Professionalism and Medical Work in a Post-Soviet Society: Between Four Logics

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Abstract

The relationship between the state, the market and professions has been in focus of sociological theories on professions. This study explores how Lithuanian physicians perceive these three sectors, called logics in sociological theories, to influence their work in a health care context which has experienced a rapid change.

The results show that the physicians perceived the state regulated health care system as a limitation to their professional identity and practice. Market elements of care did not seem to work and instead two other mechanisms bridged the provision of services between the client and the physician: peer referrals and gift-giving. The peer referral system enabled physicians to directly refer patients to a professional colleague outside the formal referral system and thereby to improve access to health services that the state directed system could not handle efficiently. Gift-giving and gratitude payments provided some consumer influence in the delivery of health services in a failing market system. The conclusion is that in a post-socialist health care system physicians are often operating in a system guided by four logics: the state, the market, professional culture, and the informal economy of peer referrals, gift giving, and extra payments.

Introduction

In the sociology of professions the medical field has been used as a prototype of a modern profession. Professions were defined in the early sociological literature as occupational groups characterized by a special knowledge and commitment to the welfare of their clients. This view derived from a functionalist perspective that pointed to functional authority and altruism as the two core features of professionalism (Parsons 1951). Functional authority was seen as based on functional specificity and biomedical authority (Parsons 1949:192). Altruism was presented as a feature that distinguishes a "professional man" from a "businessman" because the former is guided by "disinterestedness" in the monetary aspects of the transaction while latter is guided by self-interest in the outcome of a transaction (Parsons 1949:189). This difference in behavior was not seen as intrinsic to the two occupational groups. As the central figure of the functionalist perspective argued: "Perhaps it is not mainly a difference of typical motive at all but one of the different situations in which much the same commonly human motives operate" (Parsons 1949:187, see also Light 2000: 210). The conclusion was that the difference in behavior lies in the institutionalized norms that govern and regulate professional behavior in contrast to the individualistic behavior of businessmen who act on a free market.

The debate in the sociology of the professions has over the past forty years centered on the character of the norms and structures that guide the conduct of physicians as a collective group. The first prominent critic of the functionalist approach to professions was Eliot Freidson (1970a, 1970b) who presented an alternative view of the social position and professional behavior of physicians. Freidson's view was based on a social interactionist

perspective but his view on the importance of an autonomous profession changed, however, over thirty years (Brint 2006). In the early years of his work, Freidson challenged the functionalist and normative approach. His argument was that rather than acting as benevolent experts, physicians tended to promote their own collective interests and professional dominance over patients and other health occupations. The profession's service orientation is a claim that it makes in order to get society to grant it professional autonomy (Freidson 1970a: 82, 1970b). Furthermore, Freidson argued that physicians' work is not characterized by functional specificity but rather by pragmatism, subjectivism, and indeterminacy, a feature he called "clinical mentality" (Freidson 1970a:170-71). Freidson's early perspective on the medical profession's power and position has been known as the professional-dominance thesis.

The later Freidson (2001) embraced a theoretical standpoint that resembled the normative approach to professions that the functionalist perspective represents. Sensing the changing conditions for the professions between the logic of the market and bureaucratic regulation, Freidson (2001) called for a stronger role of professionalism—what he called the third logic—to protect the needs of the clients.

The purpose of our study was not to "test" the propositions presented by Parsons and Freidson but to use their concepts as analytical tools in describing the behavior and attitudes of physicians in a totally different institutional setting: a post-Soviet society. Lithuania is in the process of rapid change from a system of state medicine towards a system allowing a professional organization of physicians and some market elements of health care delivery. The question guiding the study was: How do physicians themselves define professional competence and how does their work relate to the state and the market in a health care system characterized by a rapid structural and cultural change?

For both Parsons and Freidson, the institutional setting of the medical profession was the American society, with a benevolent state granting licenses and autonomy to the profession, while the market regulated the distribution of physicians and patients' contacts with health care. But also the American setting has changed. The growing role of managed care and evidence-based medicine in U.S. health care delivery has resulted in a new external regulation of the practice of the medical profession (McKinlay and Marceau 2008, Timmermanns and Ho 2010). During the past decade, the age of neo-liberal health policies has witnessed an increasing role of consumerism and a new approach to public management. In the European context, the medical profession is no longer as strongly sheltered by the state as in the past (e.g., Kuhlmann 2006, Kuhlmann and Saks 2008). As a consequence, the medical profession now works under new conditions that can be described as a pressure from two types of logics—the influence of the market and regulatory state organizations.

Research on professions has mostly been concerned with the attributes and the power of professions in societies that have a market and a state composed of competing social forces. Professions have continued to exist under other conditions as well. In the Soviet Union the physicians were subordinated to the state not only in terms of being salaried state employees but also in terms of having no professional autonomy or an independent professional organization of physicians (Field 1957, Jones 1991).

The fall of the Soviet Union resulted not only in a gradual rise of an insurance system and a private market of health care, for example in Russia and some Eastern European states, but also in re-professionalization—that is, an effort to re-establish the academic and professional status and independency of the medical profession in post-Soviet societies (Field 1991, Twigg 2000, Rivkin-Fish 2005). As Osinsky and Mueller (2004:195) point out in their study of college-educated specialists in Russia, two features of the post-Soviet period are still different from Anglo-American professionals' status. First, most professionals in post-Soviet societies continue to work in bureaucratic, state-controlled environments. Second, most

professional practices are incorporated in the hierarchical structures of the state. Hence the restrictions in the professions' power and autonomy are not so much related to the inter-professional competition of jurisdiction in a market-based economy (Abbott 1988) as it is to the professions working in bureaucratic occupations regulated by the state (Jones 1991). The state still controls the salaries and the conditions of practice of physicians in many post-Soviet societies.

The concern with the institutional context of the normative structure of professional behavior, flagged up by the functionalist perspective on professions, has therefore gained a new salience in a context such as the post-Soviet societies. Therefore, what has happened with the physicians when the state medical system changed with the fall of the Soviet Union and the emergence of market forces in post-Soviet society is of sociological interest. In such a situation the state does not regulate the profession in the same way as before. The professional culture of a past self-regulated medical field is weak, since a working market and consumer influence have not emerged. Such changing health care systems constitute almost laboratory cases of the way in which new norms and institutional structures emerge to guide and regulate the behavior and attitudes of physicians. Such systems in transition have developed new arrangements for increasing the access to services to overcome the stalemate of the bureaucracy and the limitations of the market.

Some studies have described in general the system of informal payments in transitional economies and its function as a way for patients to get access to services in health care systems that are characterized by chronic underfunding in the former Soviet Union and Central and Eastern Europe (Thompson and Witter 2000, Gaal and McKee 2004). There are only few studies that have provided an empirical account of this informal payment system. A study of the maternity health system in the St. Petersburg region in the mid-1990s found that physicians perceived the bureaucratic health care system as a limitation of their practice. The study showed that providers and clients found it acceptable for patients to give gifts to physicians as an expression of gratitude for services rendered (Rivkin-Fish 2005).

A decade later, another study of women's clinics in the St. Petersburg area found that the physicians had adapted to the bureaucratic system by introducing an informal system of charging fees for certain diagnostic services (Larivaara et al. 2008). Although these services were provided for free by the public system, adding certain fees offered the clinics more stability to cover gaps in funding. For example, the income from the fees could be used to augment the salaries of the physicians and cover the costs in running the clinics, expenses which were not considered to have been estimated at a realistic level by the state. In short, extra incomes had become part of the operating system. This study did not include explicit questions about the transaction of gifts and extra payments to individual doctors.

The relationship between the three logics—state, the market and the profession—was in focus of Parsons's and Freidson's work. This study explores the core theoretical concern of Parsons and Freidson by examining physicians' views of what defines their professional authority and autonomy in a post-Soviet society—Lithuania. The larger study examined gender and medical careers and professionalism among Lithuanian physicians, and two widely different specialties—pediatrics and surgery—were chosen for this purpose (Riska and Novelskaite 2008). Pediatrics is almost exclusively (93%) a women's specialty, while surgery is a markedly male-dominated field in Lithuania—women constituted only 11 percent of surgeons in 2004.

An unexpected outcome of the interviews was recurrent views on the role of informal payments. Accounts on the impact of informal payments, the state, the market and the character of professional knowledge and conduct are the focus of this study. The study asks how do Lithuanian surgeons and pediatricians define their professional competence and what kind of logics governs their relations to patients in a rapidly changing health care context?

Methods and data

The data for this study were collected by means of semi-structured interviews. Lithuania lacks a complete national register of physicians, like western countries have available (Gaizauskiene et al. 2002). A snowball sample was therefore used to provide a reliable method for recruiting the informants for this study.

Thirty-six physicians who practiced in Kaunas and Vilnius in Lithuania in 2005 were recruited for the interviews: 15 surgeons (7 women, 8 men) and 21 pediatricians (14 women, 7 men). Five interviews were conducted with surgeons in Vilnius from the end of January to the beginning of February 2005. All other interviews were conducted in April 2005 in Kaunas and in May 2005 in Vilnius.

The purpose of the larger study was to explore the professional identity and professionalism among physicians in Lithuania. The interview schedule contained 18 questions that mapped the following themes: the choice of medicine as a profession and specialty, perceived qualities needed for practice, gender aspects of practice, career opportunities, the specific culture of the specialty, views on changes in medicine, information about family, and plans to migrate. The participants were encouraged to elaborate when they raised other topics.

The interviews were conducted in Lithuanian at the physicians' place of work and lasted on average between 40 and 60 minutes and were tape-recorded and transcribed verbatim. All interviews were translated into English. The acronyms MS and MP in the citations in the text mean male surgeon and male pediatrician respectively, and FS and FP stand for female surgeon and female pediatrician respectively. The informants were divided into three age groups: informants who were 40 years and younger are named "young," those who were between 41-54 years old are named "middle-aged," and those who were 55 years old and older are called "older."

The data reported here are focused on the coding frame "professional competence" and "occupational culture." The data on the two themes derived mainly from two items in the interviews that asked: 1) "What kind of skills and personal characteristics does a professional in your field need?" and 2) "Is there a certain occupational culture in your specialty?" In addition, views on the changing conditions for practice derived from the question "Has the work in your specialty changed during the past decades? How? Why?" A thematic analysis was used in the reading of the interviews (Charmaz 2006). After an initial review of all the transcribed interviews, the analysis of the data proceeded by means of focused coding (Charmaz 2006:57). Both researchers of the study reported here read all the interviews and assessed the agreement on the coding frame.

Results

It was evident from the interviews that medical practice was influenced by the fact that the Lithuanian health care system was undergoing a rapid structural change. The physicians described in critical terms the structural features of their work, how these features related to the broader division of labor in health care, and how lack of resources in the health care sector set limitations for their own work. But it was not only the health care system that was changing – other basic institutions in society, such as the state and family, were changing as well. Hence, although the physicians dwelled mainly on the character of their work and work conditions, they recognized broader structural changes in society that impinged on their own work and practice setting.

When probed to reflect on the core skills and special knowledge that define a good practitioner in surgery and pediatrics, none of the informants defined their medical authority merely based on biomedical knowledge. Instead, professional competence was perceived as a practical skill that had been refined after years of practice. For most of the physicians, professional competence was identified as a specific professional conduct expected of the members in the specialty.

Functional specificity and diffuseness in medical practice

For the surgeons, surgery was physically demanding work that required endurance and concentration. This capacity was embodied as a skill in exercising self control and having management skills. Surgery was described as performed by a larger team (i.e., nurses, an anesthesiologist) headed by the surgeon. A military metaphor was often referred to in the portrayal of both the surgeon's self discipline and his or her command of a team invading the body and fighting the disease. As two young male surgeons summarized the required qualities for being a surgeon:

> Surgery is ... physically demanding and it is related to the physical strength of the person and not so much to abilities, talents, or something like this... Of course, /.../ male surgeons might perhaps be more committed because surgery is an area where working hours are not limited. For a woman, there is a family, kids anyway. So you see, home concerns have an impact ... it is the same all over the world. Surgery, in particular, it is for sure a physically demanding job. You have to devote yourself to it. MS3

> You need endurance, time and desire. MS28

A middle-aged female surgeon presented a military metaphor to describe the requirements of being a good surgeon:

> Not everyone can be a surgeon. You can dream about it, but there are some specific requirements in surgery. People need to be well disciplined in order to be able to work under very strict circumstances, like in the army; where [it is] necessary – to leave everything else behind and only do your job. One has to act very fast. I think that it is a specialty that demands certain army [military] qualities. Not in terms, that, you know, people exert power over each other. No, rather that a certain discipline is needed, internal discipline. FS5

The expected professional conduct was framed as being aggressive and acting speedily because decisions were to be made fast as the surgical procedure progressed. As an older male surgeon depicted the work:

> The job of a surgeon, I would say, is intensive, aggressive, especially, during the operation. MS31

The male ethos embedded in surgery was evident, a feature that has been brought up in other studies that have mapped the culture of surgery (Cassell 2000, Zetka 2003). The masculine physical features of surgical work and the idea that women are not, therefore, suited to be surgeons were identified by an older female surgeon:

> First of all, I believe you have to be devoted to your job: committed to your job, to people, to your patient. Later on, of course, you need some other qualities, I would say, specific masculine features. Yes, you need physical strength – our operations are sometimes physically demanding. Well, there is just, as we say, at times the job of a blacksmith – fixing mini plates, screwing bolts, fixing broken bones. It seems sometimes that a weak woman—weak in terms of physical strength—could hardly do that. FS24

In the same way as surgeons, pediatricians did not identify a specific biomedical knowledge as characterizing the functional specificity of their specialty. Instead, professional competence was defined in cultural terms. A pediatrician needed three professional abilities: a good memory, communicative skills, and a certain professional conduct. As a middle-aged male pediatrician described the skills and professional behavior needed for "good work" in pediatrics:

> So, well, for medical doctors, one among many key things, or the main thing, is good memory. Special abilities are not necessary but you need to have a good memory, because all the time you need to have on your mind a huge amount of information about diseases, about medicines, and about everything else. So, good memory and later, communication with people is the key to successful professional activities. I would say that something like eighty per cent of the success is due to communication with the patient. If you are a nice person and you communicate easily, then you will be a good physician too. MP12

And he continues:

> We are, I guess, a little bit different from, let's say, surgeons, who are rougher (laughing). We need to be little bit more sensitive and conceal our emotions, negative emotions, control them, because there are two patients [child and parent] with us and they are very sensitive, both of them. MP12

The pediatricians viewed a certain childlike attitude to be desirable and it was often necessary to regress to this capacity in order to understand children's mental world. The dependency on the parents' (generally the mother's) presentation of the "case" was seen as an extra complication in this specialty. The anxiety of the parents often interfered with the direct communication with the child, who was the patient. These professional skills were identified by two young female pediatricians:

> I think, you need certain childlike features and ... that's different from, let's say general practice. Certain childlike features are necessary in order to get a close contact with the child. Communication skills and patience, of course. FP19

> I guess we are somehow happier because we work with kids. Well, basically, this is the issue. For every specialty, there is something specific. We [pediatricians] go back to childhood again (laughing). FP10

In conclusion, professional competence in surgery and pediatrics were defined in very pragmatic terms by the members themselves. For both surgeons and pediatricians

professional competence was defined in terms of a certain conduct and professional culture which grew out of the functional requirements of work rather than based on an overarching normative structure of professionalism—the third logic (Freidson 2001). Instead, the features that defined professional competence captured the notions of pragmatism, subjectivism and efforts to overcome indeterminacy that the early Freidson studies (1970a:170) called clinical mentality.

The fourth logic influencing medical practice

The informants pointed to certain informal practices that existed as an adaptive system in a health care system that was characterized by a flux in the three logics: the state, the market and the profession. The health care system was bureaucratic and contained quotas and limitations for the physicians and the market elements of health care delivery did not function yet. Three informal mechanisms existed to overcome the rigidity of the bureaucratic structure of the formal health care system concerned with influencing the distribution of services: 1) peer-referral, 2) having an extra income, and 3) consumers paying gratuities or giving gifts.

First, peer referral is a standard feature of a health care system where physicians have professional autonomy and work in a system controlled by the medical profession (Light 2000). In more bureaucratic systems direct peer referrals are restricted. The direct peer referral system was not part of the formal health care system in the Lithuanian context but it had grown out as an informal practice to ease access to services. The character of the peer-referral system was described by a middle-aged female surgeon in the following way:

> A man with an infarct can't wait for a month before the cardiologist will accept him, or a man with cancer [can't wait] for two months to get into the in-patient department, because the referral is administered by the family doctor. And he has limited quotas and possibilities. It's different for me – I know to which doctor I could send my child or husband, or where to go myself. I know. I'll come to him through the back door and he'll accept me. He won't refuse me. And he'll also come to me through the back door. It'll be almost impossible to get [services for others]. If your eyes feel bad and you must wait for three weeks for the ophthalmologist, what will happen to your eyes during those three weeks? FS1

The patients were also part of the informal transaction of services. As the same female surgeon described the informal network:

> In fact, my patients have helped me rather much. When I take a patient, who is beyond hope, and I cure him with the help of God, he will help me in various ways afterwards. Some of the patients are rather famous people or their relatives – or children, or parents, or somebody else, brothers, sisters—and they help me to fight for my [professional] position. Even now there are patients with [specific diseases], who are actually doomed to death, and one is not allowed to do anything. But there's one, there's a second and a third, and it's very difficult to stop [them]. Friends [of high status person] are needed. FS1

Second, the two specialties—surgery and pediatrics—were referred to in the interviews as contrasting cases in that the income of medical practitioners differed. In health

care systems in transition like Lithuania, income differentials are not merely related to the salary as a state-employed physician, but also to the opportunity to earn money on the side, for example to have several jobs at the same time or to the opportunity to get gifts and gratuities from patients. For some, the direct informal economic transaction between the physician and the patient was part of everyday work, while for others the extra income involved a conflict of interests for a profession that is not supposed to be guided by economic incentives but rather by altruistic motives.

Pediatrics had one of the lowest salaries among all the specialties. For many pediatricians the lack of economic incentive defined the moral character and hence professionalism of the work. A young female pediatrician described the low salary as a definition of the intrinsic altruistic character of the work, because there was no self-interest involved in doing the work:

> I don't have to survive on my salary. I can love my job because I don't have to survive on my job income. It is merely a hobby to me. Maybe, because of that, I love my job and maybe my attitude is different, because I love it for sure. And I don't care how much I will be paid. ... But I can afford that, because I am supported by my husband. If I was not, then, I don't know what would happen then. Probably, then, I would see every patient as, not as a possible bribe giver, but as my source of income ... Yes, I guess, I would have such an attitude then. But now, I can afford to be proud and not to treat my patients in that way. But I am not sure what would be the case if I didn't have money to buy food for my kids. FP33

In general, pediatricians (93 % were female in the specialty) portrayed their economic situation as being dependent on a partner's income. The female majority in the specialty was considered a result of the low salary and the fact that so few men were attracted to the specialty. As a middle-aged female surgeon observed:

> [Women are in majority in pediatrics] because this is such a poorly paid specialty, like many other fields of medicine, too, except surgery and gynecology. The salaries are just a tragedy, so how can a man be a pediatrician? FS35

The low salary levels were amended in surgery by earning money on the side. A middle-aged female surgeon described the way that this system worked:

> I think that physicians' salaries are very low. /.../ I think that a person is just lured to take bribes. Because… if you get, let's say, 800 litas [about 231 €] in a tenured position, and all your days and nights you spend here [at the hospital]. During weekends you must go with your own car to the patients to bandage them. And you cannot tell the patient that he needs something, so you just buy it for your own money for him. Therefore, money is a problem. For example, if a male doctor, who should support his family, gets such a low salary, he has two choices. He either quits and looks for a job with a higher salary or, if he's honest, he decides not to take [money] from patients, not to extort them. Or he stays and takes [money] from the patients and collects at least two sources of income, otherwise he can't support his family. I don't think that's very nice. FS1

Third, gift-giving or gratuity payments from patients were part of practice. Some pediatricians noted that getting money on the side is rooted in a system of gratuities flourishing in Lithuania. As a middle-aged male pediatrician characterized the difference between the practice of pediatrics and surgery:

> If you go out and ask people, they'll all say the same thing: yes, [you should probably bribe] a pediatrician, but you *always* have to bribe a surgeon, because he [won't treat] you otherwise. Everybody says it, and it means a surgeon earns more. MP32

An older male surgeon lamented that the pattern of gift giving is a problematic feature in surgery.

> The fact is that the patients tend to bring you a bottle as a sign of appreciation and it destroys some surgeons, who have started drinking and who have lost everything, health, profession, and even their lives. So, well, these are secrets. You have to resist these things. MS31

Another older male surgeon described how the system of gift giving works in surgery:

> The unofficial price list is just there in the air… And it is very well understood among the patients. As a rule, what we're talking about happens before the operation. In Lithuanian there is a concept of 'gift'—put that down as 'bribe', if you like … if the patient gives something before the operation, we shouldn't accept it, because it's a bribe ... But, [surgeons] certainly make much more [than their salary] on account of the principle that I've mentioned. MS20

In conclusion, in a changing health care system both the bureaucratic structure of the state and the market and consumer control fail as mechanisms to regulate the provision of health services. In post-Soviet societies like Lithuania, the profession is so far unable to set its own fees and its conditions of work and to act as an independent "third logic" between the two other logics, the market and the state. Instead a fourth logic has developed: an informal economy whereby patients get access to services by means of various arrangements—peer-referral, gratitude payments, and gift-giving—and the practitioners get the income that they perceive as possible with a working market. These arrangements could be characterized as consumer and physician controlled but they can also be viewed as being interconnected: clients' gift-giving and extra payments is a way to influence the services of a particular physician but this practice might also secure the use of the peer referral network in gaining access to special medical care in the future.

Conclusion

In the functionalist view on professions (Parsons 1949, 1951), the medical profession has been used as a prototype of the autonomy and special service mentality that characterize certain occupational groups. In his early work Freidson (1970a) argued that a clinical mentality, or particularism, better described physicians' attitudes and thinking than Parsons's abstract view on collective norms that guide professional conduct. In his latest work Freidson (2001) returns to a Parsonian normative approach when he highlights the importance of an independent profession because he considers the profession as a carrier of the spirit of professionalism that guarantees the quality of services and the interests of the patients.

Neither surgeons nor pediatricians in our study perceived their work as an independent profession because the state regulated health care system was identified and viewed as a limitation of their practice. Instead the professional elements of practice were defined by the professional culture of practice. Our study of Lithuanian surgeons and pediatricians shows that the skills required for professional competence were seen as based on the technical requirements for and individual experience with the practice in the specialty, a feature that Freidson (1970a) called a "clinical mentality." The surgeons were, however, more functionally specific in describing their work, while the pediatricians used particularistic criteria to describe their more functionally diffuse work tasks.

Market elements of care did not seem to work and instead our informants identified a fourth logic that secured access to services: peer referrals and gift-giving and extra payments. The peer referral system was a physician controlled system, which aimed at helping to secure patients' access to special services that the state directed system could not provide efficiently because of an underfunded health care system. Informal payments in the form of gift-giving and gratitude payments was a consumer initiated system that provided some consumer influence in the access to health services that a market promises to handle but one that is still constrained by a heritage of state medicine. Nevertheless, the peer-referral system and gift-giving should not be viewed as two totally separate systems but rather as interconnected so that gifts were given in order to obtain and secure peer-referrals in the future.

The results of this study show that in a post-socialist health care system physicians are operating in a system guided not by three but by four logics: the state, the market, a professional culture, and the informal economy of peer referrals, gift giving, and extra payments.

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