# Professional ideology of altruism of russian medical practitioners

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Resumen: *El altruismo se ha considerado una característica importante de los profesionales. De acuerdo con las críticas neoweberianas, nuestra investigación no niega la importancia de esta ideología profesional: aunque las acciones de algunos médicos puedan considerarse intentos de promoción personal, no dejan de proporcionar un servicio a sus pacientes o clientes. Según algunas investigaciones secundarias y cualitativas recientes de médicos ortodoxos rusos, la ideología profesional es una característica profesional importante. La investigación señala una discrepancia entre la sensación que tienen los médicos de trabajar en una situación precaria y la percepción más bien positiva que tienen de su profesión.*

Palabras clave: *sociología de las profesiones, ideología profesional, grupos profesionales.*

Abstract: *Altruism has been seen as an important characteristic of professionals. In accordance with neo-Weberian critiques, our research does not deny the importance of the professional ideology of altruism: even though some medical practitioners' actions may be self-enhancement, they are still providing a service for their patients or clients. In recent desk and qualitative research by Russian orthodox practitioners, professional ideology has been interpreted as a significant professional characteristic. The research pointed out the discrepancy between medical practitioners' sense of reduced circumstances and their rather positive perception of their profession.*

Keywords: *sociology of professions, professional ideology, professional groups*

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## 1. Introduction

The political changes of the 1990s and the subsequent economic problems that occurred as Russia sought to restructure the economy have destabilized existing social institutions. Russia has been through a period of rapid and dramatic change. Most prices and wages were freed from central regulation at the end of 1991, and enterprises henceforth produced not for the plan, nor for the state orders, but for commercial sale (Clark, 2002). The transition to a market economy did not bring with it the anticipated prosperity. Instead it brought unprecedented inflation; average real wages fell to about the level of the late 1960s, before the «period of stagnation»; wage inequality doubled; and total employment fell by around a quarter (Ashwin and Clark, 2002). These political and social events have been well documented and commented upon in general terms (see, amongst others, Sakwa, 1997).

The Russian health care system has also undergone deep changes. The process of privatization of medicine in Russia started in 1985 when some medical institutions were put on a self-financing basis. The privatization of state medicine, however, was legally underwritten only in 1993, when Article 41 of the Constitution gave the green light to all kinds of private initiatives. The privatization of medicine was implemented to different degrees. The conditions of the accreditation of private practice and the attitudes of the regional elite towards the introduction of private practice varied from one region to another. As a result, the de-monopolization process towards a mixed market in health care with private as well as state run services unfolded in various regions at a different pace. In 2003, the overall market of official private services was equal to 6 thousand million roubles, whereas the state allocations to medicine were equivalent to 31 thousand million roubles (Shevchenko, 2002; Zavialova, 2003). Private medicine currently comprises from 10 to 15% of all health care in Russia (Kopitaiko, 2003).

In Russia, as in other advanced industrial societies, medicine is an expert occupation. Students undergo a long training in specialized university faculties, and have been considered as part of the intelligentsia – an educated human resource within society. However, in Russia, expert occupations have been, and remain, subordinate to the state and have been subject to market forces only at the margins. In a study of profession/state relations in Britain, the United States and Germany, Moran argues that, historically, professions have been affected differently by the state and the market (Moran, 1999). In Soviet Russia, the intelligentsia was at the extreme pole with extensive state control. The health care reforms resulted in a change in the status of Russian doctors and their social at-

titudes. The medical profession has acquired some possibility of self-regulation: the scope of clinical and cultural autonomy has increased slightly. Transformations have occurred in the common standards of practice, discipline, payment and ethics. In this paper we shall focus on the interpretations of the issue of the «professional altruism» of medical practitioners in contemporary Russian society.

The paper is in four parts. The first part provides an overview of the theoretical background. It makes a critical analysis of the interpretations of the terms «professional altruism» and «professional ideology». The second part introduces the social attitudes of medical practitioners towards the health care reforms. We analyze whether Russian physicians are still attached to the altruistic socialist-oriented priorities of easy access and equity in health care. It provides a foundation for a better understanding of the attachment of Russian medical practitioners to the state sector and to the notion of socialized medicine. The third part of the paper outlines the attitudes of Russian doctors towards the issues of the value of professional expertise and professional altruism. The fourth part analyses the potential of medical practitioners to professionalize. It considers whether physicians strive to project the positive image of the medical profession.

## 2. Theoretical background

Functionalist researchers have seen the professions as centrally significant, very effective, and apolitical social institutions within society. This view was largely rooted in the classical works of Durkheim, who emphasized the importance of professional ethics (Durkheim, 1933). His view that the division of labor and occupational groups represented the moral basis for modern society led him to focus on the professions as entities that embodied all the social functions he valued and which would act as intermediates between individuals and the state (Durkheim, 1933). These Durkheim believed would save modern society from the breakdown in moral authority, which in his view threatened it. The development of this view was presented in the works of functionalist researchers in the twentieth century (Tawney, 1921; Carr-Saunders and Wilson, 1933; Parsons, 1951; Ben-David, 1964; Halmos, 1970).

Within this theoretical framework, professionals were seen as a specific structure within the social system and professional altruism was seen as a key defining aspect of the ideal model of the profession. In the late 1950s-1960s, the functional approach to sociology became so dominant that the discipline of sociology and functionalism became more or less identical (Wallace and Wolf, 1995: 17).

Most social researchers of the time saw professional altruism as a social good at which professional expertise is directed, whereas allegiance of medical practitioners was expressed through a pledge to follow a code of conduct. More recent work has not denied the importance of altruism, but has given greater emphasis to the strategies actively deployed by medical practitioners to engender a position of power (Cant and Sharma, 1996: 6).

According to the functionalist and trait writers, professional competence should correlate with the most important values of society. They argued that if those work activities that are closely connected to establishing and maintaining the main values of the society also possess other «professional» characteristics, they may be called professions (Barber, 1963). Parsons claimed that «a full-fledged profession must have some institutional means of making sure that such competence will be put to socially responsible uses» (Parsons, 1968: 545). He argued that the most obvious «socially responsible use» of professional knowledge was in the sphere of its application to medical science. At the same time, he mentioned that the skills of teaching and of research in the «pure» intellectual disciplines – the humanities, and the natural and social sciences – could also be included in to the sphere of professional activities. Most social researchers distinguished medicine (treatment of the body), divinity (salvation of the soul) and law (defense of rights) (Dingwall and Lewis, 1983).

Professionals, then, were seen as primarily disposed to serve the community, as opposed to self-interest. The technical solutions which the professionals arrived at were conceived on the basis of the needs of clients, not on the material interest and needs of the professional (Goode, 1969: 278). Thus, the system of moral and material remuneration was seen as a fair reward of the profession by the state, not as the pursuit of self-interested goals by the professionals. Some sociologists even viewed altruistic service as an inherent personal quality of the members of the profession (Barber, 1963). Later in the century, Ritzer stressed that trait and functionalist writers often confused studies of profession as collectivities and individual professional workers (Ritzer, 1973).

According to functionalists and trait writers, professionals were supposed to see their work as a kind of mission or calling. Unlike people whose work was considered to be an occupation, and who were regarded as lacking the feeling of 'commitment' to their work-activity, professionals were assumed to remain committed to an area of work during their life span. At the same time, the rewards for professionals were higher and the period of adult socialization was prolonged. Members of the profession were less willing to leave an occupation, and were more likely to assert that they would choose the same work if they were to begin

again. The level of development of formal (written) and informal ethical codes for recruits to the profession were seen as an important indicator of professional altruism, and as one of the key concepts of whether an occupation could be called a profession (Hall, 1975: 74).

In his trend report on professions in the class system, Ben-David argues that one of the most important distinguishing characteristics of professional organization and behavior is the existence of a vocational subculture which comprises explicit or implicit codes of behavior or generates an *esprit de corps* among members of the same profession (Ben-David, 1960). It also ensures them certain occupational advantages, such as an egalitarian not an authoritarian type of supervision in bureaucratic structures and monopolistic privileges to perform certain types of work. Millerson wrote that an ethical code could be both formally and informally enforced, through censure, removal from the professional association, or professional ostracism from interaction within the group (Millerson, 1964). He examined over one hundred and thirty British qualifying associations, and found that about a quarter had formal written codes (Millerson, 1964: 28-29).

Later the idea of altruistic professional service was called into question. In the 1970s, views on the professions started to change. The general public was faced with examples of professional corruption and inadequate levels of competence (Saks, 1995). At the same time, a major shift occurred in social science from the structural functionalist orthodoxy to a much more pluralistic scene, in which sociological conflict theory and action-based conceptualization began to play an important role (Collins, 1990: 24). Neo-Weberians and Marxists came to the foreground of social research. The change was important for the sociology of professions as, up to that time, the professions had been considered ethically positive embodiments of the «central values» of society. Critics felt that this approach reflected too closely the ideological image which professionals tried to convey of their own work. The functionalist and trait writers started to be seen as 'victims' of an uncritical acceptance of professional claims to such attributes as ethical behavior, altruism and community service.

Thus, it has been claimed that the functionalist and trait writers confused «descriptive» and «normative» definitions of a profession. A descriptive definition gave attributes that were essential for an occupation to be a profession and did not say anything about what professions ought to be like. Conversely, a normative definition gave the ideals that professionals ought to pursue and realize. But it was not always apparent whether a descriptive or normative type of definition was meant. As Grossman commented: «When we are told that those in a profession pledge themselves to promoting the well being and interests of their

clients, is this given in the sense that a pledge does exist or in the sense that professionals ought to have such a pledge?» (Grossman, 2004: 2)

By the mid-1970s, two new models of the profession and professionalization appeared: the neo-Weberian model of «the profession as a monopoly» and the Marxist model based on the «relations of production». Despite all their differences, the followers of these approaches tended to focus on the analysis of professional power and managed to move away from a static functionalist definition of the profession as being apolitical and homogeneous communities of competent individuals. Within the Marxist frame of reference, critics aimed to reveal that claims of professional altruism were nothing more than a mask for professional self-interest and their control and surveillance functions for the benefit of the dominant bourgeois class. Saks commented that the critical thrust of Marxists was mirrored in the depiction of the oppressive role of professions in Western capitalist countries (Saks, 1999a; 1999b).

Neo-Weberians have conceptualized professions as an institutionalized form of monopoly and/or power based on knowledge and skills maintained by particular relationships with the state and the market (Grossman, 2004: 2). They viewed the rather high position of professions in society as something that the professions had to work at, and once they had attained their goal, it was something they wished to protect and enhance (Larson, 1990: 30). The reinterpretation of the definition of «profession» was accompanied by a change in the definition of the term «professional altruism». Within the framework of the action-based approach, social scientists have emphasized that professional occupations surround their work with an ideological covering (Porter, 1995), whereas the trait and functionalist approaches viewed the professions as a «calling», not merely a job. Activity was carried out for «high motives of altruism, of glory, or of moral, spiritual or aesthetic commitment rather than for mundane gain» (Collins, 1990: 35).

Revisionists of the functionalist approach stress the fact that the high-status professions are occupations with high pay and power, which suggests that the idealization of work is additional to other rewards, and not a substitute or compensation for them (Freidson, 1994). The point that the professions appeal to the moral status of their work in order to demand a «status-appropriate wage» and a justification for their high social position is well argued in the paper by Duman on the creation of professional ideology in the nineteenth century: «Central to this process was the formulation and diffusion of a unique ideology based on the concept of service as a moral imperative. This provided doctors, lawyers, clergymen and the members of an ever growing number of other occupations with

an article of faith with which to justify their claim to superior status and special privileges, such as self-discipline» (Duman, 1979: 38).

Freidson has also examined the potential that successful professions have for producing an ideology (Freidson, 1994). He comes to the conclusion that professionals' successfully deploy cognitive and normative aspects not only to enable them to establish their social status, but also to provide them with the potential to define social reality in the area in which members of their profession function. That is, the ideology gives the professions the opportunity to use their technical expertise as the basis for a claim to a universal validity for their public pronouncements. While they can in some circumstances extend this well beyond their particular domain, they typically use it to define the standards by which their competence will be judged and the extent to which the laity can enter their domain.

Freidson's understanding of professional ideology corresponds to some extent with the interpretation of the term «ideology» by social constructionists, who interpret ideology as «knowledge deployed in the service of power» (Burr, 1995: 82). Burr claims that a version of events, or a way of representing a state of affairs, may be true or false. But it is ideological to the extent that it is used by relatively powerful groups in society to sustain their position (Burr, 1995). Thus, ideas in themselves cannot be said to be ideological, only the uses to which they are put. The study of professional ideology is, then, the study of the ways in which meaning is mobilized in the social world in the interests of professional groups.

Moreover, those occupations striving for professionalization often create a professional ideology in an attempt to acquire status honor, which is expressed in «outward signs of respectability» in their life-style. As Macdonald argues some status activities may be undertaken in ways that will significantly affect how the occupation is evaluated by others, or for the moral and self-image of the members (for example, the location of offices, the eating of lavish dinners or the granting of a coat of arms) (Macdonald, 1995: 189). Collins also stated that a professional ideology that produces an honorific status is largely based on the outward signs of respectability, and is generated by professionals who are «specialists in ritual» (Collins, 1990: 37).

However, professionals cannot keep afloat only by pursuing interest-based occupational strategies aimed at gaining control of the market through exclusionary closure (Macdonald, 1995; Saks, 2003). As Macdonald argues, while there is no need to revert to the functionalist view, which takes professionals entirely at their own evaluation, professionals do provide the services that they claim to provide in relation to the life, health, property and other matters of crucial importance to

their clients (Macdonald, 1995: 101). Some of their actions may be concerned with self-enhancement, but the reverse side of the coin is that what they provide is still a service for their patients or clients. This approach echoes Saks' understanding of the dual nature of professional behavior, which, in his view, is akin to the mythical Minotaur – part human, part beast. The analogy drawn suggests that the «precise balance of the positive and negative features of the professions is not yet known and the nature of the contours of the profile need to be firmed up» (Saks, 1999b: 21). Saks argues that there is a need to develop an analytical framework for assessing the altruistic ideologies of professions.

This paper does not aim to assess the balance that is struck between physicians' self-interest and public interest. However, we try to acknowledge that professionals attempt not only to protect their market position but also to promote public service. We believe that Russian physicians can achieve both these goals by forming strong professional associations and engaging in collective activity. We do not deny the importance of the professional ideology of altruism: we argue that some of their actions may aim for self-enhancement, whereas others aim to provide a service for their patients or clients (Saks, 1999a; 2003).

## 3. The social attitudes of professionals towards the privatization of medicine

Before we focus on the attitudes to the health care reforms, it should be reiterated that the health-care system that existed in the Soviet Union immediately prior to the 1992 reforms was highly centralized. Until the end of the 1980s, health services were funded by taxation and provided free at the point of use (see, amongst others, Allsop *et alii*, 1999). The centralized Ministry of Health dictated policy, allocated resources to the regions and districts in the Soviet Union (Davis, 1989), and even set salaries and prices for medicines and equipment. Capital expenditure was closely controlled, as was the training of health practitioners. Thus, in the former Soviet Union, medical practitioners could not operate as independent professionals. Soviet doctors differed from their Western colleagues in that they did not have exclusive jurisdiction in a particular division of labor controlled by occupational negotiation. Neither did they have a sheltered position in the external and internal labor markets based on qualifying credentials created by the professional association.

The Russian health care system has undergone a series of sweeping changes since the end of 1991. During the post-Soviet transition, health reformers across

Russia have tried to devise strategies that maintain the best of the old system – universal access – while introducing market-based incentives for providers and consumers alike that improve the quality of care (Twigg, 2002). In the Soviet Union extreme emphasis was placed on the socialist-oriented priorities of access and equity, sometimes at the expense of quality and efficiency. Despite sophisticated centers of excellence in major cities, Soviet official medicine in rural areas was starved of resources (Davis, 1989). As part of the trend towards marketization, changes were also made to the funding structure of the health system. Russia moved away from complete state funding of health care towards an employer-based national health insurance system with decision-making powers devolved to the regions and a system of contracting between the regions as funders and the medical institutions as providers (Field, 1995).

The manner of obtaining resources has changed, then, but not the principles of medical management. For the moment, the whole reform process is taking place in the financial field only; but the very idea of medical insurance also concerns such issues as the organization, management, and delivery of health care (Rozenfeld, 1996). The compulsory insurance system that has recently been chosen in Russia essentially serves to transfer money from insurance funds, through insurance companies, to the medical facilities without regard to the actual volume of services rendered. The compulsory insurance system does not function as a true insurance system because market conditions are still absent. In this case, no real incentives are present, and despite the fact that the insurance law is couched in terms that emphasize the fact that patients can freely choose hospitals and physicians, in practice such choice is extremely limited (Allsop *et alii*, 1999). As a consequence of chronically underfunded health care, the tendency towards centralized control has been preserved in Russia. There are still strong elements of price fixing and methods of payment which give little incentive to use health facilities more efficiently (Field, 1995).

As the All-Russian questionnaire showed, the functioning of the medical insurance system was not transparent for medical practitioners (Sarkisyan and Zlodeeva, 2005). In general, medical practitioners had mixed views on whether the introduction of compulsory medical insurance had had an impact on the state of affairs in their medical institutions. Research carried out at the Institute of Sociology revealed that more than half of its members said that compulsory medical insurance had had either a negative effect or no effect at all on the following things: the supply of technical equipment; medical and routine supplies; the level of doctors' wages; and the quality of patient care (Yurchenko, 2004). Many medical practitioners (69.8%) complained that they had limited information on

future health-care reforms (Sarkisyan and Zlodeeva, 2005). At the same time, there was a widespread sense that some characteristics of the system of state-socialized medicine had to be preserved. In 2005, 87% of medical practitioners were apprehensive that restrictions would be placed on a medical service that was free at the point of access (Sarkisyan and Zlodeeva, 2005).

The INTAS questionnaire (1998-2000) also revealed that the value of altruism was widespread among medical practitioners (Yurchenko, 2004). Despite the fact that more than a third of all the respondents said that they would prefer to work in the private sector, were they given a choice, the research indicated that many doctors thought that certain areas of practice, as well as certain groups in the population, should be exempt from payment. Overall, 83% of doctors said that some groups in the population must be exempt from payment for health care. They gave priority to a service that was free at the point of access for the handicapped, children, low-income families and medical practitioners themselves. The majority (60%) of doctors said that they supported partial privatization; 23% did not support privatization at all and just 15% supported privatization without reserve, even if there was some element of payment for health care. It was found that medical practitioners did not reject the idea of introducing fees-for-service within the state sector. However, their view was that fees for services should first be introduced for areas of health care not directly connected with life-threatening events and the immediate well-being of the patient (Mansurov and Yurchenko, 2008).

Recent interviews have shown that many medical practitioners were not ready for the market and privatization as they remained attached to the notion of socialized medicine, which guaranteed certain social benefits to medical practitioners themselves and to their patients. Most doctors interviewed did not give up their job at a state medical institution, as this might have led to the loss of their social and welfare benefits. Another reason was that they needed to remain registered as an employee in a state medical institution in order to maintain their work record and to qualify for a pension. In the past, registration also provided access to a further range of social benefits such as free or subsidized housing. Nowadays, although this benefit has largely disappeared as housing construction for medical institutions has been cut back, some medical practitioners said that there was still a chance that new apartments could be sold to medical practitioners at reduced prices.

Also important was the finding that the Soviet work ethic, particularly among older people, still persisted. The interviews with head doctors brought out a few important social attitudes and stereotypes that remained from the past: (1) one

priority was to remain employed in a permanent position, where the person had worked for many years. There was a high degree of attachment to the labor collective; (2) the ideal of Soviet socialized medicine was maintained although there was also partial support for the privatization process. This finding matches other research findings (see, amongst others, Twigg, 2002). Soviet ethics involved not only a commitment to the profession, but also an attachment to the labor collective, which many workers referred to as their second home. Clark's research, for example, showed that in Russia, the Soviet sense of the labor collective, shorn of its Communist rhetoric, continued (Clark, 2002).

Under economic and social conditions in which the majority of the population could not afford private medical services or medicines, private practice did not fit in well with professional ideals and values. In interviews, some head doctors shared their concern with us that their active involvement in private practice could also lead to their losing the respect of their colleagues. Private practitioners were sometimes treated by their former colleagues and patients as people who had sacrificed professional and social values for private gain. Most doctors referred to their private practice as «earning on the side» or as «earning a little extra», even though their income from private practice might become the main source of income.

To summarize, most medical practitioners (83%) said that they supported *partial* privatization or did not support privatization at all. Although medical practitioners were frustrated and apprehensive about market-oriented reforms in the abstract, they were willing to overcome those apprehensions in favor of opportunities to earn more money (for similar research results, see Twigg, 2002). Concerns expressed by these respondents about the privatization of health care could indicate philosophical opposition to the notion of privatization in general, or simply reveal scepticism about how market reforms had actually operated, or might operate in the future, in Russia. As Twigg rightly argues, concrete observations of Russian citizens about the unpleasant results of market forces in their daily lives could easily give them cause to hesitate in supporting a market for medical services in practice, even if in principle they might be inclined to back the concept of market-oriented reform (Twigg, 2002).

## 4. Professional ideology of altruism

Professional altruism has been seen as an important characteristic of professionals by social researchers writing from various theoretical perspectives. According to the functionalists and trait writers, professionals were supposed to see their

work as a kind of mission, and they were assumed to be committed to their work throughout their life. The status of medicine as a career choice was still significant to the INTAS questionnaire medical practitioners (Yurchenko, 2004). About one third of them (less in the provinces, more in Moscow) were prepared to advise their children or other close relatives to take up a career in medicine. In the provinces the proportion of those who would not give such advice to close relatives was larger, which reflected the greater opportunities that existed in Moscow (see table 1 below):

**Table 1: Advice to follow a career in medicine**

| | *Regions (%)* | | | *Total (%)* |
|---|---|---|---|---|
| | Moscow | Komi | Kirov | |
| Prepared to advise | 44 | 30 | 18 | 35 |
| Would not advise | 34 | 50 | 63 | 45 |
| DK | 22 | 20 | 19 | 21 |
| Total | 100 | 100 | 100 | 100 |

As interviews with medical specialists showed, many were disappointed with the reforms in the state health care sector. However, they were not disappointed in their profession. Overall 69% of the respondents said that they were not disillusioned with medicine, despite the fact that 82% said that they were unhappy about their wage level (Yurchenko, 2004). This proves that professionals tried to give a positive image of the medical profession and were committed to doing good work instead of economic gain. As shown in Table 2 below, satisfaction with the profession of medicine was high.

**Table 2: Disillusionment with the profession**

| | *Regions (%)* | | | *Total (%)* |
|---|---|---|---|---|
| | Moscow | Komi | Kirov | |
| Not disillusioned | 74 | 66 | 62 | 67 |
| Somewhat disillusioned | 11 | 7 | 16 | 11 |
| Disillusioned | 7 | 16 | 12 | 12 |
| DK | 8 | 11 | 10 | 10 |
| Total | 100 | 100 | 100 | 100 |

Questions about the feelings of respondents towards their work showed that the profession itself supported professional values. Almost two thirds of

respondents stated that their work motivation did not depend on income. They were committed regardless (see table 3 below). Of course, a proclaimed ideology should not be mistaken for reality. Nevertheless, it is worth noting that regardless of the reforms, doctors still wished to be seen to be supporting a professional ideology of altruism.

**Table 3: Work motivation**

| | *Regions (%)* | | | *Total (%)* |
|---|---|---|---|---|
| | Moscow | Komi | Kirov | |
| My work is a contract: the more I am paid, the more I do | 11 | 11 | 10 | 11 |
| My work does not depend on the income I earn. I do all I can regardless of income | 62 | 61 | 59 | 61 |
| My work is a necessity. If I had money from other sources, I would not work | 11 | 13 | 12 | 12 |
| I like my job, but my family (household duties, hobbies) matter most to me | 11 | 9 | 10 | 10 |
| DK | 5 | 6 | 9 | 6 |
| Total | 100 | 100 | 100 | 100 |

Like Anglo-American medical specialists, Russian doctors regard «professional expertise» and «the professional ideology of altruism» as important professional characteristics (Abbott, 1988; Cant and Sharma, 1996). Despite the fact that most Russian doctors did not gain economic or political power, professional group identities had not been entirely «wiped out». And despite all the shortcomings of the reforms, the profession itself and professional values were still important. Medical practitioners did not directly connect the issue of professional expertise and the quality of patient care with the worsened economic position. Our research detected a discrepancy between medical practitioners' sense of unparalleled material shortcomings and their rather positive estimations of the professional side of things (Mansurov and Yurchenko, 2008). In general, medical practitioners rated the quality of clinical work of their medical colleagues at a rather high level: an average of 7.2 on a scale from 1 to 10. They also gave the quality of patient care high marks: 7.8 on the same scale (Yurchenko, 2004).

The questions on the level of qualification, the quality of medical help and the opportunities to use professional knowledge and experience revealed that, despite all the difficulties, progress had been made in terms of the growth of

what could be termed «professional expertise». However, the impression that the Russian people have of Russian doctors suggests that the high marks given to the growing level of professional expertise may be somewhat overstated. Public acceptance of professional advice has been seen as crucial in determining whether an occupation can be called a profession (Saks, 1995). In 2006, almost half of the respondents in the All-Russian research (45%) said that the level of professional expertise and professional knowledge of Russian doctors was low (Fund of Public Opinion, 2006). Even more respondents (56%) were unhappy with the careless attitude of doctors towards patients. Only 34% of respondents were happy with the professional expertise of Russian doctors and 30% were happy with the attitude.

The unrealistic estimation of the level of professional expertise shown by many medical practitioners can be explained by an intrinsic desire of a professional community to protect the positive image of the medical profession. Despite low income and low professional discretion, medical practitioners in Russia were considered to be a part of a prestigious social layer of the intelligentsia. Like Western doctors, their work was still to some extent a «status» profession. Weber argued that status communities are organized to defend their social privileges and entitlements. Status groups depend crucially upon the maintenance of a life style, and they seek to reproduce themselves through educational mechanisms, in order to prevent the social mobility of outsiders. Russian doctors had no control over training procedures or entry into the medical professions. However, they presumed a special position in the labor force and a professional ideology (Freidson, 2001). Some possible professionalization strategies are discussed in the next section.

## 5. Professionalization of the medical profession

Research has found that Anglo-American approaches to the professions have hardly been implemented by Russian medical practitioners to date, who are considered as a part of the prestigious group of «the intelligentsia» in the labor force even so (Mansurov and Yurchenko, 2008). Unlike Western medical practitioners, Russian doctors have an inconsistent social standing. In the hierarchy of professional occupations, they have a low social position as far as income and power resources are concerned, but they occupy a relatively high position with regard to status and cultural authority over the client. Private medical practitioners, particularly in Moscow, have acquired greater control over the content of their work and their working conditions. They have also advanced in terms of income.

As was the case with many professional bodies, during the Soviet era the few medical associations in existence were essentially coopted by the Soviet authorities (Schecter, 1992; 2000). Since then, most professional associations of medical practitioners have not had an autonomous political voice but there has been a clear revival of professional associations and the corporate work of doctors to redefine their rights and obligations. It may be argued that some newly organized professional associations go beyond their Soviet-era status. The Russian Medical Association (RMA), the largest union of doctors and other health workers in the country, has proved to be an effective «learned society» and «representative» association (Burrage *et alii*, 1990: 208). As far as its functions as a «learned society» are concerned, the RMA gives prime emphasis to the knowledge-base of the profession: it organizes All-Russian congresses and discussion circles, publishes scientific literature and holds large-scale questionnaire surveys. It also acts as a «representative association» which seeks to lobby on behalf of the profession and to obtain some legislative relief or support.

The resolutions and other documents of the Pirogov congresses clearly show that the Russian Medical Association severely criticized the state. The first criticism was that the state had weakened its control of the health sector, while the non-state mechanisms for regulating public health had not yet developed (Komarov, 2001). The second was that the state had substituted the system of state finance of the health sector with the insufficient system of compulsory medical insurance. When the members of the RMA talked about their own rights they mainly aspired to participate either in federal or local departments of the Fund of Compulsory Medical Insurance. Doctors insisted that members of the RMA be included in these departments and incorporated into the central and local legislative political bodies to (1) draw up and adopt the main legislative documents for the health care sector (programs, laws, concepts); (2) draw up the professional standards of practice and the main principles underlying the licensing and accreditation of medical institutions and the certification of doctors. However, the RMA insisted that their participation in the legislature and licensing procedures should go hand in hand with the reinforcement of state control of the health sector (Sarkisyan, 2001).

It may be argued that the interaction of the RMA with the state is quite different from trade union strategy, generally concerned with improving salaries and working conditions. However, the RMA has not yet attempted to introduce macro-changes such as an extension of private medicine or changes in health care funding through the insurance system. Rather, it has supported minor reforms which would gradually improve the situation, imposing the responsibility on the

state. Private practitioners have sought more radical changes. As the resolutions of the Russian Association of Private Medical Practitioners showed, its goals and purposes were more proactive than those of the Russian Medical Association. Among them were the following: the introduction of a single register of private practitioners and participation of the members of the association in the accreditation procedure (Mansurov and Yurchenko, 2008).

In December 2009, several medical associations, including the above mentioned Russian Association of Private Medical Practitioners, were united in the National Medical Chamber (Kranopolskaya, 2010). This new organization proclaimed that it plans to act as a «regulatory» or a «qualifying» association (Burrage *et alii*, 1999: 208), which seeks to regulate the members of the medical profession, to examine them and certify and negotiate on behalf of its members. The members of the association insist on the introduction of a single register of all Russian medical practitioners. Local branches of the National Medical Chamber should be opened and should keep registers of medical practitioners as well as information about their successes and failures – as indicated, for example, by medical negligence cases. The members of the National Medical Chamber plan to participate in the licensing and accreditation of state and private practitioners to protect doctors from arbitrary and unjust decisions by bureaucrats.

Greater participation of Russian medical practitioners in decision-making procedures may be considered advantageous to the profession and the wider public (Mansurov and Yurchenko, 2008). However, if the state, hypothetically, grants the profession a legally underwritten monopoly in the market or in the state sector, the consequences may well be negative. To date medical professional associations are still not ready to become self-regulatory for historical, cultural and organizational reasons. They lack experience in making political decisions. The Russian Medical Association has criticized the state for weakening its control over the health sector, while the non-state mechanisms for regulating public health have not developed. For many years, the activities of professional associations have targeted relatively small groups of elite professionals on specific scientific and training issues. In addition, many state medical practitioners have adhered to the notion of centralized socialized medicine and do not aspire to self-regulatory powers and upward social mobility for their group. They look to private practice and working overtime to enhance income, rather than advancement through a collective professional project.

Nevertheless, co-operation between the state and medical profession could increase in a number of ways. Members of the National Medical Chamber could participate in the work of federal or local departments of the Compulsory Medi-

cal Insurance Fund and/or the Ministry of Health and Social Development. For example, according to Yurchenko (2004):

Representatives of professional associations could help to draw up and implement the main documents legislating all aspects of the health care sector, from medical science and education to remuneration and social benefits. They could influence remuneration by estimating the quantity and quality of work and the setting in which it is done.

Professional associations could participate in controlling entry into the profession by determining training standards for medical entrants and the main principles for the licensing of medical practitioners and medical institutions. In addition, professionals could share with universities control over the content of examinations, the conditions and goals of training and education, and the numbers of 'recruits'.

Professionals could have greater influence on policies concerning exit from the medical profession. They should take part in discussions on reducing the state medical workforce and consequent dismissals and, arguably, also in identifying poorly performing doctors and, if necessary, excluding them from practice. In addition, associations should offer financial or legal assistance to their members in malpractice cases.

Professional associations and the state medical authorities could determine work plans and work rates and co-operate in drawing up quality standards. Decision-making in the sphere of diagnostics and medical treatment should be carried out mainly by professional workers themselves, rather than by state functionaries.

Professional associations should ensure that the profession maintains an ethical code through adherence to the values of the Hippocratic Oath and professional values. As far as it is practically possible, they should take steps to ensure that these are followed in day-to-day practice. The state should encourage professional associations of private medical practitioners to create voluntary registers with information about members' successes and failures (for example, medical negligence cases).

## 6. Conclusion

We have argued that the health care reforms oriented towards privatization have created a new social dynamic and opened up new opportunities for doctors to improve their status. We have shown that many medical practitioners were discontented with the social standing of the medical profession and sought to redefine it. The research has revealed that doctors fell into two groups: one anxious to

proceed along the Western-style, market-reform path, and the other determined to preserve what they saw as the positive elements of Soviet style health care. The latter continued to see themselves as part of the intelligentsia, whose status has always implied more than just professional functions. The intelligentsia has been seen as a specific elite group who plays an important role in generating societal morals and values and protects the highest ideals of good and justice. Many Russian doctors have seen themselves in this way.

We have not aimed to assess the balance between self-interests and the public interest of physicians. However, we have tried to provide to a more stable interpretation, which acknowledges the dual aspect of professions which attempt not only to enhance their status but also promote public service. Both these goals may arguably be reached by Russian doctors through the formation of strong professional associations. If Russian doctors exercise a larger influence within the health care sector, the medical profession as a group and patients in general may benefit. They may be more motivated if they are allowed to determine their own remuneration and exercise greater discretion in working practice, to set their own standards and control working conditions and clinical performance. Cooperation between professional associations and the state can only be encouraged by improving the financial position of Russian doctors.

Future health care reforms may lead to the professionalization of Russian medical practitioners because they will have greater power, and economic or cultural resources in the market or in the state sector. Some professional associations of Russian doctors strive to deal with a balance of power in the society so that they can redefine their professional image and reform the state of things in the health sector. There have always been professionals who adopt an active civil position, but in some periods there will be more of them and in others fewer. At present a civil society is in the process of being formed in our country and the number of doctors with an active civil position is increasing. And the reaction of the Russian government is now likely to have a critical influence on the development of strong professional associations.

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