 10 to 15 years. Now there is a resurgence of ethics in Britain. Irrespective of the paymaster there will be a change of attitude.

Two participants referred to a former minister of health who "had a demoralizing and very negative effect" on professional conduct of doctors. With a twinge of bitterness evident in the voice, one of the participants commented:

> I have enjoyed medicine less the past 5 years. A lot of (doctors) have become resentful. They like practicing a lot less. . . . There is an added incentive to do a good job when you are taking money directly from patients. With the government paying doctors the public gets the impression that they own us and can determine our standard of living. They think that it is their democratic right to determine our income.

Another participant emphasized,

> One thing that really affects everything is government policy. We have a monopolistic government system. The level of health care in the last 10 to 15 years has had a great deal of problems because the government has not had enough money. There has not been enough long-term care, not enough home care. There has been inappropriate medical spending by the government. It is not us who promise things. It is the government. It creates expectations which it cannot meet.

A participant expressed extreme frustration within the profession and told of threats, "whether perceived or real," to professional independence and monetary compensation.

> In Canada if you were to take a poll you would find that physicians overall are relatively demoralized. They feel as if they have been whipped. They have been bashed by the government, they have been bashed by economic columnists as being nasty, greedy, horrible people. They have lost their (place of) respect in society. They have lost their traditional place as being the supreme person in the health care setting, and I think that they are very demoralized. . . . In 20 years we will see fewer people willing to be physicians--just because they have worked hard and are being blamed for being nasty and greedy. Physicians have contributed much personal sacrifice.

In a voice that sounded threatening while at the same time defensive, a middle-aged doctor said,

> Speaking for myself only, I can tell you that the more the government wants to take control of medical care the less I'm responsible for any of this.

Summary

There was an inordinate amount of dissatisfaction and disillusionment surrounding the comments raised by doctors concerning the influence of remuneration and the role of government on their personal policies in relation to professional conduct. Doctors felt that they were being treated unfairly. They suggested that they were experiencing a loss of more than financial remuneration. They were also perceiving a sense of loss of professionalism as a result of the influence the system of remuneration had on the professional conduct of physicians.

One alternative to the present system of remuneration that was suggested by participants involved putting doctors on salary. This option would be met with considerable disfavor by the profession if the views of the participants who raised this issue reflect those of their colleagues. Generally, these participants predicted that putting doctors on salary would result in decreased commitment to and concern for patients.

A common belief among participants was that the quality of medical care provided by doctors has deteriorated as a result of the Alberta Health Care Insurance Plan (AHCIP). Participants were generally in agreement in their statements expressing that the more time a doctor spends with a patient the less money the doctor makes. Many participants said that the AHCIP is "forcing" doctors to see a lot of patients in shorter periods of time than they would have in the past because the amount of remuneration through the plan has not kept pace with the rising costs of maintaining their practices. Some doctors believed that they were less responsible to their patients under the AHCIP than they would be in a "user pay" system. The doctors said there is a greater tendency to treat patients well when there is direct compensation from the patients.

The patients who require the greatest care, whose diagnoses are the most challenging and who require the highest proportion of the physician's time are the ones who create the least financial reward. Physicians are paid well when the diagnosis and treatment are quick and simple and the patient does not need to return for follow up. A lower fee is charged for follow up visits than for first time health concerns. Doctors in the study explained that physicians working in walk-in clinics gained higher financial rewards for their time than the family physicians because the majority of cases seen in walk-in clinics are easily diagnosed and treated and fewer patients return for follow up.

Doctors feel that the health care system has had an impact on their relationships with patients. They think that it has caused doctors to feel less responsible to their patients. They maintain that the public has lost some respect for the profession as a result of the health care system because people think they have a right to health care, to the doctor's service, and to determine the income of doctors. It was inferred by some that the government creates expectations which it cannot meet. Doctors get blamed for not meeting expectations, for spending too much, and for earning too much. Some doctors believe that the public has less appreciation and thankfulness for the service doctors are providing.

Doctors said that they are not able to meet their own standards of practice without a decrease in their incomes. This has led to extreme frustration, cynicism and growing hostility. It has created dilemmas for many of the participants who find their desires to earn a good income in conflict with their desire to serve their patients to the best of their abilities. The high level of negative emotional response that two thirds of the participants associated with remuneration and the role of government suggests that doctors are seriously bothered by the influence they believe these factors have on their professional conduct.

Propositions

1. Doctors view remuneration and the role of government as interwoven variables that have a detrimental influence on their personal policies in relation to professional conduct.

2. Generally, doctors think that being placed on salary would lower the level of commitment among members of the profession.

3. Doctors blame the AHCIP level and means of remuneration for lowering standards of practice--for driving doctors to work quickly seeing more patients in less time than they used to.

4. Doctors resent what they perceive to be the intrusion of government in the delivery of medical care.

Relationships with Patients

Participants in the study are coping with changes in the doctor-patient relationship--some better than others. Twelve of the participants (46%) stated that relationships with patients influenced their personal policies in relation to professional conduct. They associated the influence more with the changes they identified in this relationship than with any other aspect. A change in patients' attitudes toward doctors, expressed by one participant in the

comment: "We no longer carry the mystique that doctors used to," concerned many of the doctors who were interviewed.

> I think there has been a significant change in the ethical behavior of physicians. It has something to do with the role of the physician with patients. It is evolving into a relationship where the doctor is a partner with the patient rather than the paternalistic relationship that existed in the past. It is now more difficult when there is a sense of being under assault all the time and held up to a lot more criticism. Doctors are being more defensive. People are looking at health care differently now. They are better educated, and more knowledgeable than 15 or 20 years ago. They have a different set of expectations. It is tougher now.

> Doctors 30 to 40 years ago might have thought less about professional conduct than we do now. People then had a stereotypical attitude--the doctor was god, he told you what the answer was and you accepted it. Now there is more interplay with patients and more communication with colleagues. There are more opportunities now for problems to cause misconduct and more ways to get information about doctors' conduct.

There was an element of disappointment and frustration in the tone of the statements made by some of the participants.

> I think physicians are viewed differently by the public and view themselves differently. Physicians have come down from the pedestal. They are now viewed more as technicians rather than as professionals--like sophisticated mechanics. You will be cured if you find the right technician. If not then they assume that they had a bad technician--a bad doctor. A significant portion of the public views us now as technicians. Some physicians view themselves that way.

Particular discontent was expressed by a specialist who had been practicing for only 5 years.

> The medical profession is viewed differently now from when I was a child. Patients' expectations and their attitudes toward physicians are changing. It was acceptable in the past to recommend what should be done. Now people are a lot more skeptical and want to understand what is going on. Peoples' expectations are unrealistic. If anything happens to a child now people think it is the doctor's fault. They expect everything to be perfect. It puts a lot of stress on physicians.

Some participants speculated that changes in the doctor-patient relationship had been difficult to accept for some of their colleagues.

> In the contact between the patient and the physician the patient has the say. Doctors used to be viewed as all powerful. It has changed now--some older doctors have trouble dealing with that.

> Around the turn of the century there was not enough knowledge to do good. The practice of medicine was very psychological and physicians were very astute concerning interpersonal relationships. The next generation had a very paternalistic attitude--"I know what is best. I will decide" There was less independent choice for patients. There are still some physicians with that attitude. They cannot accept their knowledge being questioned. We have gone from little knowledge to much scientific knowledge and thus have neglected psychological factors. We are just getting back to that now. We are realizing that science does not have all the answers, especially with some of the ethical issues coming up now. We must deal with people issues.

One of the participants believed that a lowered image of the profession resulted in fewer demands on doctors.

> There is a minimal difference in conduct based on the esteem attributed to doctors compared to physicians in the past. It has been lowered somewhat, at least the god-like image that I remember reading about and hearing about as a child in a small town. I don't see that reference to doctors anymore and therefore I think the demands to be god-like are not there to the extent that I saw them. But the things that matter like professional conduct at the patient's bedside and contact with the patient's family have not changed.

Summary

Doctors believe that changes to the doctor-patient relationship, either from what doctors previously experienced or from what they expected they would experience, has an influence on their personal policies in relation to professional conduct. The practice of medicine has lost some of the mystique it once held for the public. People want to understand their medical problems. Doctors' relationships with patients have evolved from what was paternalistic to more of a partnership.

Some of the participants came into the profession expecting to gain respect and to be held in high esteem by the public. Instead they feel that they are being blamed in cases where a perfect cure for a patient is not found. Some of the participants appeared to have experienced a loss of satisfaction from the doctor-patient relationship because acceptance and recognition from patients was not evident to the extent that it used to be or was anticipated. This resulted in disappointment, and for some, a sense of resentment.

Propositions

1. Doctors believe that a change from the traditional paternalistic doctor-patient relationship to more of a partnership influences their personal policies in realtion to professional conduct.

2. There is some disappointment among doctors at what they believe is a loss of esteem for the profession of medicine.

Advances in Technology

Many of the doctors interviewed expressed concern over changes in the way medicine is being practiced, which they perceived to be a direct result of advances in medical technology. Nine of the 26 participants (35%)

interviewed considered advances in technology to be an influencing factor on doctors' personal policies in relation to professional conduct. A senior doctor, close to retirement, talked about the interrelationship among technology, social attitudes and professional conduct.

> There is a new attitude in the practice of medicine that is a reflection of a total societal change. The "pill" has changed the code. People are more free in their cohabital habits. There has been a big spin-off in society. This has had the biggest impact on society. These are important influences on both professional and societal conduct. What is acceptable in professional conduct changes with the values in society as they change. For example, the attitudes toward abortion that are a result of the "pill." When a person on the "pill" became pregnant doctors felt that she had a right to an abortion.

Another participant voiced strong opinions in relation to these "new" social attitudes which this doctor viewed as a loss of ethics.

> I think we are losing some of our ethical stance through doctors' involvement in abortion, for example, which is outright murder, and in organ transplantation or with surrogate mothers.

Another senior doctor who had been in practice for over 35 years expressed concern for changing values and seeming differences between societal values and professional values. This participant thought that there was not enough attention being given to value issues in the introduction of new technology. "The public has never said no to any technology."

A change in attitudes of the public toward doctors as a result of technological advances was perceived by one participant who spoke in a tone of discouragement.

> Technological advances have a tremendous impact. It has left the public with the impression that doctors can cure anything.

Advances in medical technology have been responsible for creating some very difficult ethical dilemmas for doctors. One of the most senior doctors interviewed provided an example of high technology and the ethical issues that it creates.

> Twenty years ago we wouldn't face this particular ethical dilemma. Two babies are born on the same day. One is an anencephalic (The baby has no brain but has a brain stem which allows the baby to breath and the baby's heart to beat, but it will eventually die.). The other baby born the same day has a congenital heart disease. Is it ethical to mutilate the one with a fetal abnormality (no brain) to make the other one live through the provision of a heart transplant? High technology has changed our ethics.

This doctor provided another example of an ethical dilemma created by technology--surrogate motherhood. Technology has allowed us to take the sperm from a man and to artificially inseminate a woman other than his wife who is able to conceive and deliver a child for the couple who are unable to conceive on their own. Should a woman be allowed to "rent" her womb? Whose child is it if both "mothers" decide they want it? The doctor continued by saying,

> Professionalism is very much under the attack of high technology, and professionalism and ethics are inextricably bound together.

Evidence of a perception that professionalism is "under the attack of high technology" was found in comments by other participants. They talked about situations where advances in technology have forced doctors to question their code of ethics. One participant referred to an ethical dilemma described as the "greater good verses the individual good." The doctor provided the example of large amounts of money being spent on a heart transplant for one person verses the same amount of money being spent on basic medicine for many people.

> Our code of ethics states that our obligation is to the patient that we contract with first. The overall guiding rule is that the individual patient comes first.

Should we prolong life at any cost? This question was raised in an expression of deep emotion, softly spoken through the following words:

> I think that some aspects of the code of ethics are going to have to be changed because I think that they are creating major conflicts for physicians. For instance, the idea that you basically protect life at any cost is probably not appropriate anymore. We are now able to continue life at great cost. Maybe it should be quality of life and not just extending bodily functions.

Another participant saw advances in technology at the root of some cases of professional misconduct.

> With advances in technology there is now a greater capacity to do harm. In the past the practice of medicine was more a caring attitude, the laying on of hands. The application is different now. In the past doctors had less chance to do mischief, or to do good.

In a similar vein a doctor commented on disconcertment among doctors brought on by technological change.

> At the turn of the century there was a more orderly society. There was less change, thus less stress. I suspect the doctors knew exactly where they fit in and were more comfortable.

Three of the participants linked technological advances to what they viewed as a different attitude toward medical practice, particularly by the younger doctors. One of these doctors was chagrin when commenting that while "the human side of medicine has deteriorated, the technical side hasn't." This participant continued to say that it is questionable whether the technical side will ever compensate for losses on the human side. A different perspective was presented by one of the others.

> We have evidence that technology has taken away the necessity for having great rapport with your doctor. Hershler wrote in the 1930's that in the horse and buggy days it was extremely important to have good rapport with patients because they had very little in the way of science to offer the patient. He determined that he was of value because he offered great solace. Today technology has changed that. We don't always need the history with the tests available today except where complaints are of a phycho-social nature. On weekends people go to walk-in clinics because they recognize that it is technology that determines how they are going to be treated.

A third viewpoint related to the change in attitude toward medical practice fell between the other two.

> The majority of patients are not seriously ill and get better anyway, no matter what you do. Many physicians have gotten away from sympathy due to so many techniques. There is too much to learn in medical school. The range of potential treatment is probably 10 times what it was 30 years ago. We went through an era where listening and empathy were not taught. Now we are going back to that in medical training.

Advances in technology were blamed for the rising costs of socialized health care by one doctor who expressed considerable frustration.

> Our health care system is in trouble because it doesn't have enough money to keep up with the cost of new technology. We've had five new procedures come in--each requires expensive equipment and specially trained nurses. We have to have a health care system that provides minimal health care for everyone.

Summary

Advances in medical technology have created considerable change in the practice of medicine. Just over one third of the participants maintained that these changes have influenced doctors personal policies in relation to professional conduct. With the new technology has come "new" social attitudes--attitude changes that reflect a new way of looking at some value issues. Some doctors believe that people have changed their attitudes toward doctors, seeing them more as technicians capable of curing anything.

Some of the changes brought about by advances in medical technology have come into conflict with societal values. As a result doctors have been faced with some difficult ethical dilemmas concerning issues such as abortion, surrogate motherhood, organ transplantation, individual vs the common good and prolonging life at any costs vs quality of life. The ethical dilemmas brought on by advances in technology have forced doctors to question some aspects of their code of ethics.

With the concentration on technology there came a loss of attention to the human side of medicine. Ethics were not taught at university in the medical program for a period of time. Some doctors believed that less emphasis on sympathy, human relations and patients' histories was required as a result of advanced testing techniques. More doctors observed a growing recognition within the profession that strong ethics are necessary for the kinds of decisions that doctors are faced with today as a result of technological advances.

Propositions

1. Advances in medical technology are variables that influence doctors' personal policies in relation to professional conduct.

2. Doctors are being faced with some difficult ethical dilemmas brought about by technological advances that have come into conflict with societal values. As a result doctors are questionning their code of ethics.

3. Strong ethics are necessary for the kinds of decisions that doctors today are faced with as a result of technological advances.

Litigation

One of the patterns drawn from the data was the impact of medical-legal issues. Eight of the doctors interviewed (31%) talked about the influence that litigation has had on their personal policies in relation to professional conduct. They referred to the influence with disfavor explaining that the fear of litigation has forced doctors to request many tests that aren't necessary and therefore to squander limited medical resources. One participant added,

> We are more involved in useless administrative practices at the hospital--they probably don't do anything more than save someone's behind!

In the words of one participant who had been in practice for more than 30 years, "The rules of professional conduct have changed. Legal factors influence how people behave." In a voice that rang with resentment another participant expressed similar sentiments:

> Every physician is torn between the litigious kind of atmosphere that we are now being forced to practice in--not only must we follow our rules for professional conduct but we also must follow what the government says we have to do.

One doctor attributed a loss of commitment within the profession to the potential for litigation:

> I am concerned that there has been a loss of commitment. The climate is very different from 15 years ago. There was more commitment then. . . . The climate now is "Don't get involved. Cover your ass so you don't get sued!"

Much of the change in the doctor-patient relationship referred to earlier in this chapter can be attributed to human rights legislation and the *Charter*. A participant who had been in practice for 17 years made reference to this legal authority for change.

> My attitudes are different now. Today I am trying to get away from making the decision for the patient. The attitude in the past was paternalistic, there is still some of that there, but I am trying to instill the idea of choice for patients. The courts are trying to instill it too.

Whether new laws resulted in greater expectations of people or vice versa the effects of changed expectations were being felt by many of the participants in the study. Relative to the influence of the law one doctor had this to say:

> The expectations of society have changed. We as physicians are pretty arrogant--we think we know what is best. In a contract between the patient and the physician the patient has the say. . . . The law requires informed consent. We are really hamstringed in how we do things.

An air of discouragement and frustration was evident in the tone of another participant's words:

> Many physicians are practicing defensive medicine. The medical-legal climate puts a lot of stress on the physician. The expectation is that everything will be perfect and if anything goes wrong someone has to be blamed.

Medical-legal cases have placed doctors in some very difficult ethical situations--some no-win situations.

> The law affects how we act ethically. Now we have patients making wills that say no extraordinary means should be taken if they have a terminal illness. Can we be sued?

Participants spoke of their hesitations to take risks that they would have taken in the past. One doctor who had been practicing for more than 25 years shared an experience with the researcher that had created a stressful ethical dilemma for the individual.

> The effect of law suits is a big mitigating factor in what you do. It makes you less liable to stick your neck out. We had a big law suit a few years back. The process was long and drawn out and never came to a fruitful head from our point of view. The hospital paid through the nose for that. It got me thinking about 14 years ago when a guy came in with a ruptured spleen. He was pretty well down the tube and I operated on him and took out his spleen. I was thinking after this law case, "Would I now go in and operate on that guy?" The answer is that I don't know that I would--because I had no business operating on on him in the first place. But he would have died if we had sent him into the city because he was near death. Would I stick my neck out now? I'd like to think that I would go ahead and operate on him. But if I didn't I would fill him up with IVs and send him into the city. He would probably die on route and everybody would say, "Oh that's the way it goes." And the only people who would know different would be him and me. That fundamental question of what I would be prepared to stick my neck out to do now is a difficult one. It creates a barrier between what you are prepared to do and what you would like to do. It has an effect on my professional conduct. Not in relation to what the College would have to say about it but in the way I feel about it.

This participant has expressed what just might be the most stressful ethical dilemma of all: that for which the law may prove you wrong but an individual knows in one's heart is the right thing to do.

Summary

Doctors' fears of litigation have influenced their professional conduct. Personal experiences and hearing about the experiences of colleagues is causing doctors to change their behavior. They are changing the way they practice or alternatively they are thinking and talking about responding differently to situations that they suspect carry an element of litigation risk. For many doctors this new behavior or new thinking is inconsistent with their presently held beliefs about practicing good medicine. Some doctors observed a loss of commitment and an increase in stress levels within the profession as a result of the potential for litigation.

Litigation and legislation have added new rules to the practice of medicine that go beyond the professional code of ethics--and sometimes appear to be in conflict with the traditionally accepted standards of conduct. The standards enforced by the College don't address some of the internal ethical dilemmas faced by doctors. When doctors perceive that a risk taken to save a life may cost them their licence to practice they are faced with a most stressful ethical dilemma.

Propositions

1. Fear of litigation is a variable that influences doctors' personal policies in relation to professional conduct.

2. Fear of litigation has created some difficult ethical dilemmas for doctors in some situations where choosing what appears to be best for the patient puts them at risk of litigation.

The College

The College was the only factor of influence on personal policies in relation to professional conduct that was suggested to the participants through questioning during the interviews. Participants were asked how the College defined professional conduct, how it communicated with them concerning professional conduct, what role it played and should play in influencing their professional conduct, what purpose the discipline process served, and what their level of involvement had been with the College.

Before asking participants about the College they were asked, "Who should determine what is and what is not professional conduct?" Participants' responses to this question more often than not referred to the College and therefore are reported in this section.

Setting Professional Standards

Twenty-two or 85% of the doctors interviewed said the profession should set the standards for doctors. One of the participants summed it up simply by responding, "Ourselves. That is professionalism." Another stated emphatically, "It is impossible to write the code if one is not a member of the profession." A third doctor presented a more embellished answer.

> My definition of a profession is a body of people whose work can only be judged by their peers. Doctors can only decide what their ethics are. We can't possibly escape the influence of the community around us. If we have a perceived idea of what the community expects of us I think that is sufficient. I think it should be entirely within the professional group.

A line of thought more radical than the foregoing was proffered by another doctor.

> The profession should determine what is and what is not professional conduct. That depends though on whether we believe that professions are a good thing. The College is there to protect a body of knowledge. Perhaps we don't require professions anymore. There is a movement toward a "McDonalds" approach to medicine that is completely impersonal. Perhaps it doesn't require ethical input. In the future we may be hooking (a patient) up to a (computerized) data base and let it work out (the diagnosis and treatment).

A majority of these 22 participants believed that the College should set the standards for the profession and define conduct that is not up to the standards.

> There are some very elementary standards for which we require a code of ethics. Then there are gray areas. There are certain professional standards that you can't define. For example I refer patients to a doctor because he has a certain technical expertise, but he has a very bad personality and manner with the patients and keeps the patients waiting. The College--those who are elected--makes the decisions about who has crossed the line.

Not all participants who believed the College should set the standards were satisfied with the way in which the College was undertaking its role.

> The College should determine what is and what is not professional conduct. There is some public concern whether or not the profession is objective enough though. The College should be more stringent.

Another participant, whose voice amplified the disillusionment of the words spoken, remarked,

> I think the College does a good job. The only objection I have to the (way the College does its job) is that members don't receive democratic process. The College doesn't have to follow the law in suspending a person. It is a group making an arbitrary decision without having to follow the law. The government would set out something far more draconian. . . . I think the College has gone to bed with the government due to government threats to disband the College.

Just over one quarter of the participants believed that the responsibility for setting professional standards lies with individual doctors and their peers within the profession. One of the doctors commented,

> Mostly we determine professional standards ourselves. There is a certain amount of peer pressure in urban practice or in hospital practice.

Another said,

> There are certain standards that are common to all of society that are more focused in the professions. The examples and experiences of one's professional peers should set the standards. I don't think you can legislate standards. The College tries to do that. It is not as effective as being able to point to others who are behaving (professionally) and show the profession that this is the model that has to be followed. The Scandinavian nations had a law that required people to contribute to charity. They found that they couldn't mandate charity and you can't mandate professional conduct. It is something that comes from within the individual.

A third doctor was insistent in explaining,

> You have to have a very flexible set of standards that anyone can fit into in any given community. The individual physician should set the standards for any given situation, that is where the primary responsibility lay. You have to have controls over the outer limits. That's all. The majority can set their own standards.

One doctor differentiated the teaching of ethics from what the doctor believed to be the role of the College. The doctor stressed the significance of peer role models from whom doctors learn professional conduct. "The College," the doctor said, "is guardian of the ethics rather than teacher of the ethics."

Fourteen (64%) of the 22 participants who stated that the profession should set professional standards (54% of those interviewed) said that there should be some input from the public or a consideration of societal values and mores in the determination of professional standards. One participant concluded, "Members of the profession should set the standards for the

profession themselves but not totally because we are members of society." Another reasoned that the "public should have input if it is paying," while still another who supported the notion of public input cautioned that there is potential for biased representation by public pressure groups. A senior doctor with 37 years in the profession remarked,

> In bygone days physicians would say that only they can set standards. We don't live in that traditional society now. Those standards must also stem from society. Underneath those professional values lie the values of society. Take the abortion issue for example. Values change.

Summary

Doctors believed that the profession should set the standards for professional conduct. Four decades ago in his discussion of errors within a professional colleague-group Everett C. Hughes (1951) stated that, "a colleague-group will stubbornly defend its own right to define mistakes, and to say in the given case whether one has been made. (p. 148) This still holds true for the doctors in this study, most of whom viewed the College as the body delegated to define professional standards on behalf of the profession. Some doctors thought that individual doctors should set their own standards, however most believed that professional standards should receive some public input or at the very least a consideration of societal values and mores.

Propositions

1. The right to define mistakes and set professional standards is still closely guarded by the medical profession as Hughes (1951) observed 4 decades ago.

2. Most doctors believe that standards for professional conduct should reflect current social values.

College Definition of Professional Conduct

Nearly half of the participants referred to the Canadian Medical Association's Code of Ethics when asked how the College defined professional conduct. Four said that the definition accepted by the College would be similar to their own. One of the doctors added, "Doctors shouldn't be an embarrassment to their colleagues." Another four stated that the College defined professional conduct in terms of misbehavior. Two such comments appear below.

> The College would have the 'no-no's' mapped out, for example sex with patients, over charging or impaired performance due to alcohol or drug abuse. The governing body must have the limitations in mind. The College can't say you have to act this way. They've got to say these are the limits--don't step over them.

> The College defines professional conduct in a negative way--as conduct unbecoming. This is necessary. However it is abused at times. For example we cannot solicit patients--I cannot ask you to come back to get your check-up, that would be conduct unbecoming. A doctor who moved his practice sent out notices to patients notifying them of his move. He was reprimanded by the College.

There were numerous other perceptions concerning the College definition of professional conduct. Three participants used statements similar to those made when they described their own definitions of professional conduct although they did not make the comparison themselves. Two doctors said that the College definition of professional conduct was left to the discretion of Council. Two more doctors stated that it would be defined in terms of limits on the "gray areas," and a couple said that the College would have more clear-cut and specific guidelines than individual physicians would use to describe the concept. Other descriptions of the College definition included references to "keeping up one's education," "patient welfare," and "legalistic definitions."

Only one participant said that the College would define professional conduct differently from the way the participant did. The doctor elaborated with reference to a difference of opinion over the issue of advertising.

Summary

Doctors referred to the Canadian Medical Association Code of Ethics and drew from their own personal definitions when asked how the College defined professional conduct. Drawing limits and identifying misconduct received greater emphasis in the perceptions of the College definition than in the doctors' personal definitions.

Propositions

1. Doctors describe the College definition of professional conduct in a manner similar to, yet more structured and definite than their own.

Communication

The tone of the comments made by participants in relation to communication from the College was fairly evenly spread across a continuum from positive to negative. Twenty-nine percent of the participants made comments that were fairly neutral while 21% were slightly positive and 13% were very positive. Twenty-one percent of the participants' comments were voiced in a slightly negative tone and 17% were very negative. This analysis was done by listening to the response to questions concerning the means of communication practiced by the College and for each participant placing a mark on a continuum from very positive through neutral to very negative.

The communication from the College that participants were most familiar with was that which came via the "Dear Doctor" letters from the

registrar. Twenty-two of the 24 participants who specified communication from the College identified these letters.

Among the comments that reflected positively on the College one participant commented,

> The most effective communication from the College is the written correspondence. It reinforces the conduct expected by the profession. We need the reminders so the we don't stray from the group.

On the negative side a doctor followed comments with a suggestion for more regular communication from the College.

> Occasionally we receive edicts from the College that say we should not do this or should do that. I don't see their communication as being very effective. These letters are merely crisis intervention--knee jerk reactions. They need to be far more proactive. They've got to communicate regularly.

A few of the participants reacted to the authoritative tone they attributed to the College communication via the "Dear Doctor" letters.

> The College communicates through "Thou shalt do this or not do that" letters.

> Letters come from time to time. They are warnings--you should do this or not do that. They are presented in a very intimidating way. You get the feeling that you are guilty until you are proven innocent.

Some doctors believed that the College does not provide enough clear direction concerning professional conduct.

> It communicates badly. There are "Dear Doctor" letters and a report at the end of the year. The problem is that once they have communicated it once they think that you know it for ever and ever. What happens to doctors new to practice or the doctor who forgets or was practicing in a different province? The rules are not kept in a book or anywhere. Their rules and regulations are extremely confusing. They need to have a booklet--something that is continuously updated and in a readable form with an index. They don't want to do it.

> You talk to different people in the College and you get 3 different opinions. There is nothing to standardize the rules and regulations. Each person at the College puts his own opinion in the definition of professional conduct. As a result doctors are confused.

There were those who looked to the College for guidance and accepted the role of the College as decision maker when it comes to setting limits.

> We all make mistakes. I view physicians like I do the rest of mankind. Whenever there have been concerns about questionable areas I have called the College and asked and appreciate their advice. I appreciate them being there.

> Letters and the annual report are not as effective as the College thinks they are. When you are a busy physician you have no time to think about issues in an ethical way. Thus they elect councillors to make those decisions for them.

> A lot of what the College expects is learned by reading what they don't like in the discipline reports.

Eighteen or 75% of the participants who discussed communication identified the discipline reports contained in the annual report of the College as a means of communication with members concerning professional conduct.

> Yes, I read the annual report. It reminds us when certain conduct has been unethical and reminds us concerning our responsibilities to transfer information to patients.

> The discipline reports in the annual report are the most effective means of communication. We can compare our own conduct with what the College deems acceptable.

Surprisingly, many of those who commented on reading the discipline reports at the back of the annual report thought that there were few others who read these reports.

Communication from the College through advice and opinions specifically sought by doctors was noted by 5 or 21% of the participants. This communication reportedly took place most often over the telephone. Four

doctors (17%) identified patient complaints as a means of communication from the College and three (13%) referred to registration interviews.

Summary

There was an underlying inference among participants that the College should communicate with the membership concerning professional conduct. Doctors did not agree concerning the effectiveness of communication from the College. They did, however, agree that there are three means of communication from the College:

1. "Dear Doctor" letters from the registrar that direct certain conduct on the part of the doctors,
2. the discipline reports that appear in the back of the annual report, and
3. telephone calls made by members seeking advice.

The means of communication described by the doctors is indicative of predominantly one-way communication from the College to its members. There was no evidence of perceptions of communication being sent from the doctors to the College, or conversely, the College was not perceived to be listening to its members.

With approximately half of the doctors expressing some disfavor with communication from the College, either in its form and/or in its frequency, it is evident that there is ample room for the College to improve its communication with members.

Propositions

1. Doctors think that the College should improve its communication with the membership concerning professional conduct.

2. Communication from the College concerning professional conduct has an influence on many doctors' personal policies in relation to professional conduct.

3. Doctors do not think the College is listening to its members.

The College as an Influence on Professional Conduct

The role played by the College in influencing professional conduct that was identified most often by participants was that of guardian over the health care insurance plan. Peer review as a result of exceptionally high earnings reported by the Alberta Health Care Insurance Plan administration was an issue laden with much emotion by some participants. One doctor's explanation was expressed in a tone of resentment.

> I was peer reviewed. These guys wanted to see if I was doing a good job. It was because I was working so hard. . . . Peer review was a great crisis for me. I couldn't sleep. It influenced my feelings concerning professional conduct. The College needs to do something about the good guys that get reviewed. I was very angry with the College. . . . It was the worst year for me. The computer said I was making $7500 more than the others. There was no human compassion. Academically I could accept it. Emotionally it was difficult.

Other roles that were cited often included sending reminders about professional conduct in letters to members, providing warnings to doctors, protecting and serving the public interest, and providing advice on such matters as medical-legal problems.

Participants identified a number of roles that the College should play in influencing members professional conduct:

1. Allow members voices to be heard,
2. Look more at what physicians are doing with their patients,
3. Conduct peer reviews on all doctors who practice alone,
4. Be more proactive,
5. Do something about the good guys that get peer reviewed,
6. Prepare a booklet that describes what doctors shouldn't do along with guidelines when procedures change, and
7. Run sessions.

The latter suggestion was elaborated on by one of the participants who expressed some discouragement while speaking.

> The role the College could be involved in is education--risk management. It could provide courses to show us how we can keep ourselves out of school. It is the opportune time for them to move into education, but it is difficult for them to move out of the punitive mindset.

Of the 10 participants who were asked whether or not the College influenced their professional conduct six said yes and four said no. One of the doctors who believed that the College did influence the doctor's professional conduct, said,

> Yes, the College influences my practice. One gets in a rut and the College makes you think, "Am I doing it right?" I don't know how much long term effect this has.

Summary

Doctors perceived the role the College was playing as an influence on professional conduct of members primarily as that of guardian over the health care insurance program. Although a few doctors thought this role was necessary, most believed that the College should be involved in a number of different activities aimed at influencing the professional conduct of members.

More doctors think that the College has an influence on their professional conduct than vice versa.

Propositions

1. Doctors presume that the College has taken on the role of guardian over the health care insurance plan. They view this as a focus of the College that prevents it from carrying out effectively a variety of other roles that would have a positive impact on members' professional conduct.

The Discipline Process

Fifteen (79%) of the 19 participants who talked about how they viewed the discipline process undertaken by the College described it in terms analogous to a legal system within the profession: "To ensure that rules are abided by and that standards are met," "To take care of recalcitrant professionals," "To weed out the unethical," "To punish violators," and "To set precedents for proper conduct of others." Seven participants (37%) said the discipline process was there to protect the public and three (16%) stated that it was needed to correct wrong behavior and get the wrongdoers "back into line."

Summary

Doctors view the discipline process undertaken by the College as a "legal system" within the profession.

Propositions

1. The purpose of the discipline process of the College, as conceptualized by its members, can be described best with an analogy to the legal system.

Level of Involvement with the College

A member of the College administrative staff described the involvement of the membership in College affairs.

> About 150 of our 4100 members are involved in the work of the College through Council, committees, peer reviews and as presenters at meetings. There are 21 Council members. We are trying to get more members to make presentations to Council. Councillors are elected from certain geographic areas. They don't have formal meetings in their areas. . . . Some of the Councillors take their representative role seriously, others never talk to anyone.

Twenty-four of the participants discussed involvement in the affairs of the College during their interviews. Of the 24 participants, 12 either were or had at some point in their careers been involved in the affairs of the College. It is difficult to estimate how closely this sample represents the total population of doctors in the province. Hypothetically, at 150 members involved each year a total of 3000 members could have been involved after a 20 year period. The total number, however, would likely be much smaller since many of the same people remain involved year after year in one capacity or another. As might be expected, the level of involvement among participants increased as their ages increased. Three of the participants who had not been involved in the affairs of the College were heavily involved with the Alberta Medical Association (AMA).

Of the 12 participants who had been involved with the College 11 said that their involvement had influenced their professional conduct.

> I had my eyes opened by the audit of a colleague that I was involved in. I learned a few things. It influenced my attitudes about record keeping and politics. . . . The people involved in discipline of colleagues must be particularly squeaky clean.

> I am more critical of myself than I was before.

> Until you are actually involved you don't realize that there are issues that you haven't even thought about. It made me more aware of the range of problems.

A sociological factor of influence discussed earlier in Chapter 5 surfaced again as one of the College administrators described, somewhat pensively, presumptions of the impact that the treatment of discipline cases has had on

the Councillors, and the influence that Councillors, as role models, have had upon one another.

> Councillors are at first naive about how bad some people are. They discover that some of these things really happen. They see the negative side more, and as a result evaluate themselves more. There is a positive influence of colleagues on other Council members. They are good solid people who set good examples. They learn from the goodness of some and from the unpleasantness of others.

The administrator's comments were reinforced by a statement made by one of the members who spoke with certitude.

> Involvement with the College has strengthened my convictions. It breeds pessimism, though, seeing the problems. It burns out a lot of physicians. . . . You can't help but profit from interaction with good role models--with good people. They become better doctors and better people too. It facilitates interaction. You get feedback.

Involvement in professional matters doesn't necessarily result in greater support for the way the system operates. This was evidenced by the disillusionment expressed in one doctor's comments.

> My involvement may have reinforced the fact that professional conduct is important. . . . It made me a little more cynical. Most people find gray areas where they can maximize income. Out and out fraud is dealt with but you can't get to the gray area stuff. It's difficult to prove. The system encourages that kind of behavior.

One of the 12 participants who had been involved in the affairs of the College didn't know whether or not the experience had influenced the participant's personal policies in relation to professional conduct.

Of the 12 participants who had not been involved with the College, six thought that involvement would influence their personal policies in relation to professional conduct if they were to become involved.

> Yes, I think there would be an influence if I were to serve on the discipline committee. One might do a bit of self-evaluation as you see these cases come before you.

Three of the six previously referred to were involved in the affairs of the AMA at the time of the interview It appeared that their opinions were the result of opinions based on their AMA experiences.

> Involvement heightens your awareness that you have a responsibility to more than just yourself. You appreciate the broader picture. Some people come onto the board of directors of the AMA with a cause and go away with a broader view and more concern for the common good of society.

Three of the 12 participants who had not been involved with the College thought that such involvement would not influence their personal policies in relation to professional conduct.

> I am not interested in political activity or committee work. Wielding power and getting recognition from colleagues is not of interest to me. The people on Council are self-selected to be elected to those positions. You can't make general statements--getting involved in political affairs doesn't mean that you are a better person or that you are a worse person because you don't get involved.

> My professional conduct would be as it is regardless of the College. Those who get involved are there because they accept the tenants of the College.

One of the 3 participants who expected that involvement with the College would not influence professional conduct saw only a reverse relationship whereby those who chose to get involved would influence the direction of the College.

> No. I think they would influence the direction of the College rather than the other way round.

Three of the participants who had no previous involvement in College affairs said they did not know if such involvement would influence their personal policies in relation to professional conduct.

Summary

Of the doctors who had been involved in the affairs of the College only one was not sure whether the experience had influenced the doctor's personal policies in relation to professional conduct. The others perceived that the College had influenced their professional conduct.

For many of these doctors modelling was a powerful influence on their personal policies in relation to professional conduct. Colleagues on Council provided a positive influence and were emulated by others. Members' behaviors that were reviewed or disciplined were measured against the doctors' own practices, reinforcing limits for conduct.

Half of the doctors who had not been involved in the affairs of the College thought that their personal policies in relation to professional conduct would be influenced if they were to become involved. One quarter of this group did not think that there would be an influence and the remaining quarter of the group was not sure.

Propositions

1. Involvement in the operation of College affairs influences the involved members' personal policies in relation to professional conduct.

Summary of Findings

The findings in this chapter pertaining to the factors of influence on participants personal policies in relation to professional conduct were conjoined and consolidated into 36 propositions which are repeated below. Conclusions were drawn from these findings and from findings reported in Chapter 4. Conclusions and recommendations are reported in Chapter 6.

Proposition 1: Personality has some influence on personal policies in relation to professional conduct.

Proposition 2: There is some concern among doctors that not enough attention is paid to an individual's personality characteristics when selecting candidates for medical school.

Proposition 3: The formative years exert a powerful influence on personal policies in relation to professional conduct for doctors. Basic values that lead one to practice professional conduct are implanted during these years.

Proposition 4: The greatest influence on doctors' personal polices in relation to professional conduct stems from doctors modeling other doctors in practice.

Proposition 5: The period of greatest influence for modeling is during the doctor's internship.

Proposition 6: Current peer modeling is also a major influence.

Proposition 7: As a doctor's experience grows the ability to extrapolate greater meaning from the behavior of others increases.

Proposition 8: Positive role models are generally held in high esteem by doctors during the period of greatest influence.

Proposition 9: Learning what is not professional conduct from behavior of others which a doctor judges to be unacceptable, is also part of the modeling process.

Proposition 10: Professional conduct is learned more through example than as a result of classroom teaching.

Proposition 11: Lifestyle factors, which include (1) attempting to balance professional, family, and leisure obligations and (2) striving for a healthy level of job related stress, are powerful influences on doctors' personal policies in relation to professional conduct.

Proposition 12: Experienced doctors believe that professional service commitment among doctors is waning as concerns for personal lifestyle increase. Experienced doctors attribute this transition more to the younger generation of doctors than to their own generation.

Proposition 13: Doctors are bewildered about where the "new attitudes" toward professional conduct are taking the profession and the kind of impact these attitudes will have on the practice of medicine. Some doctors are frustrated and disappointed by the impact this is having on professional conduct, some see it as a positive move toward a more balanced and healthy lifestyle and some are not sure what the ultimate effects might be.

Proposition 14: Doctors think they are getting less respect and reward for their high levels of dedication and service than in the past and as a result feel less responsible and less committed to the traditional "service before self" definition of professional conduct.

Proposition 15: An increase from approximately 10% to 50% female practitioners within the space of one generation has influenced personal policies in relation to professional conduct.

Proposition 16: The lifestyles of doctors working in walk-in clinics verses doctors in traditional family practices has become a contentious issue for doctors and has an

impact on their personal policies in relation to professional conduct.

Proposition 17: Doctors view remuneration and the role of government as interwoven variables that have a detrimental influence on their personal policies in relation to professional conduct.

Proposition 18: Generally, doctors think that being placed on salary would lower the level of commitment among members of the profession.

Proposition 19: Doctors blame the AHCIP level and means of remuneration for lowering standards of practice--for driving doctors to work quickly seeing more patients in less time than they used to.

Proposition 20: Doctors resent what they perceive to be the intrusion of government in the delivery of medical care.

Proposition 21: A change from the traditional paternalistic doctor-patient relationship to more of a partnership influences their personal policies in realtion to professional conduct.

Proposition 22: There is some disappointment among doctors at what they believe is a loss of esteem for the profession of medicine.

Proposition 23: Advances in medical technology are variables that influence doctors' personal policies in relation to professional conduct.

Proposition 24: Doctors are being faced with some difficult ethical dilemmas brought about by technological advances that have come into conflict with societal values. As a result doctors are questionning their code of ethics.

Proposition 25: Strong ethics are necessary for the kinds of decisions that doctors today are faced with as a result of technological advances.

Proposition 26: Fear of litigation is a variable that influences doctors' personal policies in relation to professional conduct.

Proposition 27: Fear of litigation has created some difficult ethical dilemmas for doctors in some situations where choosing what appears to be best for the patient puts them at risk of litigation.

Proposition 28: The right to define mistakes and set professional standards is still closely guarded by the medical profession as Hughes (1951) observed 4 decades ago.

Proposition 29: Most doctors believe that standards for professional conduct should reflect current social values.

Proposition 30: Doctors describe the College definition of professional conduct in a manner similar to, yet more structured and definite than their own.

Proposition 31: Doctors think that the College should improve its communication with the membership concerning professional conduct.

Proposition 32: Communication from the College concerning professional conduct has an influence on many doctors' personal policies in relation to professional conduct.

Proposition 33: Doctors do not think the College is listening to its members.

Proposition 34: Doctors presume that the College has taken on the role of guardian over the health care insurance plan. They view this as a focus of the College that prevents

it from carrying out effectively a variety of other roles that would have a positive impact on members' professional conduct.

Proposition 35: The purpose of the discipline process of the College, as conceptualized by its members, can be described best with an analogy to the legal system.

Proposition 36: Involvement in the operation of College affairs influences the involved members' personal policies in relation to professional conduct.

Conclusion

There is no one factor that stands out among the rest as a major influence on the personal policies in relation to professional conduct in the minds of the doctors interviewed. These personal policies evolve over a period of time, although it appears that the period of greatest influence is during the latter part of the training phase. A specialist who had been in practice for 12 years explained this socialization process:

> It is a gradual process. I think the medical profession lacks professional conduct or ethical education. It is something you kind of absorb through osmosis, through seeing what happens with colleagues--how they behave, how they conduct themselves. It is communicated through medical journals on misconduct and professional correspondence from the College. It evolves very slowly. I don't think there is any one particular time or educational process which distills professionalism in you. I think that if most doctors are the same as I am, you change with time too so that your professional conduct now after 12 years of being in practice is different than it was after being in practice for 2 or 3 years. I think differently, I behave differently, I feel differently about different things now than I did in the past so there is a degree of evolution to professional conduct.

CHAPTER 6
CONCLUSIONS AND RECOMMENDATIONS

The meaning that participants derived from the concept *professional conduct* and described in their definitions of the concept was classified and reported in Chapter 4. In Chapter 5 the meaning that participants attributed to factors they perceived as having influenced their personal policies in relation to professional conduct was classified and reported. Participants were encouraged to direct their attention to their social interaction as members of the medical profession--to how they viewed themselves as individuals operating within the collective.

The following conclusions are drawn from the propositions generated in the two preceding chapters and from the review of literature.

Conclusions

1. Professional conduct is an evolving concept that goes beyond the intellectual and the practical to a way of living.

Personal policies in relation to professional conduct evolve over a long period of time beginning with the values learned during the formative years and continuing well past the years of professional training. The process continues throughout the entire career of the professional.

Professional conduct extends beyond one's professional practice. Jackson (1970, p. 6), in his introduction to *Professions and Professionalization,* described the true professional as "work-oriented to the highest degree." For the true professional work is,

> . . . a code of ethics and ideology comprehending not merely the work situation but extending beyond this to define a status and a style of life of universal relevance, in all aspects of life. A doctor or a priest is always "on duty" in this sense; his vocation is a twenty-four hours a day, seven days a week, lifetime commitment. His occupational role is comprehensive and the implication is that membership of the occupational group confers an acceptable and comprehensive life-style. For such occupations the broader aspects of a socialization process and educational framework, which not only closely controls selection but also provides training in terms of a general tradition, is clearly particularly appropriate. A trained mind is given precedence to technical competence which it is assumed can be readily picked up once the formal education process is complete.

Doctors agree that professional conduct is a way of life, not limited to behavior while practicing medicine. They believe that the image of doctor remains with them in their social as well as their professional activities.

2. Perception is a vital cognitive process in the evolution of personal policies in relation to professional conduct.

Kolasa (1969) applied a systems approach to the definition of perception.

> Perception is a basic cognitive process with many variable aspects to affect behavior. It may be defined as the organization of material which comes in from the outside at one time or another. Perception may also be considered as the interpretation of the data that is received from inputs. The system, or organism, recognizes the information, assembles it, and makes comparisons with material previously stored in the "central information processing storage." This involves a whole history of what has happened to the individual over his lifetime, since it is the organization of inputs through an inner process that is dynamic, that is, a constantly changing one. It is a process that shapes whatever comes in from the outside; in turn, what is there is changed by what comes in. (p. 229)

Analysis of the factors of influence on doctors' personal policies in relation to professional conduct reveal perception as a cognitive process through which the concept of professional conduct takes on meaning. This may explain why doctors predominantly used cognitive phrases to define professional conduct.

Perceptions "provide the basis for understanding reality--objects, events, and the people with whom we interact--and our responses to them" (Johnson, 1987, p. 206). Behavior is based on the way people interpret reality, not on reality itself (Baskin & Aronoff, 1980; Fisher, 1981; Johns, 1988; Johnson, 1987; Kelly, 1980). This may explain why members of the same profession will define professional conduct differently, and why individual interns will each model different behavior from observing the same doctor's conduct. The more accurately one perceives the world, the better able he or she is to make reasonable predictions, and to act reasonably in response to the perceptions. Conduct that is reasonable in one particular situation may be viewed as somewhat unprofessional in another. Professional judgement is an important aspect of professional conduct.

3. Professional judgement can be learned through modeling.

Modeling was found to be the greatest influence on doctors' personal policies in relation to professional conduct. For many of the doctors, modeling other doctors in practice crystalized their systems of basic attitudes, values, and beliefs into knowing and deciding how to behave in certain situations. Polanyi's theory of tacit knowledge can help to explain this phenomenon.

Polanyi described tacit knowing as the process by which we "become aware of subliminal processes inside our body in the perception of objects outside" (1966, p. 14). He used "physiognomies" as a reference and said they cannot be fully described in words, nor even by pictures, and that in teaching these appearances we must rely on the student's ability to understand the meaning.

> But can it not be argued, once more, that the possibility of teaching these appearances by practical exercises proves that we can tell our knowledge of them? The answer is that we can do so only by relying on the pupil's intelligent co-operation for catching the meaning of the demonstration. Indeed, any definition of a word denoting an external thing must ultimately rely on pointing at such a thing. This naming-cum-pointing is called, "an ostensive definition;" and this philosophic expression conceals a gap to be bridged by an intelligent effort on the part of the person to whom we want to tell what the word means. Our message had left something behind that we could not tell and its reception must rely on it that the person addressed will discover that which we have not been able to communicate. (pp. 5-6)

For modeling to be effective the doctors must have a basis for "catching the meaning" of the professional conduct being modeled. Throughout their careers doctors continue to learn from the behavior modeled by their peers With greater experience they are able to extrapolate greater meaning from observing the behavior of others.

In addition to modeling conduct which was viewed as appropriate, doctors also observed conduct of which they did not approve. Doctors consider the rightness or wrongness--the goodness or badness--as they observe the way another doctor handles a situation. Through this process of introspective scrutiny of other doctors in practice they developed their own set of criteria for professional decision making.

Handy (1987) claimed that few organizations use modeling in a systematic way to develop desirable characteristics and behavior in an individual. He suggested that "fitting people to people might well be a more effective strategy for development than fitting people to tasks" because it is easier for people to learn by modeling than by conceptualizing experience (p.284). Evidence that the College is cognizant of the influence of role models surfaced during an interview with one of the administrators of the College. The administrator stated:

> The role model of those who we train under is another factor of influence on a physician's professional conduct. I often think about what two of my teachers would have done when I get into difficult situations. That is why we are so particular about who our medical students intern with.

Modeling has considerable influence on doctors personal policies in relation to professional conduct, particularly in the development of professional judgement. It is a factor of influence that should be incorporated into programs designed to influence the professional conduct of doctors throughout their careers.

4. Changing relationships are contributing to a sense of loss of authority, power, prestige, and esteem among doctors.

Changes to the doctor-patient relationship, from what was a paternalistic relationship to what doctors now describe as more of a partnership, are causing considerable strain for many doctors. Some are finding the relationship transition difficult while others are reacting to a perceived loss of authority, power, prestige and esteem. People are better educated, more informed and aware of their increasing individual rights. Medicine has lost its mystique for the public.

Some doctors are experiencing difficulty adjusting to this recent trend where patients became privy to some of the "mystique" surrounding medical practice. In the past this element of mystique was part of what set professionals apart--what incited people to look upon the professional and his or her craft with a sense of awe. Earnest Greenwood (1957) described the relationship between the professional and the client in his definition of a profession:

> In a professional relationship . . . the professional dictates what is good or evil for the client, who has no choice but to accede to professional judgement. Here the premise is that, because he lacks the requisite theoretical background, the client cannot diagnose his own needs or discriminate among the range of possibilities for meeting them. Nor is the client considered able to evaluate the caliber of the professional occupation. . . . The client's subordination to professional authority invests the professional with a monopoly of judgement. . . . The client derives a sense of security from the professional's assumption of authority. The authoritative air of the professional is a principal source of the client's faith that the relationship he is about to enter contains the potentials for meeting his needs. (p. 48)

This aspect of Greenwood's concept of a profession was commonly held during the period when a majority of doctors received their training (Gross, 1958.; Jackson, 1970; Parsons, 1939; Vollmer and Mills, 1966). The doctors who still maintain a "monopoly of judgement" in the doctor-patient relationship perceive a threat to their professionalism in the "new" partnership-relationships with patients.

Doctors believe that public esteem for the profession has declined, either from what they previously experienced or from what they expected they would experience upon entering the profession. They attribute this to patients who want to understand their health problems and make their own choices, government control over their earnings, and advances in medical technology that have made their work appear more technical. Many doctors are disappointed. There is a sense among doctors that they have lost their place in society.

5. Prestige and public respect influence doctors' levels of commitment to their work.

Etzioni (1975) explains that *moral involvement*--feelings of commitment and loyalty associated with a highly positive orientation toward one's work--forms a congruent relationship with what he terms *normative power* that rests on the allocation of symbolic rewards such as prestige and

acceptance. When the symbolic rewards are perceived to be removed what is left is an incongruent compliance relationship, which Etzioni contends will strain the system. Ultimately, he says, a shift in one of the bases of compliance will result, forming, once again, a congruent compliance structure.

In the context of Etzioni's *theory of compliance* the transition that has taken place in the doctor-patient relationship is an example of a *normative power-moral involvement* relationship that has lost the normative power (the symbolic rewards of authority, prestige and esteem), resulting in an incongruent relationship. Evidence of the "strain on the system" was heard in the comments by some of the participants. The shift in the bases of compliance referred to by Etzioni may become evident ultimately as the disappointment and bitterness felt by some doctors culminate in a diminished sense of commitment and loyalty to the practice of medicine. Etzioni would describe this as a transition from a *normative power-moral involvement* relationship to a *remunerative power-calculative involvement* relationship where the focus for satisfaction becomes extrinsic-reward related, i.e., monetary, increased leisure or family time.

Alternatively, a redefinition of the service ideal to one that is appropriate for present day may result in more realistic symbolic reward expectations, thus restoring the *normative power-moral involvement* congruent relationship. Doctors need to feel satisfied that they are giving enough at a level that strikes a healthy lifestyle. *Normative power* referred to in Etzioni's typology is the result of experiencing intrinsic rewards for one's work. Symbolic rewards such as prestige and public acceptance will arise from a group of professionals who exude self confidence, contentment, and feelings of satisfaction with the level of service they are providing.

6. The traditional service ideal has lost support among doctors.

A strong sense of professional identity is evident among doctors. For most, a commitment to serve patients takes priority in their reasoning while discussing professional issues. Their right to set professional standards is

strongly defended and almost every doctor agrees that professional conduct extends beyond professional practice. The image of a doctor is one that doctors maintain they take with them wherever they go.

Although doctors in the study demonstrated a strong sense of professional identity many left the impression of growing resentment within the profession. And, although doctors spoke of their priority to serve patients, their comments concerning remuneration and the role of government did not always reflect this priority. Doctors are sensing a number of oppressive strains on their personal policies in relation to professional conduct. They identify changing attitudes among the younger generation of doctors, among their patients and within society in general.

Experienced doctors believe that many of the younger doctors are far less committed to the concept of the service ideal than they themselves are or were. Some doctors view this new attitude within the profession as a less service-oriented approach to the practice of medicine while others see it as a more positive approach that will avoid the stress-related pitfalls that many highly dedicated senior doctors have fallen victims to.

The profession has grown from approximately 10% to 50% female practitioners within the space of one generation. The male doctors believe that the females in the profession are less willing and/or able than their male peers to give up family time. More women than men are operating shorter work-weeks in their practices and this is creating a desire among some of the male doctors to take more time for their families as well.

The bewilderment among doctors over the potential impact of the "new attitudes" within the profession suggests that a redefinition of the service ideal is timely. Doctors identify a challenge in trying to balance demands of family and the need for some leisure time with the demands of their professional practices. They believe that there has been too much substance abuse, burn out and family breakdown among extremely highly committed doctors. They maintain that professional demands have increased, brought on by what one doctor termed the "information explosion" and new technology. The result, they say, is falling standards "because physicians just can't deal with it all" nor can they "know it all."

Etzioni's theory may help to explain the appearance of less commitment on the part of the younger generation of doctors. The younger doctors may have observed the incongruent relationship--disheartened doctors in the older generation who displayed high moral involvement and who once enjoyed the symbolic rewards of prestige and authority, now feeling criticized and challenged. The younger generation of doctors are entering the profession with different expectations. Their personal policies in relation to professional conduct may be characterized by calculative attitudes. They are seeking only remunerative returns. Thus a congruent relationship on Etzioni's "typology of Compliance Relations" may exist for these doctors. Many are content working in walk-in clinics for an 8 hour shift, taking home a comfortable salary and enjoying their family and leisure activities outside of their professional practice. This presumption requires further study.

Oppressive strains on doctors' personal policies in relation to professional conduct are also apparent in doctors' comments concerning the Alberta Health Care Insurance Plan system of remuneration. Doctors believe that the government system of remuneration has created a difficult ethical dilemma for doctors who find their desire to earn a good income in conflict with their desire to provide the best service possible to their patients. Comments such as "Economic factors have driven the level of commitment down." and "We should have a system that drives you toward ethical behavior." demonstrate the level of frustration of some doctors.

This dissatisfaction with the system of remuneration may be more evidence that the traditional service ideal has lost ground. Earlier in this century professionals were expected to accept a responsibility to serve the public interest, even at the expense of serving one's own interests. Leake (1927, p. 4) stated that professionals have "more specific moral issues confronting them than the mass experience of humanity has evolved rules to cover." He pointed out a conflict for the professional who must daily make choices between the interests of humanity and his or her self-interests.

Looking again to Etzioni's theory of compliance for an explanation it appears that the professional is willing to accept this responsibility as long as the symbolic rewards are present. Doctors are especially frustrated because an

acceptable level of *remunerative power* is not available to replace the loss of *normative power*. A doctor explained that when medicare first came in the commitment to service before self had changed with the "intrusion of the state." The physician was no longer responsible to the patient but rather to the state. However, doctors were well paid at first so they were quiet.

A converse relationship exists. The public has lost some of its esteem for doctors. Doctors have lost some of their commitment to the service ideal. The two have some interdependent characteristics and one is not likely to change without some observed change in the other.

7. Strong ethics are necessary for the kinds of decisions that doctors are making.

The previous comments concerning a loss of the traditional service ideal suggest a serious need for a revitalization of the service ideal among doctors. Doctors need to reconsider their reasons for choosing a service profession over other career paths. A renewal of a sense of pride in the service of humanity will help to restore greater prestige to the profession.

In addition to financial concerns, advances in medical technology and increases in litigation have presented doctors with difficult ethical dilemmas. Doctors question the relevance of their code of ethics in some of the situations they are being confronted with. A doctor presented the following example: quality of life verses preservation of life at any cost when the costs to maintain life can be astronomical thereby depleting resources necessary to provide basic care to the public at large.

Today, demands on professional judgement are indeed great. A doctor needs a strong sense of ethics to guide decision making. Professional judgement in a human service profession demands more than extensive technical and theoretical knowledge.

Recommendations

This study was undertaken to gain insight into means through which professional associations might influence the professional conduct of their members. The investigation employed a case study of the College of Physicians and Surgeons of Alberta. Accordingly, it is recommended:

1. That the College foster a redefinition of the service ideal through the development of a list of rights and responsibilities of doctors.

Some doctors may have unrealistic concepts of what is expected of them professionally. There are doctors who experience difficulty setting reasonable limits on their work--balancing their family obligations and relaxation needs with professional demands. Other doctors may benefit from opportunities to reconsider their responsibilities in a human service profession. Likewise, it would benefit the profession to raise the awareness among the public concerning the rights and responsibilities of doctors so that public expectations of doctors are realistic.

When doctors were asked what the College should be doing to influence professional conduct a number of them suggested that it take action aimed at informing members better about the kind of conduct that is expected. This could be achieved through the development of a document outlining rights and responsibilities of doctors. Such an undertaking would also encourage doctors to consider and discuss their concepts of the service ideal and to provide their input to the College.

2. That the College "listen" to its members.

As the interviews progressed for this study it became more and more evident that doctors need an outlet to voice their concerns--opportunities to discuss professional issues with one another. Following their interviews most doctors commented that they enjoyed or appreciated the opportunity to take part in the study. One of the doctors remarked, only half jokingly, "This

is a ventilation session for me. You should charge me psychotherapy fees for the session!" Another complained that doctors won't take time away from their practices to attend conferences on ethics. Some doctors expressed a desire for greater interactive communication with the College. The College needs to be perceived by doctors as "listening." Meetings and short seminars held throughout the province could provide an outlet for members to discuss professional issues. Such meetings would also improve the image of the College with its members.

3. That the College develop and implement programs that optimize the influence of peer modeling on members' professional conduct.

Doctors in this study identified peer modeling as a powerful influence on their personal policies in relation to professional conduct. The College should develop ways to optimize this influence throughout the professional careers of its members.

4. That the College urge the universities to integrate the teaching of professional ethics into medical school programs.

Doctors in the older generation say they consider ethics more in their decision making than doctors in the younger generation say they do.. Doctors in the older generation received some ethical training in medical school whereas most of the younger generation of doctors have not. Further study is necessary to determine whether there is a causal link.

Strong ethics are necessary, nevertheless, for the kinds of decisions that doctors are making. There is a need to integrate the teaching of professional ethics into medical school programs where students have opportunities to learn about professional conduct through example. The teaching of ethics should be aimed at raising the awareness level of doctors so that ethical concerns are considered in their professional decision making. The College could play a role in urging the universities to meet these goals.

5. That the profession urge the provincial government to review and revise the Alberta Health Care Insurance Plan with an aim to provide more equitable remuneration for doctors.

Some doctors are feeling discontent at the inequities in the system of remuneration that allows doctors working in less stressful and less demanding situations than their colleagues to earn more for equivalent hours of work. Many traditional family physicians are feeling resentful toward the walk-in clinics. The family physicians in traditional practice see the chronically ill and those suffering from long term illnesses more often than the physicians working in walk-in clinics who deal mostly with symptomatic illnesses. This division of care discriminates financially against the family physician in traditional practice. The fee schedule administered by the Alberta Health Care Insurance Plan (AHCIP) pays a higher rate for a first time visit than for follow-up visits. If the majority of visits to the walk-in clinics are one-time only the remuneration for the physicians working in these clinics can soon exceed that of the traditional family physician. One of the participants associated with the administration of the College stated that the doctors working in walk-in clinics "basically view their practice as a job that ends when their shift is over. They have no worries about follow-up."

An interview with the director of the AHCIP and a review of the doctors' fee schedule corroborated the structure of fee payment described by the participants. The system pays more for what one would assume to be less serious illnesses that require only one visit to the doctor's office. The health care insurance system is operating in a manner that sults in an unfair distribution of remuneration. In a sense it penalizes doctors who devote their time to chronically ill patients. The system should be reviewed and revised with an aim to encourage the highest ethical practice possible.

Recommendations for Further Research

1. That the propositions ascertained through analysis of the data of this study be tested and refined through the collection of further empirical evidence.

The findings in this study are summarized in the propositions that appear at the ends of Chapters 4 and 5. In relation to the purpose of this study the propositions are *credible* and *fit* the context to which they are applied (Guba and Lincoln, 1981). If these findings are to be generalized to a population other than the one studied they will require further refinement and testing.

2. That a study similar to the one reported in this dissertation be conducted with doctors new to the profession, and that the results of such study be compared with the findings of this study.

Assumptions about the personal policies in relation to professional conduct of the younger generation of doctors were made by the experienced doctors who participated in this study. A replication of this study with doctors in practice for less than 5 years would present findings which could test those assumptions.

3. That a study be undertaken to determine whether or not there is a significant causal link between the teaching of ethics in medical school and the consideration of ethical issues in the professional judgement of doctors.

The final conclusion of this study was that *strong ethics are necessary for the kinds of decisions that doctors are making.* A study such as the one suggested in this recommendation 3 would provide valuable information for those who wish to foster strong ethics among doctors.

Concluding Remarks

The purpose of this study was to generate propositions about the developmental nature of personal policies concerning professional conduct of members of the College of Physicians and Surgeons of Alberta. The findings of this study contribute to an understanding of the meaning of professional conduct for those doctors who participated. The findings also help to explain how the concept of professional conduct evolves.

The results of this study lend knowledge to Mintzberg's pursuit for "solutions to a society concerned about its professional bureaucracies." Mintzberg suggested that professional associations play a role in promoting a recognition of professional work for what it is and in changing the professional bureaucracies "by the slow process of changing the professionals." (1979, p. 379) Information about how the professional's sense of responsibility to serve the public and concept of professional conduct evolve will assist the professional association in fulfilling this role. The propositions generated by this study will contribute to the accomplishment of these goals.

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APPENDIX A
Semi-structured Interview Questionnaire

The following issues were discussed with participants at the outset of the interview.

1. Purpose.
   This is an exploratory study. It will attempt to describe the views--attitudes, principles and beliefs--in relation to professional conduct of members of a profession and it will endeavor to determine if any patterns exist in the means of influencing members' views. The study will also examine the impact of the professional association and its discipline policy implementation

2. Confidentiality and anonymity of participants.
   Confidentiality of tapes.

3. Nature of the questions: i.e., not looking for specific answers in most questions --answer in relation to what the question means to you.

1. What is your educational background and experience.

2. How do you define professional conduct? Restricted to practice? Outside practice? To what extent?

3. What has influenced your views--attitudes, principles, and beliefs--in regard to professional conduct? What impact has that had on your actions/behavior/practice?

4. How are your views--attitudes, principles, and beliefs--about professional conduct different from what may have been common among medical doctors practicing around the turn of the century?

5. Who should determine what is and what is not professional conduct?

6. How does the College define professional conduct?

7. What, and how, does the College communicate to you concerning professional conduct? What message, or messages,do you receive from the College? What means of communication are most effective?

8. a) What role does the College play in influencing your professional conduct? What role should the College play in influencing members' professional conduct?

   b) What do you think has, or has had, the greatest influence on your professional conduct?

9. What is the purpose of the discipline process within the College of Physicians and Surgeons?

10. What is your level of involvement (hold office, participate in meetings, attend conferences, read publications) with the College? With the AMA? Does your level of involvement with either of the professional organizations influence your professional conduct? If so, to what extent? Do you think your views--attitudes, principles and beliefs--in relation to professional conduct would be influenced in any way if you were to become more involved?

11. How would you describe the level of commitment of members to the College? the AMA? the profession?

12. What further comments would you like to make in relation to any other aspects of my investigation?

APPENDIX B
Invitation to Participate

«DATA addresses»

January 27, 1989

«addressee»
«street»
«city»
«code»

Dear Dr.«name»:

Your name was given to me by Dr. Larry Ohlhauser, Deputy Registrar for the College of Physicians and Surgeons. He suggested that you would be a good person to talk to in relation to a research study of doctors' attitudes toward professional conduct. Dr. Ohlhauser thought that you may be willing to spend one half to one hour with me for an interview.

The College has approved this study which is briefly outlined on the enclosed prospectus. Further information can be provided when we meet if you decide to participate in an interview. This research is the major focus of my Doctor of Philosophy program in Educational Administration at the University of Alberta.

I want to include your views in this description of doctors' attitudes about professional conduct and in the interpretation of factors which influence those attitudes. Along with comments from 20 to 30 other doctors, your participation will provide the College with valuable input. All participants will remain anonymous. Only the researcher will have access to the interview data which will be destroyed following its analysis.

Some participants will be selected in ways other than by the recommendation of the College. I know that the people selected by the

College and recommended to be participants in the study are among the busiest physicians and surgeons in the province. They are also, I understand, the doctors who have the most to contribute to the study. For this reason, I entreat you to seriously consider allowing me access to one half to one hour of your time for an interview. I assure you, Dr.«name», that your contribution will be received with gratitude, and treated with respect and confidentiality.

If you are willing to be interviewed, please have your secretary call me to arrange a time which is convenient for you. I may be contacted, or a message may be left for me at 459-7684. If I do not hear from you before February 08, I will contact you by telephone.

Sincerely yours,

Vicki Lyall

APPENDIX C
DEFINITION OF PROFESSIONAL CONDUCT

Organization of the Raw Data

The following table identifies the frequency of the descriptors used by the 26 participants to define the concept of professional conduct. The descriptors are organized in three categories: (a) cognitive, (b) affective, and (c) behavioral, and by country where training was received and by years in practice. Each category is listed in descending order of occurrence. Total frequencies are listed in the right hand column. The researcher identified a total of 50 descriptors.

Cognitive, Affective, and Behavioral Descriptors identified in Doctors Definitions of Professional Conduct

Cognitive							
	Years of Practice						
	Canadian training			British training			Total
	5-10	11-20	21+	5-10	11-20	21+	
number of participants	7	10	1	1	2	5	26
descriptor							
code of ethics/standards/set of guidelines	1	3	0	1	2	3	10
difficult to define, cannot define by writing down	2	4	0	0	0	1	8
moral/ethical component	4	1	0	1	0	1	7
central concern/doing what is best for the patient	3	4	0	0	0	0	7
respect/concern for patient's rights/dignity	2	4	0	0	0	0	6
responsibility that comes with privilege/social status	0	1	0	0	2	2	5
service before self/ altruism	0	4	0	0	0	1	5
public expectations	2	1	0	0	0	1	4

responsibility that comes with privilege/social status	0	1	0	0	2	2	5
service before self/ altruism	0	4	0	0	0	1	5
public expectations	2	1	0	0	0	1	4
the Hypocratic Oath	0	1	0	0	1	2	4
a way of life	2	0	0	0	0	1	3
a pattern of professional practice	2	1	0	0	0	0	3
dictated by the organization you belong to	0	1	0	0	1	1	3
something known intuitively/gained through osmosis	0	1	0	1	0	0	2
a culture distinct to the profession	0	1	0	0	1	0	2
little/no need for supervision	0	0	1	0	0	1	2
image/how one presents self to the public	1	1	0	0	0	0	2
provision of best/highest level service	0	2	0	0	0	0	2
good boy/girl	0	1	0	0	0	1	2
professional	0	0	0	1	0	0	1
tendency to think of misconduct	1	0	0	0	0	0	1
tradition	0	1	0	0	0	0	1
professional competence	0	0	0	0	0	1	1
to avoid stress created by stretching conduct to the limits	0	1	0	0	0	0	1
unstated or stated contract with patients	0	1	0	0	0	0	1
not judgmental	0	1	0	0	0	0	1

follow the 10 Commandments	0	1	0	0	0	0	1
an all-encompassing phrase	0	1	0	0	0	0	1
protect the public	1	0	0	0	0	0	1
preservation of individual/self	1	0	0	0	0	0	1

Affective

	Years of Practice						
	Canadian training			British training			Total
	5-10	11-20	21+	5-10	11-20	21+	
number of participants	7	10	1	1	2	5	26
descriptor							
trust	0	2	0	0	1	1	4
kind/caring	1	0	0	1	0	0	2
honesty	0	2	0	0	0	0	2
dictated by a clear conscience	0	2	0	0	0	0	2
empathy	1	1	0	0	0	0	2

Behavioral

	Years of Practice						
	Canadian training			British training			Total
	5-10	11-20	21+	5-10	11-20	21+	
number of participants	7	10	1	1	2	5	26
descriptor							
behavior/conduct/involvement	4	6	1	1	1	3	16
confidentiality	2	2	0	0	2	1	7
following government restrictions	0	3	1	1	0	2	7
relationship with patients	1	3	0	0	1	0	5
conduct with colleagues/ other health care workers	2	2	0	0	0	0	4
no sex with patients	0	1	0	1	1	1	4
no criminal behavior/fraud	0	2	0	0	0	2	4
stricter standards for medical profession	1	1	0	1	0	1	3
listen, include patients in decision making	2	1	0	0	0	0	3
fair billing	0	0	0	1	0	1	2
double jeopardy	0	1	0	0	0	1	2
conduct is very definite, ie. appearance -- lab coat and tie	0	1	0	0	0	0	1

unethical to "steal" colleague's patients	0	0	0	0	0	1	1
self-educating	0	0	1	0	0	0	1
can't have a drink at noon	0	1	0	0	0	0	1
interpersonal communication ability	1	0	0	0	0	0	1