Contemporary Themes

Changing status of doctors in Finland

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Summary

This short sociological study discusses the changing status of doctors, in regard to both non-medical administrators and the public. Though based on observations in Finland I also see similar trends in other countries, trends which are associated with rapid social change in the West generally. These developments will lead to changes in the esteem in which a community holds its doctors.

"The medical establishment has become a major threat to health. . . . In rich countries medical colonisation has reached sickening proportions, poor countries are quickly following suit. This process . . . medicalisation of life, deserves articulate political recognition. Medicine is about to become a prime target for political action that aims at an inversion of industrial society"—IVAN ILLICH¹

In modern states, the pressure for equality comes up against the Olympian prestige of professionals. The tension between these two forces has partly added to the increasing demand for centralised control of many activities which have previously been more loosely controlled. One example of this is the present-day trend towards increasing state control of health services in many countries.^{2 3}

Since it became independent Finland has been short of doctors, often resulting in a heavy work-load for doctors, especially those working singlehanded in the country. As a result many doctors have been receiving what others regarded as unreasonably high incomes and in the last few years they have been under heavy attack, particularly from radio, television, and the press. One might almost suspect that there has been a deliberate attempt to lower the esteem in which doctors are traditionally held. For example, in a radio broadcast in September 1974, a child asks a question of its mother, "Why do people who heal need the sick instead of the well?" Answer: "Well, isn't it a question of money?"⁴ In an article in the *Finnish Social Democrat*, a Finnish doctor, who is also a member of Parliament, writes: "The incomes of health workers vary even tenfold. Ten rounds ahead of others are the chemists, dentists, veterinarians, and doctors. They form perhaps 15% of the manpower in the field, but from the salary pool they are taking 30-35%." He ends his article thus: "Make the Medical Association insignificant! Form the Union of Health Workers."⁵

Community Health Care Act 1972

The Community Health Care Act, a major Act, reformed community health care: it introduced a systematic planning

procedure into the health service, whose aim was to introduce a uniform standard of care as to quantity, quality, and availability of services throughout the country. It aimed to change from hospital-oriented medicine towards preventive and outpatient care. It also introduced the concept of health centres as functional organisations in communities, and thus affected only those doctors working as community health officers, whose work included both public health and curative medicine. This welcome and basically sound Act took 11 years to prepare. Nevertheless, the Act included details connected with the relationship between the doctor and the local board of health as well as the former's position and security.

This relationship was changed in three ways. Firstly, the doctor's former voting rights on the local board of health were taken away, thus diminishing his influence. Secondly, contracts for the principal jobs in health centres were given for only four years, thereby tying them to the local elections. This led to feelings of insecurity about the future which might have affected the doctor's morale. Thirdly, local councils, which had formerly been unable to dismiss a doctor, were now allowed to do so without even consulting the National Board of Health.^{6 7}

The post of treasurer, who was also secretary of the board, was created as a link between the decision-makers and the medical technicians, although the doctor in charge of the "functional organisation" still had the right to be present at board meetings and to make proposals. Even so, the board had full power to withdraw this right. This change sometimes led to anomalous situations: for example, at a committee planning for local health needs, the doctor might even be excluded in the beginning—though this was the exception rather than the rule.

The new working conditions

The method of payment was also changed and doctors put on a fixed monthly salary, with an average 37-hour week with overtime pay based on a fee for consultation (paid by the local authority). This mixed salary system brought with it various restrictions on the normal daily work of doctors. One of these was the detailed work schedule which every doctor had to complete, giving his various activities three weeks in advance. He was restricted as to how often he could see patients during his overtime work in order to be entitled to a fee, on the number of paid procedures such as minor surgery, and on the fees for various certificates. In other words, ordinary doctors working in health centres were subjected to relatively strict controls.⁸ (This reform of the pay system was not in the Community Health Care Act but it was connected with its introduction.)

At the end of 1973 Finnish Medical Association statistics showed that for every three doctors working in hospitals one was working in health centres. Some 60% of hospital doctors undertook private practice, at least to some extent in 1973. There has been criticism for some years about private beds in general hospitals, and increasing concern about the effective use of hospital outpatient clinics. Already plans have been made

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which, if realised, will mean outpatient clinics working in shifts between at least eight in the morning and eight at night thus indirectly, but effectively, making it more difficult for doctors to work in private practice.* These plans may be justified by the expensive equipment in outpatient clinics and special departments which is underused.⁹

Similar pay for similar work

Increasingly during recent years the pay of hospital doctors has been compared with that of other hospital workers, but that of the former has usually also included income derived from private practice. These comparisons, which have also found their place in the *Journal of the Finnish Federation of Nurses* and elsewhere have aimed to show unfairness in the distribution of income and the principle, "equal pay for equal work" has been emphasised. This maxim also appears in the Report of the Committee on Education of Health Personnel.¹⁰

The number of doctors has increased relatively rapidly in the last decade (from 3693 in 1965 to 6020 in 1973. The density in 1973 was 1:790). The number of new students increased from 388 in 1965 to 599 in 1973.¹¹ With reform in medical education, the length of university training for doctors was shortened from 6½-7 years to about 4½ years, the major emphasis being on community health and behavioural sciences. After this academic period, training continues in hospitals and health centres for another three years or so when the doctor is licensed to work independently (that is, also in private practice). The final form of this additional training, such as length and qualifications, has not yet been decided. The first students training under the new system will finish their university course early in 1977. One curious inconsistency is apparent from comparing the current national five year plans for health centres and hospitals with the number of doctors expected to leave the universities in 1979-80: in 1980 1000 doctors will have no opportunity of completing their training.¹²

The selection policy for entry to medical schools has also changed and instead of the former six week course there is now a three-day one, and two new universities admit 10-15% of people who have had some higher education, including nurses. It has been suggested that all universities should reserve 10-15% of places for such people and that their education might count towards shortening their medical course.^{11 13 14} On the one hand, this reduction in the length of medical education might be justified by the shortage of doctors and the increasing demand for medical care, etc; on the other hand, there seems to be a danger of a glut of young doctors without a final medical qualification.

Plans for future legislation

The recent Bill by the Ministry of Health and Social Affairs *Practising Medicine in Finland*,¹⁵ makes some interesting points about a doctor's status. Its main emphasis is on education and qualifications but two features point towards restricting a doctor's independence and his right to continue his practice. Firstly, by a proposal to limit the age of a practising doctor to 65 (this is possibly unique in the whole world). Secondly, when dealing with a doctor's right to practise† it suggests that a doctor can lose his licence if he is imprisoned or dismissed from his job, even if his crime is unconnected with practising medicine (for example, imprisonment for theft could be a reason).

*The questions in the recent dispute between hospital consultants in the British National Health Service and the Government seem similar, with the State trying to gain more control over consultants by putting them on a standard working week of 31½ or 38½ hours, and the consultants seeing this as a threat to their traditional clinical freedom.

†At present a doctor may lose his licence only because of mental illness, abuse of alcohol or drugs, or because he is unable to practise without causing danger to his patients.

This Bill has not yet been presented to Parliament. In the proposed Bill *On Hospital Care*, the Ministry deals with plans for setting up hospital regions (where all the hospitals in the same region would be under a single governing body) instead of the current system where every special hospital in the region is governed by its own federation of communes. This would centralise the hospital administration beneficially and at the same time simplify the planning for the region. In the same Bill, the Ministry suggested, however, that the doctor in charge of a hospital would no longer have the right to attend meetings of its executive board. The doctors there would, in fact, have very little influence on running the hospital, and would hold their positions for fixed periods. This would also apply to the chief medical administrator of the region. Such an attitude is in tune with trends in many countries to reduce the status of medical administrators to an advisory or consultative role without administrative responsibility; and, instead, to increase the number of lay administrators (who often lack ability and insight into medical and health matters) who act as a selective link between the "experts" and the decision-makers.¹⁶ For example, the job description of the Chief Administrative Medical Officer of a Scottish Health Board states that he heads the team of community medicine specialists in the health board and is the chief medical adviser to the board. At the same time the chief nursing officer is responsible for the nursing services of the Health Board area. In addition, the executive groups consist of two key persons, the treasurer and the secretary (the administrator) and the latter seems to be the real "co-ordinator."¹⁷

The Government has also proposed to separate the university from the university teaching hospitals, but this Bill also has not been presented to Parliament.^{18 19} These ideas may have been carefully thought out, but their arms are not clear.

Some reasons for the current trend

Some of the main reasons for the current trend are: increasing knowledge of health by laymen; the uncertainty inherent in clinical medicine; the insufficient training given to doctors about society; the progress of medicine during the last 10-15 years; the emergence of other professions into the arena of patient care; the doctors' inability to see this development in time; the dissociation of doctors from other professional groups such as nurses, physiotherapists, hospital physicists, and psychologists, caused by the fear of losing some of their status and prestige to the other groups; the increasing political interest in health matters among people and politicians; the almost complete ignorance of political decision-making processes and community politics of most doctors; and general trends in the development of Finnish society (and modern society in general).^{16 17 20 21}

If we consider in more detail some of the points made earlier, especially those about education and salary, we can draw two interesting conclusions.

Firstly, the new kind of training, with emphasis on behavioural sciences and community medicine, will lead in a relatively short time to an entirely new generation of doctors whose attitudes and ideas may be alien to those of today's doctors who were trained in a different mould. We may call this stage a stage of changing attitudes and ideology among doctors. This changing of attitudes to meet more effectively the needs of the community at large, and possibly give more insight into the social and psychological attributes of the sick person, could be said to be beneficial to both patients and doctors. For doctors, we could call this stage one of psychological socialisation. But we must question whether these doctors, with their new kinds of education, are as well equipped to meet the demands and needs of curative medicine. After all, medicine is not merely social science, social work, or community health. Only time will answer this question. A relevant point here is what status patients will give to these newly-trained doctors with their shortened and reformed training.

Secondly, considering the salary structure in Western society, we can see that an interesting change has taken place. At one time a man's salary was regarded as compensation for his long training which provided him with superior knowledge and skills, and with responsibility, status, and prestige. This idea has, however, changed during the last decade. The new concept emphasises the principles of "salary based on task" and "the harder your work is, the better you should be paid." This comparison between "hard work" or "blue collar work," and "soft" work or "white collar work," emphasises the importance of former at the expense of the latter and is an interesting change in the western cultural ideology.

This change is not in any way limited to Finland, but is related to supply and demand in any western community. It reflects the increasing bargaining power of the "blue collar" worker which is connected with increasing income, increasing leisure time, and decreasing working hours. It is also true that if there were a change in education which would bring unskilled and skilled workers closer together, the wages of skilled workers would fall relative to those of unskilled workers.^{22 23}

In conclusion, all these changes represent a stage of development which is characterised by some of the classical methods for decreasing a profession's status—namely, increasing political control over working conditions and job security; increasing control over selection for entry into a profession; change in the educational system; an increasing supply of professionals; and the engineering of public opinion.

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The blood pressure of a 32-year-old woman with a normal reading of 120/70 rises to 170/100 after two months on the pill. The pill is the only practical method of contraception in her case. What advice should the doctor give?

It would be very unwise to persist with the present pill. Presumably it is one containing both an oestrogen and a progestagen, since these are the commonest. If there really is no alternative, then tentative trials might be made of one of the microdose pills, or one containing a progestagen only. But nobody has yet died of using a condom or Dutch cap, and in cases like this they really must be more than lightly considered despite their inconvenience. Best of all would probably be a laparoscopic sterilisation, or a vasectomy if there is a steady partner. The fallacy here is the belief that the pill is the only practicable method for her. Surely nobody would wittingly run the risk of serious disease and death because of contraception.

How can "hacks" of the palmar aspects of the distal phalanges of the thumb and fingers be treated? The condition seems common among housewives.

"Hacks" (fissures) of the volar aspects of the phalanges are commonly a feature of more generalised skin conditions such as atopic dermatitis and psoriasis, but also occur in people with just a dry skin. They are more common in conditions of low humidity. It is most important to avoid contact with detergents, which remove fats in the horny layer together with water-binding substances. Loosely fitting cotton-lined rubber gloves are helpful. Any primary skin condition should be treated on its own merit (for instance, local steroids for eczema—polyethylene occlusion should help but should be used only for short periods). Protection with a paste dressing (such as 1% ichthyol paste applied on old clean sheeting and kept in place with tube gauze) is often soothing and allows quicker healing. Once the fissures have healed the most important thing is the regular application of an emollient cream or paraffin ointment to the fingers immediately after washing the hands. Oil-in-water emulsions such as aqueous cream BP may be used as a soap substitute.

Does the regular use of liquid paraffin affect the absorption of essential constituents in the normal diet?

Liquid paraffin was introduced by Arbuthnot Lane in 1913. It interferes with the absorption of fat soluble vitamins A, D, and K and its use in the composition or preparation of food is forbidden by the "Mineral Hydrocarbons in Food" regulation (1966). By interfering with the circulation of bile liquid paraffin may disturb pancreatic digestion. A recent report describes a child with rickets resulting from overdosage of liquid paraffin who was cured by withdrawal of the drug.¹ Liquid paraffin may also interfere with the absorption of drugs. Patients with carcinoma of the prostate on oestrogen treatment are reported to have relapsed when given liquid paraffin.² The absorption of L-dopa may also be disturbed. Liquid paraffin may also cause lipid pneumonia. A full assessment of the drug is given by Avery Jones and Godding.³

¹ Sinclair, L, *Lancet*, 1967, 1, 792.

² Jameson, R M, *Lancet*, 1967, 1, 896.

³ Jones, F A, and Godding, E W, *Management of Constipation*, p 50. Oxford, Blackwell, 1972.

Are some children more susceptible to mite and flea bites than others, and are children more affected than adults?

Itching from the human scabies mite results from an allergic sensitivity to the mite protein, and the response varies from one patient to another, but age makes little difference. The other mites commonly concerned with irritation in man are those whose natural habitat is domestic animals and birds, and possibly fodder. These do not survive on man, and continued irritation comes from a persistent source of the mites. Again there is considerable variation in the response, but the age difference is not very obvious. The position with regard to flea bites is less certain. Fleas are usually found on cats and dogs. The reaction in humans is also due to an allergic response to the material injected at the site, and there is considerable variation in response, children usually reacting more than adults. This is why only some members of the family in contact with fleas have papular urticaria, and others, particularly adults, do not react in this way.