

The Discontent Doctor Physicians' Experiences of Medical Practice and Health Care in Sweden 1990-2002. A Qualitative Study

HOŞNUTSUZ HEKİM

İSVEÇ'TE HEKİMLERİN TIBBİ UYGULAMA VE SAĞLIK BAKIMI DENEYİMLERİ
1990-2002 NİTELİKSEL BİR ÇALIŞMA

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Abstract

During the last 10-15 years a discontent of the medical doctor is obvious in international literature. In a qualitative study using a phenomenological approach data were collected by interviews. I have interviewed 10 Swedish physicians about their clinical work. Half of them worked in general practice and the other half in different disciplines in hospital care. The purpose was to describe the experiences and self-assessed attitudes of medical practice among Swedish physicians the last decade.

The interviews were analysed by a phenomenological method. As a result I found that physicians have a feeling of frustration, control, misunderstanding but at the same time joy over clinical work. A common pattern was a lack of understanding for the new organisational demands, mainly economic and priority thinking. The implications for practice by understanding the mechanisms of this collective frustration are obvious. Physicians as well as the health care organisation must provide education in ethics, philosophy in science and medical sociology, concerning the new demands in health care. Together all parts must create better ways for communication between administrative levels and physicians. A true dialogue can result in a trustful relation.

Key Words: Discontent physician, medical practice, health care, Sweden, medical sociology

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Özet

Tıp doktorunun hoşnutsuzluğu, son 10-15 yıl boyunca uluslararası literatürde aşikardır. Olgusal yaklaşımın kullanıldığı niteliksel bir çalışmada, bilgiler, görüşmeler yoluyla toplandı. On İsveç hekimi ile klinik çalışmaları hakkında görüştüm. Bunların yarısı genel hekimlik ve diğer yarısı hastane hizmetlerinde farklı disiplinlerde çalışıyordu. Amaç, son 10 yılda İsveç hekimleri arasındaki tıbbi uygulamalarda deneyim ve özdeğerlendirme tutumlarını tanımlamaktır.

Görüşmeler olgusal yöntemle analiz edildi. Sonuç olarak, klinik çalışmalar sırasında, hekimlerin hüsran, kontrol, yanlış anlama duygusuna sahipken, aynı zamanda haz duygusuna da sahip olduklarını buldum. Genel örnek, çoğunlukla ekonomik ve öncelikli düşünme olmak üzere, yeni organizasyonel talepleri bir anlayış eksikliği idi. Bu ortak asabiyet mekanizmalarını anlayarak pratiğe dahil etmeleri açıktır. Sağlık bakımı idaresi gibi hekimlerin de sağlık bakımındaki yeni taleplerle ilgili olarak etik, ilim felsefesi ve tıbbi sosyolojide eğitim sağlamaları gerekir. Bütün kısımlar hep birlikte, idare ve hekimler arasındaki iletişim için daha iyi yollar yaratmalıdırlar. Doğru diyalog, güvenli ilişki ile sonuçlanır.

Anahtar Kelimeler: Hoşnutsuz hekim, tıbbi uygulama, sağlık bakımı, İsveç, tıbbi sosyoloji

Medical practice and health care in Sweden, as well as in other western countries, has undergone a massive change during the last 10-15 years. Today, new and expensive technologies and more tight financial frames, have put forward the need for a new leadership.

At the same time the awareness of treatment possibilities in the population has increased. Medical practice is

more potent than ever but at a higher cost. The financial support in Swedish health care is provided by taxes, and has not increased at the same ratio.

Medical practice is regulated by political and administrative decisions. The physician must co-operate with these parts. Therefore the physician also must have skills in communication, not only with the patient and the clinical co-workers, but also with political and administrative levels. Competence in economy and how to make medical priority decisions is needed. Today all parts must accept choices between patient groups and therapeutic modalities, based on priority and cost-benefit. The role of the physician has since antique Greece tradition focused upon the single patient. That is still the case, but the physician must be sure that the patient in front of him is the one with the largest needs.

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The role of the medical head of the department has changed the last 10-15 years. By tradition the most clinical experienced physician became head of the department. In the 70-80ths the financial demands was more flexible and new therapeutic modalities were incorporated in clinical practice no matter the cost. The hierarchic structure in clinical medicine was pronounced and no one questioned the leadership. Patient autonomy was rare and a patriarchal view was the rule. In the 90ths new demands came up. The medical leadership became a profession of its own, with economic and administrative responsibilities.

During the last ten to fifteen years physicians have seen their autonomy being gradually eroded and the decision making process becoming mechanised. Economic and political forces have contributed to this change. The professional caregiver has become purely operative.¹

The discontent of the medical doctor is a recent international discurs. If one takes part of the scientific literature this discontent is evolving from 1980ths. The deep and frequency of this question becomes obvious from 1995. D. Mechanic (2003) describes in JAMA how most physicians report overall career satisfaction, but increased public and patient expectations and administrative and regulatory controls contribute to feelings of time pressure and erosion of autonomy. Adoption of information technology and disease management programs is pointed out as constructive strategies that can empower physicians and relieve frustration.²

In the physicians discontent and frustration is also embedded and anger. In a paper, "Dr. Discontent", R Haugh et al (2002) describes how angry doctors is setting up niche facilities that compete with hospitals.³

Another study showed that physicians' cost awareness is related to greater discontent with working conditions including personal well-being. Physicians autonomy and influence over the work processes need to be considered Forsberg et al (2002) stated in order to decrease the discontent.⁴ A structured telephone interview with over 400 generalist physicians investigated the impact of the physicians' perceptions of the health care system on their discontent. Findings suggest that physician discontent can be predicted by their negative perceptions of the health care environment.⁵ Another important study compared physician satisfaction between 1986 and 1997. General internists and family practitioners in Massachusetts participated. Physician satisfaction was measured. Overall, physicians in 1997 were less satisfied in every aspect on their professional life than 1986 physicians. Family practitioners were less satisfied than general internists. The majority of the physicians were dissatisfied with the amount of time they have with individual patients.⁶

Sotile (2003) has investigated physician burnout and the complex work / life balancing. The importance of visionary medical leaders recognizes this dilemma.⁷ The

complexity is also reflected in a study where doctors' emotional responses to recent death of a patient were investigated. The more time and continuity with a patient the physician get to know them better but this also makes the physicians more vulnerable to feelings of loss when a patient dies.⁸ Health care systems today with time pressure seem to shelter physicians from this emotional stress.

Material and Methods

In order to fully describe the experience of working as a physician in Swedish health care, a phenomenological study was undertaken. Interviews using an unstructured format were chosen as the research method. The philosopher Edmund Husserl created the modern phenomenology. It focuses on the lifeworld perspective, which goes back "to the things themselves".⁹ It understands the world as a phenomenon, i.e. as people experience it. The lifeworld is unique for each person, but can be shared with others. Phenomenology as a research approach aims to describe the experience of the everyday world in its varied complexity.

The phenomenological method involves, according to Giorgi (1997), three criteria. In the analysis of data one first make a description of the concrete and specific experience. Secondly the phenomenological researcher must try to withhold past knowledge about the studied phenomenon. Thirdly one search for the so-called "scientific essence", in other words the general structure of the phenomenon.¹⁰

Sample. Inclusion criteria

The sample consisted of ten Swedish physicians. They were all interviewed in the year 2003. Their age varied between 35 and 64 years and they were all in clinical work during the period 1990-2002. Five of them were general practitioners and the rest worked in hospital care (1 surgery, 2 internal medicine, 1 orthopaedic, 1 dermatology). They were strategically scattered in the country and the aim was to gain a broad spectrum of specialities. The physicians were selected randomly.

Procedure and data analysis

Consent to interview was obtained from each physician. They were assured that participation in the study was anonymous and that all information would be treated confidentially. The regional ethical committee at the Karolinska Institute, Stockholm, Sweden, obtained ethical approval and permission to undertake the study.

The open, unstructured interviews lasted 40-80 minutes. The initial question was: *Can you tell me how You experience Your medical practice in Swedish health care 1990-2002?*

The physicians were asked to describe the experience as deeply as possible using narrative to express all their feelings and thoughts. During the interview dialogue the researcher posed questions such as: *What do you mean? Can you explain it more? How did you feel? What did you think? Please give an example!*

The interviews were transcribed and analysed to identify meaning. Meaning units were marked and organised into different themes. Finally the essential structure was formulated.¹¹

The investigated phenomenon was the physicians' experiences of their medical practice. An open attitude was maintained even in the analysis process by repeatedly returning to the data. Since the researcher also is a physician it was important to protect an open approach and try to withhold past knowledge about the studied phenomenon.

Findings

The physicians' experiences of their medical practice in Sweden between 1990-2002 were expressed in four themes. From these themes an essential structure emerged.

1. Frustration

Among these physicians there existed a strong feeling of frustration. This occupational frustration has a complex background. Increased patient autonomy and decreased professional autonomy belongs to this background. Unrealistic view of the abilities of medicine as expressed by the public is another factor. A pattern in the interviews was a strong feeling of not participating in the development of the care.

"It does not matter what one thinks and says. Nobody is listening. The administrative people do not understand us. I feel like a guest worker without influence".

"Decisions is taken above our heads, every day it is the same thing".

This quotations reflects a feeling of diminished power. The frustration can be described as a discontent that is cultured in the medical group:

"One important room for discussions about our discontent is during lunch. We can sit some hours and talk about the misery. But sometimes I feel even worse after".

In some interviews a feeling of collective and personal insufficiency is prominent:

"I think we have a deep feeling of insufficiency. We are misunderstood".

This has connection to changes in medical practice:

"We must recognize the limits of our work. Is it our problem that many people have difficulties in their lives?".

Increased public expectations is also a factor that helps to explain frustration:

"The demands from the public has increased, that is a major change. Of course we can do more nowadays but peoples expectations is the hardest thing to cope with. And many patients are frustrated and even angry. And they blame us. I use to tell them that it is not my fault that they became ill".

2. A feeling of administrative and regulatory control.

This theme is of course also a factor of frustration. It includes fear of report of misconduct:

"And all the time there is a risk of being accused for malpractice".

Control is experienced as increased emotional stress. The feeling of pressure is overall but mainly concerns time pressure:

"We have no time for reflection"

In front of all time pressure relates to decreased time with individual patients. This is related to decreased satisfaction with the quality of care:

"Today the meaning of caring is curing. We have no time for compassion and comfort. Perhaps it must be like that, I don't know".

The interviewed physician have a ambivalence in relation to regulatory control concerning clinical practice, i.e. evidence based medicine (EBM). EBM can offer a safe structure and a certainty that they make the best choice. But several of the interviewed physicians also discuss the risk of reducing the art of medicine when EBM is practiced.

Regulatory control demands a higher cost-awareness, but:

"When administrative leaders demands that we should select patients they never themselves have to say to the patients that no help is available. It is frustrating when the demands and the resources is incommensurable"

At the same time physicians experience decreased private economic incentives:

"Our work has expanded, but our financial outcome has relatively decreased. Then it is not hard to understand that many colleagues have private practice parallel to the ordinary work"

They express lack of knowledge about health care re-organisation. The increased paper-work is experienced as a negative factor. Physicians also talk about decreased potentials of achieving professional goals. The trust of the system is very low:

"All the leaderships beautiful words are only empty shells".

Changes as a threat is a perspective in several interviews:

"The feeling of the occupation, the right attitude, it takes time, several years, to reach that. To become a real doctor. And when I reached that point suddenly everything around changed".

Or:

"It was a lovely thing to be a doctor, but today everything has changed".

Or:

"We are a profession of supermen but someone has stolen our wings"

3. A feeling of being misunderstood. Fight for physicians' perspective and patients rights.

A general perspective among the interviewed physicians seems to be the feeling of being a part of the medical society or sub-culture. Inside this group one understands each other but outside there is a mutual misunderstanding. In several interviews physicians regard themselves as advocates of the patients:

"We only care for our patients".

In some interviews the perspective is sharper:

"We take the fight for the patients, we struggle against the administrative leaders and the politicians because they want to rule us. They want us to be depressed. We are the victims."

Medicine is a cultural system and its concept is embedded in the medical practitioners. Even if this medical cultural system is very complex in this study we can recognize some common patterns. One key quotation is:

"We have a language that only we understand and so it must be. It is precise. We are another kind of human beings". Or:

"No one knows how it is to carry all the clinical responsibility upon ones shoulders".

The medical cultural system offers a protection from the outside world, but can also be repressive:

"Some of the colleagues that have joined the enemies, for example co-operated to much with the administration, is no longer welcome at our meetings. They are no longer real physicians".

Or:

"Physicians that become leaders must fight for the rights of other physicians, otherwise they are no good doctors. Otherwise they are traitors".

The medical profession is characterized by a high degree of autonomy:

"I don't want anyone to decide what I shall do. No one should interfere".

Inside this culture there are a more or less visible hierarchic structure:

"We are still highest in rank, no matter what the administration says, we are at the top of the pyramid".

This struggle against the system causes discomfort:

"We suffer, exactly as the patients of lack of continuity". Another interviewed physician talk about the doctors loneliness:

"Perhaps we doctors are very lonely. And we don't know who to blame".

The same interviewed physician tried to explain the discontent:

"Perhaps all this discontent is more a symptom of a shortcoming in self awareness and a lack of understanding for the needs of others. I think it is a reminiscence of paternalism".

Another interviewed physician puts a diagnosis to the medical profession:

"Perhaps we have a collective depression".

About the discontent another interviewed physician states:

"The discontent is soon the only thing that keeps us together. It has perhaps become a self up filling prophecy".

4. Joy over clinical work

Even if a high proportion of the interviews was about discontent and frustration the interviewed physicians all talked about the joy of working within the field of medicine.

"After all, this is the best and most important one can have. It is so very meaningful"

"I can be frustrated, but that is about organisation. I still love my clinical work"

The essential structure

The essential meaning of physicians' experiences of medical practice in Sweden 1990-2002 was a feeling of frustration, control, and misunderstanding but at the same time joy over clinical work. A common pattern was a lack of understanding for the new organisational demands, mainly economic and priority thinking. The classical medical ethics focus upon the single patient. To make medical priority decisions, that is, to be sure that the patient one meet as a doctor is the "right" patient, seems to be a relatively unknown perspective for most of the interviewed physicians.

Physicians feel a marginalisation and diminished power, both actively (by their own force) and passively by mainly administrative and political levels.

Many of the interviewed physicians asked themselves what was the right reaction. Should one struggle to preserve practice as it appeared in the 70-80ths, or should one try to re-orientate and understand the new demands, i.e. to accept them? Or perhaps modify them?

New technological and pharmaceuticals were accepted without doubt, but new economic and administrative structures were very much questioned. Most interviewed physicians meant that "some one else" should take the economic responsibility. Money could be taken from somewhere else.

Control over the situation results in increased self-esteem and self-confidence. Traditionally physician has a high self-confidence and self-esteem, but the recent decade(s) this has been challenged. Perhaps the often-described medical omnipotence of yesterday does no longer exist. This loss of subjective control seems to be the main reason for the collective frustration, discontent and

even unhappiness. Still physicians have the power over most diagnosis and treatment, even though they hardly think about it.

Another pattern in the interview material seems to be an unwillingness to change. This rigidity is perhaps something that characterizes the medical profession. Mentality changes is usually slow reactions, partly because of their quality preserving properties.

Discussion and Conclusion

The purpose of this study was to analyse physicians' experiences in order to increase understanding of the professional medical culture, ie it was a medical anthropological, sociological study.

The method of conversation applied in phenomenological research is a useful way to communicate. Physicians are used to be the giving part in health care relations. In this study this was reversed. In the research situation they felt free and comfortable.

Although the interviewed physicians are not representative of all physicians, there are some lessons to which can be learnt from this study.

The attitudes in medical profession today are partly characterized by discontent and frustration. But at the same time there is joy over clinical work beyond administrative regulatory control.

When hospital beds is lacking, when waiting time to elective operations is counted in months and even years, a gap in confidence between medical and administrative staff has emerged.

Physicians' experience of decreasing power leads to a feeling of being outside the system. This is serious and perhaps threatens medical quality. Medical and health care organisation must incorporate every profession in caring. The result of this study points out the need of a more deep dialogue between physicians and political and administrative professions.

To summarize there has during the last decade(s) been some important changes in health care: -An increasing gap between financial support and the medical technology

-Increased cost of pharmaceuticals

-A stronger and more imperative administrative management

-Altered indications for some operations (ex orthopaedic and ophthalmologic surgery).

-Higher demands in clinical documentation (more paper work)

-A movement towards more policlinic care.

-Patients' autonomy and decreasing paternalism. This is actually one of the most important changes since the 1980ths.

Physicians have since antique focused upon the individual patient in front of him. The medical society as well as health care organisations must also bear in mind that the concept of EBM excludes important structures in medical practice, i.e. the art of medicine.

Everything in medical practice is not measurable, and therefore qualitative studies have a complementary place in medical science.

If we focus on the physicians discontent it seems to be related to:

- Working conditions (time pressure, organisation etc)
- Expectations (physicians, societies, health organisation, public)
- power
- Self-attitude and the mentality of the medical profession.

For a more deep understanding of the mentality of the medical profession we need new scientific studies, both qualitative and quantitative. This is of crucial importance for the future of health care in a changing society.

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