

*Full Length Research Paper*

# Health and illness, between culture and territory: On the practice of medical profession in Italy at the beginning of the third millennium

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In international literature there is a hypothesis on a shift in medical profession between elite and basis professionalists. Some authors are more radical, because they consider some medical specializations in different autonomous professions, sometimes in conflict between themselves. On the basis of these considerations, what does it mean to be a general practitioner in Italy nowadays? What is the relationship between doctors and patients in Italy? What are the relations in Italy, between doctors and other health professionals? The object of the research analysis is constituted by a sample of 1162 GP professionals who work in 38 Italian provinces located in 10 different regions. The data were collected with a questionnaire, composed by 60 questions, delivered through a face to face interview by trained inter-viewers. On the basis of Cluster analysis, 3 ways of interpreting the medical profession were detected: disaffected, enthusiastic and detached, the 3 identified possibilities to practice the medical profession – disaffected, enthusiastic and detached doctors - manifest themselves with different modalities especially if considered at a geographic (and cultural) level while confirming the fact that to be doctors - and practice - is intimately connected with the concept of health (disease-sickness and well-being) that from every culture and every territory emerges.

**Key words:** Health, illness, medical profession, GP, culture.

## INTRODUCTION

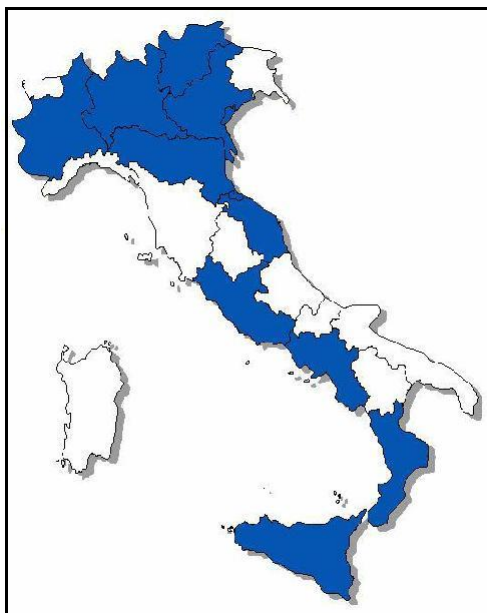
Is common opinion among social scientists that it's possible to split medical profession evolution in industrial countries into 3 particular periods, first of all the "professionalization" ones till the beginning of 20<sup>th</sup> century, the second, from the first world war to the 70's, in which the medical profession assume a dominant position among other health professions due mainly to the big development of know how of biomedical technologies and their applications in hospitals. Then, the third one from the beginning of 80's, due to the increase of sanitary costs, that consists in a radical change of health systems and professions. International sociological literature agreed on the fact that, in reason of the transformations in health systems also health professions are going in the direction of a radical change of their own relationships. On the other way round there is no agreement on the effect of these processes of change on the rule of medical profession, on one hand it could be in a substantial decline, on the other hand medicals will retain their dominance even if it will go to a different form.

In Italy there are non many sociological studies about medical profession as the rest of international literature, e.g.

France (Herzlich et al., 1993), Sweden (Svensonn, 1999), USA (Colombotos and Kirchner, 1986; Haug and Lavin, 1983; Hoff, 2000). In some of the international contribution, the hypothesis shows that there is a shift in medical profession between elite and basis professionalists (Speranza, 1999; Freidson 1970a, b). Some authors are more radical, in the sense that they consider some (not all) medical specializations in real, different autonomous professions, sometimes in conflict between themselves and are enabled to have identity more strongly than the whole medicine (Halpern, 1990 and 1992; Arliaud and Robelet, 2000; Tousijn, 2000; Zetka, 2001). On the basis of these considerations, what does it mean to be a general practitioner in Italy nowadays? What is the relationship between doctors and patients in Italy? What are the relations in Italy, between doctors and other health professionals? These are a few of the questions that the research has tried to address. The research has involved more than 1000 professionals nationally, who are working in 10 Italian regions (Cipolla et al., 2006).

**Table 1.** GPs interviewed for research unity.

Research Units	Regions	Frequencies	Percentage
Ancona	Marches	101	8.7
Bologna	Emilia Romagna	124	10.7
Cassino	Lazium	161	13.9
Catania	Sicily	138	11.8
Cosenza	Calabria	100	8.6
Milan	Lombardy	129	11.1
Salerno	Campania	128	11.0
Turin	Piedmonte	88	7.6
Trent	Trentino-High Adige	100	8.6
Verona	Veneto	93	8.0
Total		1162	100

**Figure 1.** Interested regions of sample selections (in blue).

In the context of the paper, after having presented a few of the socio-demographic characteristics of the GPs in Italy, the focus of the analysis will be on the different modes of interpreting the medical profession at the level of health care in relation with patients, colleagues and other health professionals in an historical moment in which deep transformations have occurred in Italy. The themes discussed in the research are rooted in the massive transformations that have impinged not only on the Italian health system (that has been particularly affected), but also the systems of other developed countries in the last 15 years. Let us think about processes of privatization of regionalization, the diffusion of consumption attitudes and behaviors even even in health and the processes of converting many health occupations into profes-

sional ones. These transformations brought to being, by various complex social operational dynamics, such as the crisis of the welfare state, changes at the political, demographic and educational levels (changes of the political system, demographic composition of the people and their education) have exercised a strong impact on the medical profession and its relation with other actors of the system. Literature relatively agrees on the process of change. The the medical profession had conquered in the past and maintained for a long time a position of power on the health system. Now this is changing. The medical profession is changing its place, if not declining.

## MATERIALS AND METHODS

The object of the research analysis is constituted by a sample of 1162 GP professionals who work in 38 Italian provinces located in 10 different regions. This research has been developed through the Italian federation of GPs. The universities of Ancona, Bologna, Cosenza, Cassino, Catania, Milan (Cattolica), Salerno, Turin, Trent, Verona have been involved in the analysis and sampling. They have worked under the direction and coordination of the university of Bologna and had previously worked together in other investigations regarding the sociology of health and medicine.

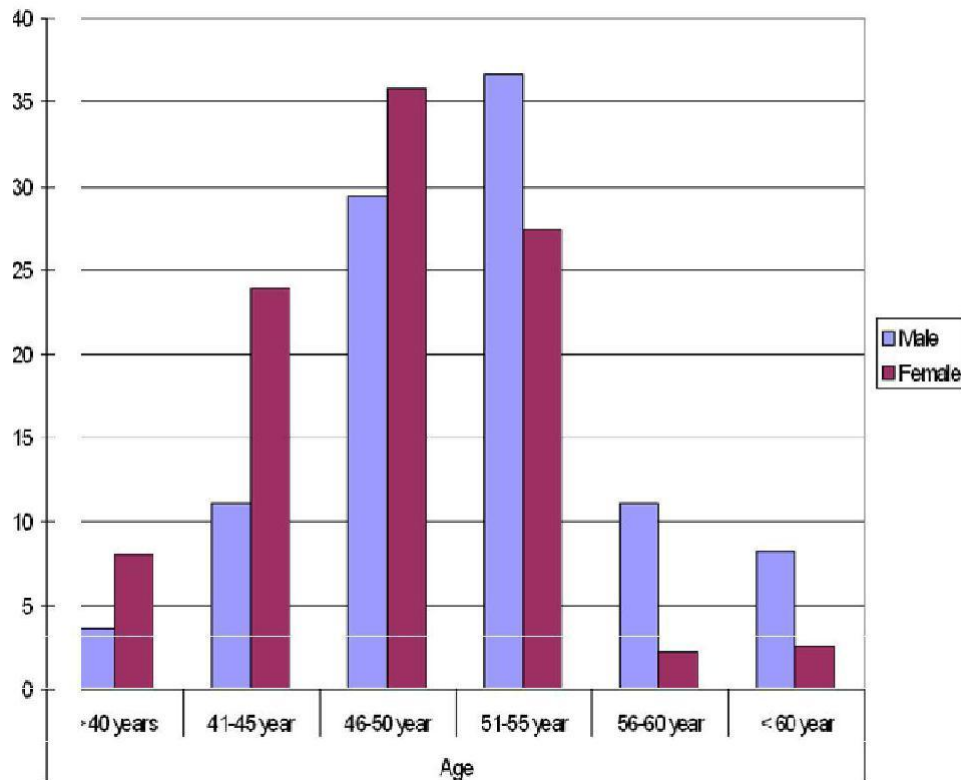
The regions and the provinces whose doctors are included in the sampling unit are the following, Piedmont (Turin), Trentino (Trent), High Adige (Bolzano), Sicily (Palermo, Catania, Caltanissetta), Emilia-Romagna (Bologna, Ferrara, Ravenna, Forlì, Parma, Piacenza, Modena, Reggio Emilia, Rimini), Lombardy (Milan, Brescia, Lecco, Praises, Mantua, Sondrio), Veneto (Venice, Verona, Treviso, Belluno, Padua, Vicenza), Calabria (Cosenza), Campania (Naples, Salerno, Avellino), Marches (Ancona), Lazio (Rome, Latin, Frosinone, Viterbo, Rieti).

In Table 1 we see the frequencies and the relative % of GPs interviewed from each research unity. In Figure 1 the Italian regions that have been involved in the research have been emphasized.

The main themes round which the voice of GPs have been documented are multiple and various, how are the challenges coming from the other actors of the systems perceived?. What is the evaluation that GPs make of the changes?. How have the relationships with the patients changed?. How have the relationships with the other health professions changed?. How do they evaluate guidance lines in health patterns and the spreading of non conventional therapies?. Which relationship do they entertain with the new information technologies?. What sort of needs do they have in relation with education and training?. Along these questions the research investigates also other more traditional sociological themes such as, the social origin of GPs, the professional identity of GPs, gender issues, the professional motivations, the tendency to associationism and other issues of interest. The load of data coming from the investigation performed, make up a rich empirical basis. On such basis, it is possible, nowadays, for the lively debate happening to develop arguments and make hypotheses which discuss the role of general medical practice in the Italian health system.

## Sampling method

The sample of GPs that it is used for the survey is not closely - a probabilistic sample. This is because not all the Italian regions have been object of interest from part of the investigators (and consequently the requirement of the equiprobability of being part of the sample for Italian GPs is denied). The research équipe has discussed over a long time span on the modalities of sampling in the phase of planning of the search and considering also the total



**Figure 2.** Age and gender of GPs.

budget available for surveying, the equipe has opted for a sample that included the GPs who works in the regions, who were also part of one operating unit of the Miur co-funded research. The research deals with a sample selected from the lists of the doctors practising in the various regions that is proportional to the variables of gender and province of work. The sample choice (nearly-obliged, for what it regards the selection of the zones) has been constructed with awareness- after reasoning.

Differently from probabilistic samples, the samples that are not probabilistic do not allow the statistics determination of the esteems that are related to the universe from which the same samples come (Corposanto, 2002). Considering the reasonable homogeneity in the opinions, the good number of opinions in relation with the topics dealt, the research equipe has estimated that, considered to the territorial level, the outcomes of the delivered questionnaire can become useful object of scientific and professional discussion in the appropriate centers.

### The questionnaire

The questionnaire is composed by 60 questions and has been delivered through a face to face interview by trained interviewers. The questionnaire has been structured in 7 sections:

- i) Professional activity and associationism: Past and present professional activities, weekly work hours, specializations, opinions with regard the action of the unions and other associations, medical identity.
- ii) Professional autonomy: Opinions on the autonomy of the medical profession and the practical experience of the doctor.
- iii) The relationships with patients: thoughts and reflections on the changes occurred in the relation with the patients.

iv) The relationships with colleagues of one's own and other professions.

v) The medical profession. General aspects: training needs, general opinions on changes in the health system, opinions on general medical practice.

vi) Socio demographic data.

vii) Aspects of professional practice (numbers of patients, opinions about GPs associationism, types of patients in care).

## RESULTS AND DISCUSSION

The 1162 GPs interviewed considering the gender variable are males (72.8%) and females (27.8%), between 28 and 76 years old (the medium data is 50.55 years, the values of the median and mode are equal to 50 and the standard deviation is 6.4 years). The gender compositions of GPs in different classes of age are interesting. From an analysis it emerges a good presence of women even though such presence is significantly consistent only in the younger generations. Differently there remains still a vast bulk in the profession between genders as far as the elderly generations are concerned (Figure 2).

The educational level of the relatives of the interviewed GPs allows some surprise. First of all, we have to signal the expected elevation of the parent's education at a degree level to a generational level, if the 5.4% of the fathers and 6.2% of the mothers of the GPs did not have a degree, only the 0.8% of the married partner is found

today in this situation. Still more sensitive are the differences if we consider the elementary license, in this case the % come down drastically from 26.3 and 37.3 respectively for fathers and mothers of the interviewed doctors to the 0.2 for what it regards instead the married partner. To the highest level of education, instead, we signal that fathers graduated with a degree in medicine (laurea) are 21.4% (7.2% the mothers) and differently from the case above the married partners are a substantial 56.1%. And if the rare cases of married/partner without a degree regard exclusively the regions of the North, the greater % of graduated is found instead in the southern regions of Italy. However, from which families come the GPs?. A question of the questionnaire has tried to answer to this question mark, confronting GPs with their past memories when they were 14 years old. What were their parents doing job wise at that time?. In the case of the father we find primarily white collars (12.6%), followed by fathers in commercial activities or business men and of course - by medical doctors (more than 10% in both cases). The northeast and the south of Italy the 2 macro-areas in which the "passage of deliveries" between father doctor and doctor son appears to have happened more. Concerning the maternal profession, 62% of the women have chosen to define themselves as "housewives", 11% teachers and a scarce 5% of women in commercial activities. A big bulk distanced the mothers from the fathers who were GPs only for the 0.7%. In order to better comprehend the meaning of this argument, which tells about the composition and the cultural structure of the Italian family of an entire generation, we can observe the values of the odd (odd is an index of prospect versus something... that is obtained dividing the number of "favorable" cases when a certain event happens in relation to a number of "not favorable" cases. Differently from the values of probability, always comprised of interval 0-1, a value of odd can also be greater than 1. The greater the value of odd, the greater will be the prospect that a certain event happens versus the taking place of the other event) in relation to the choice of undertaking the medical profession.

The odd (chance, prospect) of simply becoming doctor having the parents (indifferently father or mother) medical doctors themselves is equal to 0.05. The situation changes remarkably if we consider instead the odds conditioned by the variable of gender, in fact, if the doctor is the father, the prospect the children will follow the tracks of the father is equal to 0.11, that is a much greater value than the first one. If we instead consider the prospect the children will follow the maternal tracks, then the index drops down drastically to the value of 0.007. It is revealing, from this point of view, the last value we are introducing, that is that one of odds ratio, arranging the gender of the parents and the propensity to become GPs by the children we obtain an equal value to 15.82. In other words, to have a father GP "conditions" the choice of the children almost sixteen times more than to have the mother GP. And all that regards children of both sexes. Considering the level of socio-cultural status of the original family as a whole that is a

measure of the familiar influences at a cultural level (title, degree) and at a socio-economic level (profession). It is possible to notice that GPs coming from families with a low status constitute a paltry % (1.8%), in contrast with a great proportion of medical doctors coming from families with high status (17.7%) or upper-mid-dle status (34.5%).

### **When I grow up I want to be a medical doctor**

#### **On the motivations of choosing the faculty of medicine**

The questions which analyze the motivations why medical doctors have chosen their profession have been grouped in different dimensions:

- i) An economic-instrumental dimension, oriented to the security/stability of the job (with regard to autonomy and independence; the security of finding a job easily; the enjoyed social prestige-status; the satisfactory economic treatment, stability).
- ii) An "epistemic" scientific attitude (interest for natural sciences; possibility of developing research; interest for Human Biology).
- iii) A traditional "domopeto" orientation (the parents dreamt about their son being a medical doctor; reliable persons advised the doctor to become a doctor; there were other doctors in the family).
- iv) A "Philanthropic" altruistic profile (to be useful to others; work on people): the altruistic orientation, virtuously related, perhaps, to the very famous tendency to answer favorably to social acceptable alternatives in choosing a profession is diffused in little less than 90% of the interviewed and does not let to differentiate from any of the socio demographic variables considered (who would deny to have chosen the faculty of medicine for non altruistic reasons?). Hence, the orientation seems outlining a transversal dimension to all the doctors considered (and, probably, to all the helping professions) more than constituting an analytically independent attitude.

To a precise question on the degree of satisfaction of one's own expectations, more of the half of the GPs answered that the degree of satisfaction of their expectations was a lot or enough (16.1 and 46%). Almost a third of the GPs (30%) answered that only some expectations had been satisfied, while the 7% of the interviewed said they were little satisfied or not at all.

#### **The problem of the professional identity**

This topic has been faced in a specific way, asking the interviewed a precise question: Would you say, there is still a basic identity in the medical profession today? An identity which makes us assume a unitary body even if there are distinctions between doctors (for example between GPs and doctors working in hospitals or among

**Table 2.** In which way do you think the following subjects and actors question your autonomy?

<b>What is a problem for professional autonomy of doctors?</b>	<b>No</b>	<b>Little</b>	<b>Relatively</b>	<b>Very much</b>
Single patients and relatives	30.7	44.8	20.8	3.7
Care associations for the rights of the sick person	42.1	41.6	13.2	3.1
Health managers	9.7	19.9	40	30.4
Local political leaders	20.6	23.9	32.1	23.4
Media	15.1	23.2	24	27.7

different consultants)?.

Without necessarily being pessimistic, the leaders of the medical profession are aware of having to manage a professional body with fractures and tensions that include a not negligible minority of GPs, who deny the unity of the profession. That means that the other members of the profession, to begin with the hospitals doctors who are the numerically more important, perceive even more remarkably the fractures than the GPs.

On these results there is no influence in relation to gender or job place (metropolitan area, main town in the province, provinces). Surely, there is instead influence as far as age is concerned in the ways in which medical doctors answer. Young doctors (until 40 years) are more optimistic than older doctors. "Yes" catch up 44%. In the central age group (41 - 55 years) optimism diminishes a little and diminishes even more in the older generations of doctors, where it is attested around the 25%. It is probable that in younger doctors there is still a socializing effect still influencing them from the faculty of medicine, while the old doctors have perhaps being experiencing fractions and had the time to accumulate tensions. Some differences, even if not striking, emerge in relation to the various geographic areas of Italy. In some areas of the north (Veneto, Trentino-High Adige, Turin, Lombardy) doctors who feel there is a basic identity in the medical profession, the so called "unitarians" are a little bit more numerous, between the 37 and 43%. On the contrary, doctors who disagree with this interpretation reach or exceed the 30% in Ancona and in Campania.

### **The threats to the professional autonomy**

Till now, the existence of the perception of threats to the professional autonomy of the medical profession had been documented mostly by analysis coming from official documentations (Giarelli, 2003), articles found on medical reviews (Marjoribanks and Lewis 2003), or interviews considering small local samples (Calnan and Williams, 1995) . Our inquiry offers a very significant data to the request to declare their degree of agreement or discordance with the affirmation: the changes of the sanitary system have weakened the autonomy of the doctors, the GPs answered in a very clear way without ambiguity, 42% were partially in agreement with the statement and 31% were completely in agreement with the statement. 10% were uncertain and only 15% were partially or completely in dis-

cord. Analogous answers of consent were manifested to the affirmation. Today the technical requirements of care are sacrificed to the economic logic. 45% were partially in agreement with this statement and 29% were completely in agreement with such statement. In these data there is no great regional variability, nor variability for age, the negative appraisal prevails everywhere; in the perception of the GPs, the weakening of the medical profession is real.

Table 2 shows a few of the possible threats to the professional autonomy, according to the GPs, these threats are not constituted by the patients and still less by their professional memberships and associations. The consumption challenge, indicated from part of the literature as relevant, is deeply cut-rate from our data, only a minority of GPs is worried about it, 21% enough, the 4% is very worried. Health managers are worried (40% enough and 30% very worried), followed by national legislation (44 + 25), from media and from the local political leaders. Beyond the possible "effect halo" that the formulation of the answers can have generated, it is obvious that the managerial logic, channeled, above all, from the national sanitary legislation, is perceived from the GPs like the main source of the weakening of their own professional autonomy.

From this data remarkable tensions in the sanitary system emerge. The gravity of these tensions is confirmed from the answers given to another drastic question-affirmation, the control exercised from the manager on the sanitary attendance has diminished the quality of the care. With regard to this statement many GPs partially agree (34%) or totally agree (30%).

### **The doctors' training requirements**

The answers of the interviewed have widely focused on the strict technical and biomedical aspects of the medical profession. Interviewed greatly prefer diagnostic (It is specified that the interviewed had three alternative answers: therefore, the reported analyses have as measure-unit the given answers or the interviewed subjects along the manifested requirements). knowledge (16.6% of the answers), theoretical-scientific knowledge (12.6%) and useful therapeutic knowledge related to disease and care (12.5%). These data, together with the interest doctors entertain in relation to pharmaceuticals updating and rehabilitation (respectively, 3.7 and 7.2% of the answers), seem to close the ideal cycle of the medical profession, at least for how it is perceived from the research partici-

pants. From theoretical and scientific knowledge there derives the ability to produce effective diagnoses, hence the possibility, to advise, knowingly adequate therapies. What is clear from the above data analysis is pulling ahead force of the technical and biomedical traits of the medical profession. So that the 79.9% of the doctors interviewed identify in such traits, one of the areas in which investing in one's own formation. Furthermore, more than fifth of the doctors (26.9%) has chosen to answer only in relation to this area. This data is eloquent if put in relation with the doctors who have chosen to speak only about the aspects linked with managerial skills (4.3%), the relationships with territory (1.7%) and to the relations with the patients (0.4%). The prestige, authority exercised from the more technical and professionalizing component of medicine is manifested by the strong preference doctors show towards organizational and managerial aspects of health care, that are functional to the implementation of the profession. These regard the 50.6% of the interviewed ones. With this regard, a greater importance is given to informatics, system technology (6.6% of the answers) and to the legal aspects which aid the professional practice (4.8%), followed by the strict managerial aspects (in total, 6.3% of the answers, with less attention given to hospitals services in comparison with the territorial ones and the outpatients' ones), from the management of the quality of services (4.2%) and finally, from the knowledge of alternatives or not conventional healing practices (3.4%). On the other side, the two less specialized-technical dimensions of health care that are oriented to the more relational dimension of health enjoy a considerably inferior consent. The section which considers the relationship GPs/territory collects 37.4% of the interviewed. It is interesting how doctors in this section require inter-professional collaboration (7.8% of the answers), that is the 5th on the list of the scale of expressed requirements (is this a sign of an acknowledgment of the complexity and necessity of integration between professionalists while health education and research on the territory constitute respectively the 4.3% and the 4.2%. At last, the sector of medical humanities, formed from the 2 items that characterize the dimension of the relations with the patients and that presuppose cross-sectional competences that go beyond the technicalities of science, constitute and a little more of 5% of the answers. Substantially, nearly a tenth of the interviewed subjects realize that in medical training communicating with the patient is fundamental and of 5% think that also an analysis of ethics with regard to care relations would be a training requirement. Another interesting data that emerges from the national survey refers to the cross sectional character of technical, scientific and biomedical training necessities in relation to the social background and the professional experiences of doctors. Their gender, age, place of job, status of origin, professional motivations, studies and previous working experiences do not seem to have any meaningful influence on the perceptions that they them-

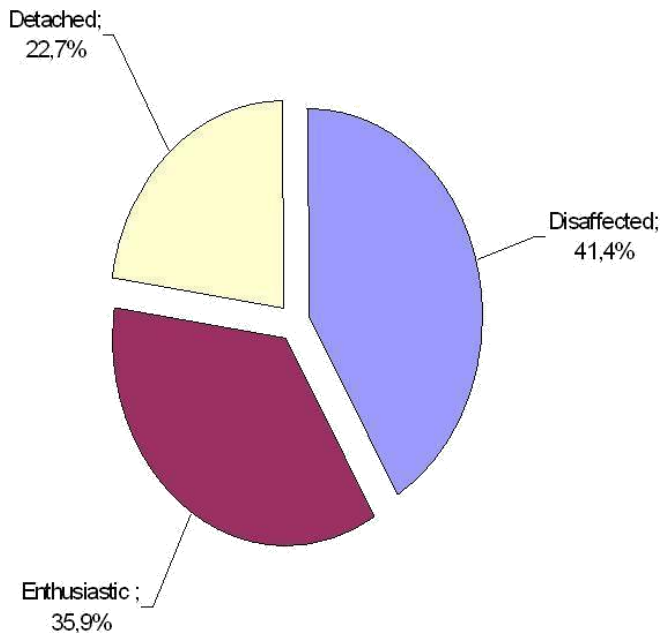
selves have of the own professional capability. This confirms the starting hypothesis even more forcefully, the transmission and the internalization of the role of the doctor goes almost exclusively through the channel of scientific and technological knowledge, privileging the diagnosis of the disease and health care, while sacrificing the relation with the sick person (and the reference to her his social context) which, however, constitutes another fundamental requirement of medicine.

### **“My patients”**

The patients, as we have seen, are not perceived like threats to the professional autonomy of medical doctors. This does not mean, that the patients have not changed. The answers to other questions of the questionnaire, confirm changes in patients have been recognized by the GPs: nearly half of them admit that patients tend more to take care of themselves and to change doctor than before. The 65% of the GPs say that the patient is more aggressive, the 70% that patients want more a second opinion, the 83% of the GPs say that patients want to participate more to the decisions taken by the doctors as far as their health is concerned. At last, the 91% of the GPs say that the patients demand greater explanations by them as far as their health is concerned. One would say however that, these new patient requirements are not perceived from the GPs as threats to their own professional autonomy. Hence, the hypothesis that can be set out is twofold. On one side, we could suppose that the modalities with which new patients manifest their requirements discuss the more authoritarian aspects of the traditional doctor-patient relationship, but they do not compromise the professional autonomy of it. According to Calnan and Gabe (2001), evidence exists that indicates that the patients want to be informed and consulted, but a few want to actively and truly participate to the decisional process. On the other side, we can suppose that GPs have been able to adapt and to transform the traditional type of relation (authority-deference) they were entertaining in the past with the patients, without endangering their professional autonomy. The first point discussed above is homogenous with the results of the investigations on health consumer satisfaction, than generally reward the professionals (doctors and nurses) and penalize the system and its bad organization. The second point in our surveying is confirmed from the answers given by the GPs on the changes brought about by them in their relationships with their patients: the 74% of GPs recognize that, at least partially, they leave more time for what the patient have to say, and the 79% explains more to their patients what they do as GPs.

### **Three ways of interpreting the medical profession**

To the end of describing the various ways in which the doctor's professional identity manifests itself in everyday practice, we have jointly subordinated the 13 indicators -



**Figure 3.** 3 ways of being doctor.

previously introduced to cluster analysis. The identity, we are talking about, is unique and transcends the specific territorial and gender realities. The indicators characterize three different medical practices (the relationship with the patients, with health professionals and the health profession itself). As acknowledged with the term cluster analysis - or analysis of the groups we want to identify a family of statistical techniques sharing the objective to assign single cases or individuals, a narrow number of classes or groups, while maximizing as much as possible the heterogeneity among the defined groups and, speculatively, minimizing the heterogeneity among the individuals within the same groups (Corposanto, 2001). 3 are the adopted dimensions in order to obtain the distinguished groups of doctors who characterize the various ways of "being a doctor"

**The personal relation of the doctor with the patients:** where there is a reflection on the changes in the relationships of the doctor with the patients.

**The personal relation of the doctor with consultants:** where there is a reflection on the nature of the relationships between consultants and their colleagues and the opinions on the changes acquired from the other health professionals.

**The relation of the doctor with the medical profession:** where the degree of satisfaction of the expectations on the profession is discussed and an assessment of general medical practice is given together with a judgment relative to job family relations. Cluster analysis has prompted the formation of 3 groups, that we have

respectively called disaffected, enthusiastic and detached on the basis of the dimensions that, as it will briefly see, will characterize every one of them. As the diagram shows, the most considerable group is that one of the disaffected, than for amplitude is more than the 2 fifth of the sample (41.4%). The other 3 fifth of the doctors are distributed in the remaining 2 groups extracted from the cluster, one of a similar consistency to the first group (the enthusiastic ones), while the detached doctors constitute less than one fifth of the sample (22.7%). Cluster analysis extracted groups. Enthusiastic 35.9%, detached 22.75%, disaffected 41.4% (Figure 3).

### The disaffected

The first group extracted from the cluster analysis collects 41.4% of the interviewed and tends to be characterized by the most negative evaluations on the profession and its relations with patients and the colleagues. In the total judgment of the profession, great part of the disaffected doctors think that general medicine is substantially a bureaucratic profession (19.6%) unsatisfactory and laborious (17.5%). With respect to the other groups of doctors, in this group there is the minimal proportion of doctors that consider it a stimulating profession (49.8%, 18 points % less than the enthusiastic group) and an art (12.2%). Moreover, a few are the disaffected doctors who have seen their professional expectations totally satisfied (8%, nearly 20 points % less than the enthusiastic ones), while nearly half of them believe that their own expectations have not been satisfied at all (approximately half of the doctors, 12 points more than the average %). It is, moreover, interesting to notice that more than a third of the disaffected doctors, in relation to job and family, consider themselves more focused on the job (36.2%, beyond 14 points % more than the enthusiastic group). While the proportion of the ones in which job and family are substantially in equilibrium it is inferior than the other groups of doctors (58.4%, beyond 5 points less than the average %). The relationships with the other doctors are generally of cordiality, but this group of doctors evidently, more than the others, have conflict relationships or relations of indifference among colleagues (little more than a tenth share this experience - beyond 6 points % more than the enthusiastic group).

Moreover, GPs pertaining to this group, think in greater measure than the other groups that the relationships among consultants are characterized by competition (nearly 7 points more than the average %), while only 15.3% of them think that cooperation prevails (8 points % less regarding than the enthusiastic group). Again, if on one side, the majority of disaffected doctors believe that the changes inferred by the other health professions are positive for the quality of the health care (completely positive for 59.8% of them, partially for 28%). On the other side they believe that such changes will make the relationships with the doctors more discordant: this data regards nearly 50% of the disaffected interviewed, a good

30 points % more than the enthusiastic doctors. They also differ from the others in the relation to the patients. The disaffected doctors perceive their own relationships with the patients more controversial in comparison with the past (beyond 43 points more than the average %) and more fatiguing (nearly 94% of them say so, 23 points more than the average %). On the other side, they show on the whole attention to relationships with their patients, leaving them more space (86.3%) and explaining them more about what they are doing 96.3%.

### **The enthusiastic doctors**

The second group extracted from cluster analysis of a nearly similar consistency of the disaffected group of doctors, collects 35.9% of the interviewed ones and is characterized by the positive judgments on the profession and the relations entertained with the patients and colleagues.

General medical practice, in fact, represents for nearly 7 interviewed out of 10 a stimulating and rewarding profession (10 points more than the average %) and for 2 interviewed out of 10 it is an art and a vocation. Diversely for a little more than a tenth it is considered unsatisfactory or bureaucratic (13 points less regarding than the average %). This group, differently from the other groups is composed by doctors who consider job and family substantially on the same level (73.1%, 10 points more than the average %). Moreover, nearly the four fifth of them declare totally that expectations with regard to the medical profession have been satisfied, for the 27.4 and 51.3% of them feel partially satisfied (respectively, 10 and 6 more than the average %).

Considering inter-professional relations, this group is distinguished for the strong presence of doctors who entertain relationships of professional exchange with their colleagues (nearly a third of them, more than 3 points than the average %) and of mutual esteem (22.8%) and more than a tenth of these doctors declare of entertaining friendly relations with other doctors (11.3% of them, nearly 4 points more than the average %). Moreover, the enthusiastic ones coming from the other health professions are almost all convinced (93% approximately) that their professional growth will not create tensions in their relation with doctors and is very positive for the quality of health care (63.3%, over 21 points more than the average %). The enthusiastic ones distinguish themselves from the other groups for a less conflict vision in their relationships with their patients.

In their minds, in respect to the past, their relationships with the patients have not become more discordant (83.6%, more than 38 points more than the average %), but they have become more satisfactory for both (completely satisfactory for the 39.5% and partially satisfactory for the 45.6%). Nearly the totality of these doctors (95.6%, 20 points more than the average %) leaves more space to the patients and explains them more what they do (95.6%, 15 points more than the average %).

### **The detached doctors**

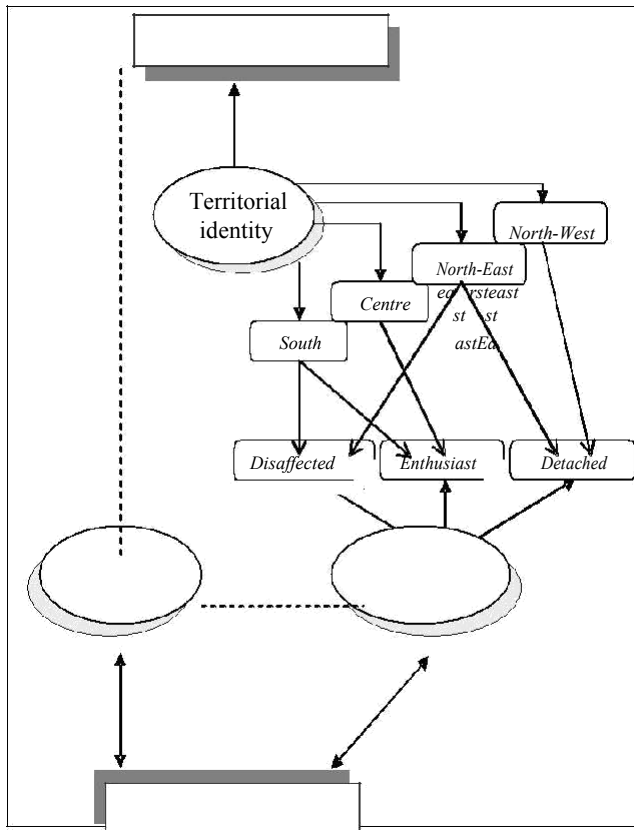
The last group extracted from the cluster analysis is less numerous. The group gathers the 22.7% of the doctors as a whole and it is characterized by a general attitude of detachment in relation with the different issues presented to them, particularly the issues regarding the relationship between them and the patients. To the questions related to the above issues with respect to the other groups, the detached doctors more frequently answer "neither in agreement nor in disagreement". In referral to their relations with the patients, the detached doctors believe that present relationships doctors-patients have become more fatiguing than the past (48.7%) or they do not express a precise position in merit (24.4%, beyond 12 points more than the average %) even if they tend not to perceive them as tense (59.8%). Half of them (50.8%) declares of being, neither in agreement neither in disagreement with the affirmation "I leave more time for what the patient has to tell me" (34 points more than the average %) and with the affirmation "I explain to them more what I do" (46.3%, +33 points average %). Also to the question "the relationships are more satisfying for both", more than a third party of the detached doctors (36.6%) prefer not to take a position or thinks to be substantially in disagreement with this statement (in total, 49.6%). Similarly to the other groups, the detached doctors generally entertain relationships of cordiality with their colleagues (43.1%) and like the enthusiastic ones, relationships of professional exchange, they more frequently believe that the relationships between consultants are characterized by cooperation and partnership (27.6%, 6 points more than the average %) and secondarily they believe that cooperation and competition coexist (39.8%). They understand the changes inferred by the other health professions have

been positive for the quality of health care (81.7%), however, even in this group there is also a greater proportion of doctors that do not express their opinions (17.1%, 8 points more than the average %) and believe that this will not bring inter-professional tensions (40.2%, also in this case is always higher than the other groups, the proportion of the indecisive doctors up to 30.1%). The medical profession remains, like for the enthusiastic doctors, stimulating and engaging for greater majority of them (58.5 % approximately) or a vocation (19.1%), even though for a very high proportion of subjects it is very much a bureaucratic profession. At last, half in between the enthusiastic and disaffected doctors, the detached ones believe that generally their expectations on the profession have been rather satisfied (42.7%) or for almost 36% of them, that only some of the expectations have been realized.

### **Being a doctor, practicing medicine**

As we have had the opportunity to see, cluster analysis has generated three distinguished groups of interviewed doctors that interpret various ways of practicing the medical profession within a shared doctor identity: the enthusiastic, disaffected and detached doctors entertain diffe-





**Figure 4.** To be a doctor and to practice medicine (source Cipolla, Corposanto, Tousjin, 2006).

rent modalities in relation with their colleagues, the patients and their attitude in relation to the profession. Modalities that, seem to be independent and however not conditioned from the associate-demographic characteristics and the personal experience of the doctors, in other terms, the various ways of practicing the profession referred to the relationship doctors patients, doctors -health and doctors profession, pertaining to the 3 groups identified, does not show any relation with gender, age, the number of patients or workload, the professional history or the motivations of the doctors. These results give a further confirmation of the idea of the transversal character of the experience and professional practice of doctors and gives further confirmation of its strength, in rendering homogenous the differences discussed. The only important and statistically meaningful variable in shaping the differences among the 3 groups of doctors is the terri-

torial division (That is the value of  $X^2$  significative at the level 0,001; coefficient of contingency equal to 0, 246 (relationship which is present but of moderate intensity). It turns out that, more than a third of disaffected doctors (35.1%) comes from Southern regions (the salernitana and catanese areas) and beyond a quarter (28%) from the regions of the north-east (above all from the Verona junction), that the 3 fifth of the enthusiastic doctors come

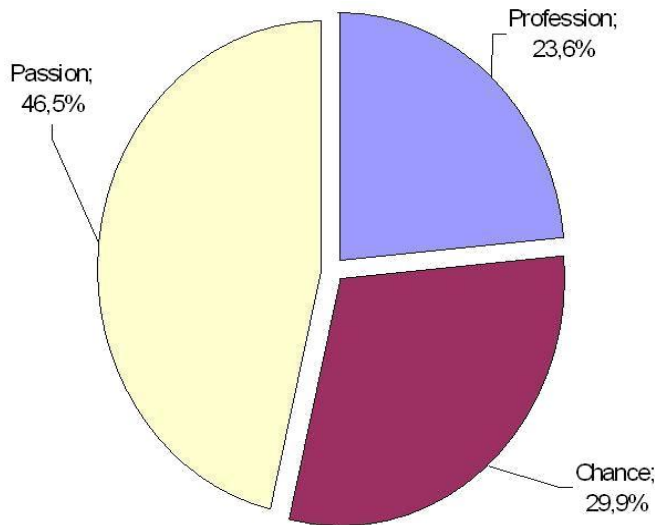
from the regions center-south (of which more than a fifth from the area of Cassino); that the detached doctors come above all from the north-east (40.2%, of whom more than a fifth from the area of Bologna) and the north-west (26.4%, of which beyond the half from Milan). In brief, from the point of view of the professional identity, a doctor referring about his/her own professional identity could say: "I am a doctor and I am equal to all my female and male colleagues in whichever part of Italy". Though if I then "practice the medical profession", then the territory (the place) I work on, with its cultural specificities and peculiarities, allows me "to be a doctor in various ways" because of an interaction with the territory.

In Figure 4 we have outlined the relationship between being doctor, practice medicine and the professional and cultural identity of the doctor. As it can be noticed, the professional identity expresses itself through being and practicing the profession, being a doctor does not appear mediated from culture and territorial realities, on the contrary practicing the profession appears some instead very strongly enmeshed with culture and territory, giving existence to the ways, of practicing the profession in relation with patients and other actors of the public health sector already discussed. Confirming in some ways the affirmation of Foucault (1963) for whom the "medical gaze appears socially and culturally situated". A different analysis has instead lead to the construction of a different typology, based on the motivations that have brought the GPs to choose their profession, distinguished in 4 sub classifications (Hope, 2006) - "economic-instrumental", which regards important, but not specific and intrinsic or exclusive motivations of the choice, emergency/stability, autonomy and independence, social prestige, economic treatment, - "scientific", relating to the intrinsic aspects of the choice possibility research, interest in Biology and natural sciences - "traditional and of status", that remind us about the aspects having to do with the socialization of the medical profession; - "altruistic", to be useful by others, working with people. The cluster identifies three groups of doctors: - the "doctors for passion", characterized by a prevailing scientific and altruistic orientation - the "doctors for profession", characterized by the presence of average values in every orientation - the "doctors (a bit) by chance", in which all the orientations are low, excluding the altruistic and the scientific one that are average.

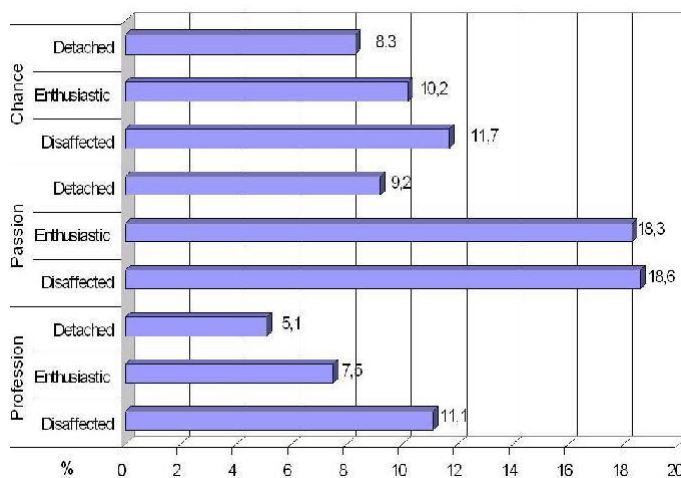
The two types above described have been summarized in a synthetic index, represented in Figure 5 and 6.

## Conclusions

As discussed above, the two original constructed typologies give a reading of the motivations that have carried the GPs to register in the faculty of medicine and their lived experience in professional practice. The figure shows how these two dimensions of the medical identity cannot be perfectly placed one above the other. They delineate a somewhat spotted and not linear category of lived experiences. The doctors, for the greater part,



**Figure 5.** Doctors and Professional Motivations- chance, passion, profession.



**Figure 6.** Classification of doctors according to their motivations (value percentage).

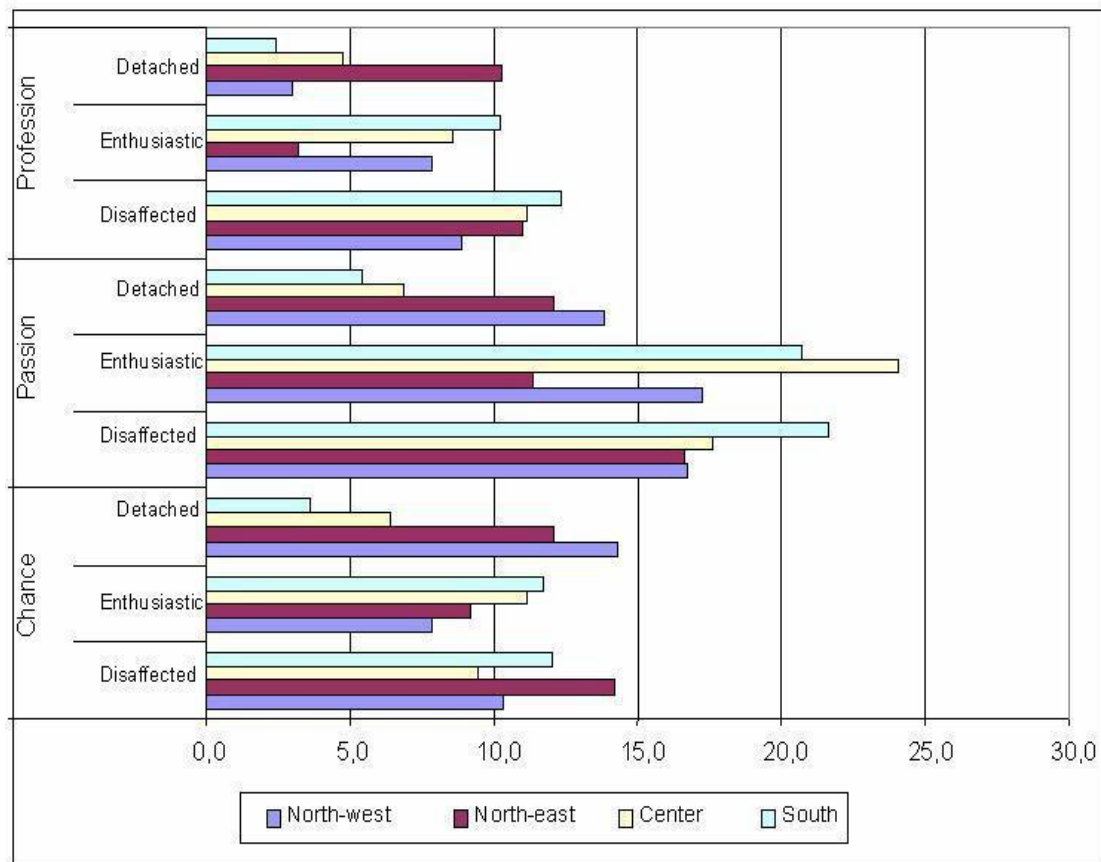
gather in the category “disaffected GPs for passion” (in total, 194 subjects): these represent the people who Registered in the faculty of medicine because of a scientific drive and express negative appraisals of their own profession of the relationships with their colleagues and patients. Also the category “doctors for passion enthusiastic” reunites a consistent number of doctors (in total, 192 subjects), whose expectations on the profession have evidently been satisfied in the daily practice. There follows, the doctors by chance who feel disaffected (respectively, 123 and 116 subjects). By undertaking the medical profession without any particularly strong motivation or just about a little moved from the above discussed

motivations, they have been fundamentally been by their profession. The remaining classes collect less than a tenth one of the subjects. Consistently with the results emerged in the investigation, the index shows how meaningful relations do not exist with the main socio-demographic variables, like if the profession and its practice, cancelled every difference of gender of age and various lifestyles of experiencing the profession existed inside common identity. The only variable that showed to be is statistically meaningful and significant in stratifying the groups of doctors, even if slightly, is the geographic origin of doctors, that shows a considerable presence of the average doctors by chance in the Northern areas of Italy (above all in the north-east), the doctors for passion in the areas of the center, the doctors for profession in the north-east and south. At the same time, the disaffected doctors significantly characterize the southern areas, the enthusiastic doctors the areas of the center, the detached ones the Northern areas (Figure 7).

The last analysis that we propose in this context is that one related to the discriminant (The discriminant analysis is an analysis of grouping that, starting from the constitutive groups (on a natural basis or as an output of a cluster analysis as in this case) verifies the cohesion of these groups through a scrutiny. In our case we have started from the cluster obtained on the basis of the variables relative to the relations entertained by the doctors with other colleagues, with various health professionals, and with the patients and we have verified the cohesion of the groups in the light of the motivations that have convinced, pushed or influenced the doctors to choose their profession.) Analysis (Corposanto, 2001) in order to try to understand how the variables that have contributed to obtain a cluster related to the exemplification of the motivations that have influenced the choice of the profession interacted with the groups connected to the relationships with colleagues and with the patients.

In Table 3 it is possible to notice as the group defined of “disaffected” is, after all, the best characterized. More than 50% of the doctors continue to stay in that group even in the light of the division in the three categories deriving from the motivational variables linked with their starting professional career. However, consisting fractions of the enthusiastic and the detached doctors “migrate” towards that group; re-classified to the light of the motivations, in fact, more than 50% of first ones seem better allotted between the disaffected ones, as the 46% of the detached ones.

Hence motivations, definitively count, they allow that the 3 identified possibilities (routes) to practice the medical profession disaffected, enthusiastic and detached doctors manifest themselves with different modalities especially if considered at a geographic (and cultural) level while confirming the fact that to be doctors and practice is intimately connected with the concept of health (disease-sickness and well-being) that from every culture and every territory emerges.



**Figure 7.** Groups of doctors organized according to geographical origin (values percentage in relation to the geographic area).

**Table 3.** Classification results – discriminant Analysis.

		Groups classified according to their professional character	Predicted Group Membership			Total
			Disaffected doctors	Enthusiastic doctors	Detached doctors	
Original	Count	Disaffected doctors	236	72	123	431
		Enthusiastic doctors	195	74	106	375
		Detached doctors	110	39	90	239
		Ungrouped cases	31	19	12	62
	%	Disaffected doctors	54.8	16.7	28.5	100.0
		Enthusiastic doctors	52.0	19.7	28.3	100.0
		Detached doctors	46.0	16.3	37.7	100.0
		Ungrouped cases	50.0	30.6	19.4	100.0

A 38, 3% of original grouped cases classified correctly.

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