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The Impact of Changes in the Medical Environment On Physicians' Identities

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Abstract: The study explores to what extent recent changes (in the last decade) in the medical environment impact physicians' identities. It has been conducted in Northern Italy (Emilia Romagna Region), interviewing 16 doctors between specialists and general practitioners and linking their insights with the literature. Our aim was to relate the de-professionalization and proletarianization debate to an identity issue: we studied whether recent changes may have relevant impact on doctors' understanding or not.

The rising of the Internet as a provider of medical information, the spread of guidelines developed on evidence-based medicine, the need of prescription savings and the clustering of doctors in new organized forms (*Medical Homes*) are interpreted as revolutions of the last decades. Physicians do engage in an *identity work* in order to make sense of the surrounding world and in doing so they consider and re-consider their role and how they are seen by patients, colleagues and society. Nevertheless, differently from past professional studies (about managers and consultants) these changes do not have the power of endangering doctors' identities: they do not eventually feel threatened by the on-going questioning of patients and institutions. The strategic solution that physicians adopt is to draw upon their logic of *autonomy* and *power* as professionals: even though they acknowledge that the *thaumaturge* doctor is an anachronistic feature, they still keep their strong identification as decision makers. Furthermore, the de-professionalization debate, mostly because of the trivial oscillations that doctors' identities experienced, has been criticized and substituted with the realization that an adaptation to change is necessary. Doctors do understand that their response to change has to entail either an enlistment of current scenarios and a reinforcement of the partnership with colleagues, patients and controlling organizations. Eventually, this study stresses the need of an increasing attention on economic matters which are becoming a pressing issue for physicians.

Keywords: Professionals, Identity, Change, Medicine, De-professionalization, Proletarianization, Self-esteem, Partnership

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1. INTRODUCTION

1.1 BACKGROUND

The medical environment, in the last decades, has profoundly changed. This has been due to different reasons that are seemingly independent but, by means of a deeper and less unilateral analysis, strongly interconnected.

A sort of bureaucratization of medicine where doctors are less independent regarding their autonomy (both for their individual organizational domain and for the way they are provided with guidelines to follow), the rise of the Internet as a provider of "lay" medical knowledge, and a changing relationship between doctors and patients are undoubtedly setting the ground for a new scenario that has to be acknowledged. Patients are becoming more and more cultured about medical knowledge (the so-called "knowledgeable patient") or, at least, know how to find it.

Moreover, medicine from the early 80s is gaining an increasingly important economic value, where main goals are not only the well-being of the patient but also the seeking of economic efficiency with cost curbing strategies and the spreading of "group medicine" (health units where doctors are somehow linked).

A vast area of the recent literature regarding an analysis of the medical environment in different countries has interpreted these changes as a sort of "de-professionalization" (when we talk about an educated public about medical issues, the spread of computer technology and an emerging division/routinization of labor) or a "proletarianization" (when we notice a declining control of professionals over their working conditions).

Doctors are therefore apparently experiencing a change from an era where they were the only keepers of the knowledge and the only ones who could shape their working conditions to a scenario where what they do is both controlled and questioned by others.

An issue which stimulated our interest is to study in depth how professionals interpret this situation in terms of identity. Several studies have been conducted regarding professionals' identity in modern times, especially regarding consultants and managers. Nevertheless, we found a lack of studies related to the very specific of the medical profession. This has to entail a shift of focus from the understanding of professions whose body of knowledge is uncertain and sometimes ambiguous (as the one of consultants or managers) to professions which stand on a more scientific and robust background, as the medical one.

In addition to that, the medical profession has always been interpreted as a kind of "élitarian" job, where power and even politics have played a relevant role in creating and keeping doctors' privileges and high statuses. Consequently, we assume that doctors have developed a very strong identity and attachment to their job.

As we mentioned above, several and various changes that are occurring in the medical environment could have had consequences which are not solely related to organizational and economic outcomes. It is likely that the way in which professionals view themselves and how they think that others view them is being shaped by what is happening nowadays. Following Watson (2009) we are therefore trying to relate identity issues to a particular historical and social context: the Italian one. This is the background where we are setting our study and that will hopefully lead us to a deeper understanding of doctors' view of today's scenario.

Going even deeper, we are interested in the understanding of their identity fluctuations or insecurities, if they are present, due to the reasons that we listed above. Alvesson (2004), studying the identity of professionals (in particular, the case of management consultants) shows how the ambiguity of their outcomes creates a situation where professionals are questioned by others, thus reducing their self esteem

and causing frustration. It will be interesting to analyze whether this could be applicable for our particular kind of professionals i.e. physicians. Basically, we aim to study to what extent recent changes had an impact on a category of professionals who, because of their tradition and experience, seem to be a very particular and challenging phenomenon to analyze. Broadening the perspective to a higher macro-economic discourse, we aim to understand whether economic and institutional development is standardizing and levelling human capital resources through an on-going routizination of professionals' tasks.

1.2. PURPOSE AND RESEARCH QUESTION(S)

What is the impact of these changes on physicians' identity?
Our aim is to study whether the above mentioned events have somehow had the power of changing professionals' perceptions of their identity, both in how they see themselves and in how they think that others see them. It is important to us to understand how (or if) physicians' identities have been shaped by what is now happening and we conducted this study to evaluate the impact (or the relevance of the impact) on this kind of professionals. We are basically interested in the personal interpretations of these changes by doctors: the perspective that we are using is therefore from that side.
We will draw upon the notions of self-identity and social identity (especially, the conceptions of Social Identity Theory and identity as a "struggle").
Our aim is going in two directions which are, nevertheless, connected. Analyzing the image and role that physicians have of their work and their role (identity side) we will question the theories of de-professionalization and proletarianization in the medical environment (professional side), especially regarding the supposed loss of autonomy that doctors might be experiencing. In doing so, we will have to separate the notions of identity, role, image and then connect them to the social environment where professionals operate.
We will relate our findings to similar studies on different kinds of professionals and we will underline the differences and the consequences of relying on different "bodies of knowledge" of the professions.
It will therefore be challenging to find out whether the most recent theories of identity can be related to a profession with such a strong tradition and history and what could be our contribution in understanding this changing environment.
Our study can also suggest managerial implications. Since our departure point is a managerial notion of identity (coming from a business administration literature) we are not solely interested in doctors' identity *per se.* We would like to understand the interconnections between medicine and economics, in order to understand how doctors conceive their role and their contribution both to the patients' well-being and to an achievement of necessary economics goals. More specifically, in the last decades we are facing cost cutting needs which can be interpreted as leading to somehow different directions than the one of the patient satisfaction. When it comes to drug saving to contain the national spending, how can this fit the "mission" of guaranteeing the best cure for the patient? It will be interesting to see to what extent being a doctor nowadays entails the need of having other skills, in particular the economic capability of managing the resources in an efficient way and whether this could clash with the primary aim of physicians: a focus on the health of their clients.
Last, related to the mentioned interest in linkages between medicine (our human capital target) and economics, we are interested in studying whether recent changes have the power of standardizing how professionals work. Can the on-going bureaucratization of the work be interpreted as a levelling of human

capital resources by institutional and economic forces? Can professional autonomy and power be eroded by these dynamics?

1.3. METHOD AND SELECTION

Our paper is a qualitative study of professionals' perceptions about their identity and role in the society.
It is basically divided in two main areas: a literature review and an analysis of the data the we gathered.
The first part is necessary in order to both analyze and criticize the literature and get the tools to broaden the discourse, to study whether some identity aspects are applicable to our case study and to hypothesize possible developments.
The literature review will touch upon two main topics: identity and profession.

Regarding the identity side, we will analyze different conceptions and definitions, both related to self-identity and to social identity, following the Social Identity Theory. In the wake of the recent research, we will conceive identity as a temporary element which continuously entails an "identity work".
Moreover, we will deepen the issue of insecurities and oscillations at work, trying to understand how people's self-esteem can be affected by others. We will therefore analyze how professionals conceive their personal identity as a struggle which comes from the interplay of several discourses, trying to evaluate whether a clash of these discourses can cause any problem in their work routine.

Regarding the professional side, our focus is on physicians and we will analyze their role in the society in the last decades. More specifically, the theories of de-professionalization and proletarianization will be studied and questioned, suggesting different interpretations of what some scholars interpreted as a progressing "loss of autonomy" of doctors over patients and working conditions. We will try to study these theories relating them to an identity view of the matter: we are not only interested in analyzing a supposed loss of control over doctors' expertise but we look for the link between these theories and a decrease of professionals' statuses and identities. More specifically, we will try to find out whether a knowledgeable patient can somehow hamper doctors' maintenance of their prestige or not.
We believe that a detailed and critical analysis of the literature is necessary and could permit the development of a framework to understand both the individual identity side and the socio-economic background where doctors operate.

Concerning the empirical part, we will transcribe relevant excerpts of the qualitative collection of data that we gathered and analyze them. In order to make sense of the data that we got through the interviews we will try to use what we studied in the literature. More in detail, we will see whether what appears in the literature regarding identity and professional issues can fit our special case and, if it can, to what extent.
Moreover, we grouped our results in tables in order to clearly show the number of doctors who experienced troubles in dealing with the issues that we deepened and, if they did, how many of them succeeded to solve them.
In this way, it will be possible to appreciate both some qualitative excerpts of our data collection and the precise number of positive or negative statements. We will therefore be able to reach our conclusions regarding the supposed de-professionalization and proletarianization phenomena, always related to an identity side.

We decided to conduct a qualitative study inasmuch as, since our final outcome will be an understanding of professionals' attitude, this could not be gained through a quantitative collection of data: the perspective would have been different. Impressions, feelings, emotions, understandings and attitudes will give us a valuable picture of the particular situation which characterizes doctors in an era where changes are relentlessly leading to new scenarios.

Concerning the selection that we made in order to gather data, we decided to conduct semi-structured in-depth interviews to both GPs (general practitioners) and specialists.
The tool of the semi-structured interview has been preferred to structured ones and especially to other kinds of collection of data as questionnaires. In our opinion, only a face-to-face contact with our respondents could allow us to deeply understand their conception of identity and role in the medical environment. The questions that we asked were referred to a time-limit of approximately twelve years.
We contacted 20 doctors between GPs and specialists, 19 of them agreed to be interviewed and we decided to only elaborate 16 of the interviews that we got. [1] Furthermore, 2 of our respondents have been interviewed together for a scheduling matter. One of them, being particularly interested in the topic, contacted us to participate in another interview some days later, again in couple with another doctor.
Further details are presented in section 3.1 The Interviews.

2. THEORETICAL BACKGROUND

2.1 IDENTITY

The main interest of our paper is to study identity, from the way it has been conceptualized and understood to the implications that it has nowadays on human relations. At the same breath, we do not claim to exceedingly deepen psychological domains that could endanger the implications of our study, which is try to relate individual attitudes with the changing economic and social environment.

What is therefore identity? According to Alvesson (2004) identity is how people see themselves and, as a consequence, how they should act; it is possible to distance from other conceptions (as the "role") but not from identity. We can understand how identity has recently been conceived as an element which shapes both the personal view and the behavior that a person has to show. This definition of identity implies a form of subjectivity (or self-identity) and it is linked to specific beliefs and values (Knights and Willmott, 1992). Giddens (1991) also talks about self-identity as the concept of "self" understood by the agent: it is not a peculiar characteristic of the person but the result of an interpretation of the self. This implies that the person, in understanding and defining his identity, go through a sort of process, that we will later introduce as "identity work". If we consider this conception in an unilateral way we risk of seeing it as solely personal and individual issue: we will see how the discourse is broader. Collinson (2003) expresses his concern about how western traditions have interpreted human beings as single and unitary and who could exist detached from the outside world. The philosophy that we are following regarding the identity issue has its roots instead in the structuralist and post-structuralist conceptions, that brought revolutionary

[1] Three interviews have been conducted in Sweden for a temporary location of the interviewer. An initial idea of comparing two different healthcare services has been left for future research as the data collection was not balanced enough to make a comparison (16 Italy, 3 Sweden).

changes to the identity thinking. Burkitt (1991) and other post-structuralists have conceptualized a strong link between people and the world around them, interpreting them as 'social selves'.
A breakthrough within the identity field has been the conceptualization of the so-called "social identity theory" which is finally connecting the individual identity to the social world. Ashfort and Mael (1989) in their seminal paper argue that people "*classify themselves and others into various social categories*" and, as a consequence, this allows the agent to define himself/herself in the social environment. Ashfort and Mael, in the same study, also pinpoint factors that increase this identification: *distinctiveness, prestige* and *awareness of out-groups*. We can therefore notice how the definition of the self has shifted to a conception where people define their selves also according to the others (the social world) and to what exists right outside specific groups they belong to. We are not solely what we think we are but, especially in modern times when rhythms and routines are ambiguous and chaotic, we are also related to the others. That means both feeling the belongingness to a group and the competition with other groups, increasing the understanding of what *you are not* (as Sveningsson et al., 2003, showed as *anti-identity*). It will be interesting to study to what extent this is applicable to professionals and, in our specific case, which is the relevance of this element in doctors' definitions of themselves.

An element which is strictly connected to identity and that we found both in the literature and in our empirical data is the concept of *role*. According to Alvesson (2004), role is the position that people take when they interact with others: it is possible to distance from it but not from identity. Ashcraft (2007) also studies the concept of role, defining it as when people wear job identities in a "*mundane fashion".*
We can therefore find the link between a strictly personal interpretation of the self and the shift to a social understanding: can be the role the connecting point between the self and the social part of the world?
Furthermore, following Ashfort and Mael (1989), since people belong to different groups, people's identity is composed by an '*amalgam of identities*': the conflict in organizations and in life in general is not caused by the identities but by the different values and components inside the identities. We do interpret this as a role conflict where people act differently according to the situation. It will be challenging to understand what is specifically affected in our case study. Is it really the very concept of identity which is affected in the relationship with people or, on the other hand, it is the role which changes according to different situations?

The interpretation of identity as an amalgam of identities that we mentioned above leads us towards another and more comprehensive understanding. We noticed how identity is not only related to the individual definition of the self. Besides, we introduced the Social Identity Theory which broadens the horizons theorizing a connection with the social world. A step further has to be done: Alvesson and Willmott (2002) and Sveningsson and Alvesson (2003) argue that social identity theories assume a way too stable view of identity, while they should instead entail a definition of identity as a temporary construction that is negotiated and formed in different moments according to an elaborated process. The idea of "identity work" is introduced, referring to *"people being engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness"* (Sveningsson and Alvesson, 2003). We can therefore understand how identity is defined as an on-going construction and not anymore as a fixed element. Sveningsson and Alvesson (2003) also show how individuals *struggle* in order to shape their personal identities in a changing environment, where worries and ambiguities increase the skepticism of people and hamper the maintenance of a stable conception of the self. In this fashion, people's identity is not innate while it is something that they struggle for, facing continuous difficulties. Furthermore, in the paper that we analyzed, individuals construct "*various*

managerial and non managerial identities in a complex, changing and multi-ordered organization", and the individual (the manager, in that case) strives to create meaning between different *discoursive forces* that create tensions in the organization; some *discourses* constitute resources for the manager's identification while others can clash (Sveningsson and Alvesson, 2003). We can understand how people have to deal with a role conflict which is due to the synergy of several expectations and discourses and the so-called *identity work* is fueled by that struggle. The result is a sort of internal competition, or *role conflict*, where people have to face several scenarios and find a balance between different forces leading to opposite paths: this is the identity work conceived in this part of literature.

Last, it is interesting to see how everyone has a particular way of solving her/his internal issues. In the study that we mentioned above the manager solves her problems creating a *self-identity* which is sustained by the discourses she feels closer to and which help her to make her identity struggle more comfortable, even at the expense of some troubles within the company (the adoption of cultural and personal discourses that are not completely shared by colleagues) (Sveningsson and Alvesson, 2003). A brief mention to a related studies is needed (Muhr and Kirkegaard, forthcoming), where a manager solves his work-life balance relying on fantasies that give him the illusion of being *something else* in order to, we add, make the identity work easier.

Applying what we pointed out to our study, we are strongly interested in unraveling which is the attitude of our respondents (physicians) regarding the idea of identity that they have related to their profession, how this identity can change, adapt or be fueled by different discourses during their work and how they solve their internal issues (hypothesizing that they have some). This last point helps us to connect to another relevant issue that has to be deepened. We assume that the so-called *identity work* would not happen in such a high degree in stable and not changing environment. Given the ambiguity and the constant change that are happening nowadays, both in organizations and in the social world, we conclude that the more the world is challenging and the work of the professionals is questioned, the more easily they engage in the construction and strengthening of their identity according to an identity work. In the literature we found several insights concerning the fact that professionals' identities are more and more questioned and we are interested in understanding to what extent this is applicable to doctors. Moreover, the growing body of literature that theorizes a sort of de-professionalization or proletarianization of the medical profession might show that what was once conceived as a stable and strong identity (the one of doctors) can be somehow be affected by the changes of modern times, this even causing frustrations and insecurities.

What we would like to analyze from now on is what Gergen (1991, cited in Collinson, 2003) called the impact of economic and social forces on the changing subjectivity. As Stryker (1980, cited in Haines and Saba, 2012) states, a fundamental idea of identity theory is that the external social environment impinge on the structure of the self. We assume that an increasingly changing environment can have some effects on people's identities, causing oscillations of their attitude.

Alvesson (2004) in his study about knowledge intensive firms points out the oscillation between an ideal idea of professional and a less glamorous status of a simple worker caused by the unpredictable and relationship-dependent character of knowledge intensive organizations, this causing questioning and skepticism of professionals' service and difficulties in their daily identity work. Moreover, Collinson (2003) also studies insecurities at work and points out how they can be triggered by personal attachment to notions of the self. We can notice how both the ambiguity of modern times and the very character of professionals' services can cause a sort of confusion regarding the professionals' subjectivity and the outcome of their work. The world is seen as unsecure and the professional, who builds his identity upon his knowledge and the result of his work, feels more and more threatened, experiencing a decrease of his self

esteem and a questioning of himself. How are professionals' attitudes affected in a world where people are questioned and continuously have to maintain and nurture their identities?
Another study that we found relevant for our purpose has been conducted by Haines and Saba in 2001. They studied how some events, challenging the individual identity, can cause *"emotional exhaustion"* and, in the wake of Thoits (1991, 1995) they agree that *"events occurring in highly-salient identity domains will have a greater impact on psychological well-being than events occurring in less salient domains",* interpreting salience as the degree how a person is committed to his/her role. We can understand how professionals (in the paper, working in the Human Resources field) are likely to be destabilized by some events and by the "fight" of different roles that compose their identities. We interpret the medical profession as a highly-salient domain, where people have to deal with life issues and where a lack of trust in doctors can even cause a "psychological exhaustion" that could affect the final outcome. It will be interesting to find out to what extent this is true, and whether the specific esoterism and power of knowledge that physicians have can be a sort of safety net that prevents them to have dangerous identity fluctuations.
We nevertheless have to underline that most of these theories draw upon professionals working in knowledge intensive firms in "soft" science-related areas, as consultants or lawyers. As Alvesson (2004) continues, professionals in "harder" science-related fields as doctors and scientists are less likely questioned. We would therefore like to study to what extent recent changes can impact on this particular kind of professionals: are they still the only keepers of the knowledge?

2.2. PROFESSIONALISM

In the previous part we introduced the concept of identity. We first analyzed it in a self-understood way, answering to the question "*Who am I?"*. Then, we related it to the social world, drawing upon Social Identity Theory and entailing questions as *"How others see me?"* and "*How do I see myself belonging to the social world?"*. Furthermore, we noticed how modern times can cause identity fluctuations and insecurities, showing how identity work is a necessary tool in order to fuel and maintain a personal identity.
We would like now to relate our reflections to the very specific concept of professionals. We will deepen what professionals are and examine the theories which introduce some doubts in the professionalism of doctors: is a de-professionalization in medicine really occurring?

As we aim to analyze the supposed phenomena of de-professionalization and proletarianization, what is needed is to define what professionals are, according to some definitions that we found being relevant.
Scholars as Freidson (cited in Sullivan and Porter, 1993) have paved the way for a conception of professionals: their most relevant characteristics are the control and mastery of a complex and esoteric body of knowledge and abilities and a constant orientation towards the interests of the public.
According to Faber (2002), professionals entail a high ethical self-consciousness and a high social status: these elements are strictly connected inasmuch as professionals are "*ethically obligated to maintain their distinctiveness and the social and economic power that comes from this elitism".* Alvesson (2004), mostly studying professionals in knowledge intensive firms, stresses their elements of prestige and autonomy and he talks about *professionalization* when it comes to politics and struggle for a high status and a sort of *closure* that excludes other people from the share of a specific condition. We can understand how the elements of power and prestige are introduced, interpreting professionals as an élitarian category that

differentiates from others for several idiosyncrasies. Several scholars agree on the importance of knowledge to professional autonomy and identity (Abbot, 1988 for example). We therefore expect that doctors, our specific category, rely on their power and prestige in order to conceive themselves as *different* from other social categories. In the previous part we noticed how individual identity is also defined as an anti-identity i.e. *who are not* and it will be interesting to analyze, with the data that we gathered, to what extent this is present in the doctors' understanding.
Since professionals position themselves as the only providers of their services, this excludes other categories from sharing what they do (Faber, 2002) and they shape the market with regulations and certifications in order to favor the professional group and somehow create a sort of *monopoly* (Savage, 1999). We can easily understand how the identity theories that we deepened above are applicable here: the perspective is different but the main goal is the same i.e. how people or professionals understand themselves and position in the outside world. Linking identity with professionalism, a recent paper (Brooks et al., 2010) studying IT workers' identity as '*oneness to a profession*', pinpointed the importance of organizational identification and similarity to others in their profession. Moreover, it has been found out how in the IT field characteristics of identity changed with time (Reybold and Alamia, 2008, cited in Brooks et al., 2010). Since IT field is a rather new area, changes and adaptations will be more frequent, and less stable will be the identity of professionals working in that field. On the other hand, we assume that in the medicine terrain identity features are less likely to change: we are interested in analyzing how modern times can impact on the ones who work in a sort of "classic" field as the medical one: is identification in the profession changing physicians' attitudes?

After having briefly defined what professionals are, we are now fully focusing on the professional category we are interested in: physicians. In the wake of several scholars' studies, we try to follow Friedson's conception of doctors' *dominance-position.* We will therefore analyze whether in the literature phenomena as de-professionalization or proletarianization can affect this theory and, using our data, we will build upon a *professional perspective* in order to analyze whether some relevant modern changes are affecting doctors' identities or not.

Freidson (1970, 1980) argues that medical profession controls the health system in all its aspects and this comes from its monopolistic power: *"*(it is) *clearly political in chara*cter*, involving the aid of the state in establishing and maintaining the profession's preeminence".* Even some years later he stresses the fact that there is no doubt that in the next years this situation of power will change (Freidson, 1985).
This is an important starting point for our analysis. Is that still true? Are recent changes affecting the supposed doctors' autonomy? Is this having any particular effect on their identities? In order to answer these questions we need to explain what new phenomena exactly are.
Furthermore, we have to add that even though Freidson's thesis has been shared by several scholars, there are different opinions. According to Navarro (1988) the problem is not that physicians have lost power in medicine but that they never had such a control. Both because there is not space here to question this last argument and considering the particular characteristics that we found fitting professionals (high status, vast body of knowledge, autonomy…) we will entail as starting point Freidson's position of doctors' dominance. In other words, we will not consider the possibility that physicians never experienced this power (the characteristics they show seem to support Freidson), but we want to analyze instead if this is still applicable nowadays.

Starting from the end of the 80s, some scholars underlined the fact that doctors were losing their dominance. The *New York Times* (Pear, 1987) showed how doctors were losing some of their power, this causing frustration, to bureaucrats who claimed to tell them how to be doctors: *"…The judgment of physicians has been usurped by cookbook criteria created by people who are not doctors".*
According to several authors (Oppenheimer, 1985, McKinlay and Arches, 1985, cited in Navarro, 1988) a process of proletarianization is occurring, interpreted as the moment when professionals lose control over their working conditions because of an on-going bureaucratization: doctors were likely to be reduced to workers carrying on a proletarian function. The phenomena of both proletarianization and de-professionalization have been widely studied in the literature (some interesting studies are Coburn, 1994, Hardey, 1999, Filc, 2006). According to Hardey (1999) and Broom (2005), the latter roughly twenty years after the first appearance of these theories, we are facing both a process of proletarianization (when the medicine is extended beyond the control of the medical profession) and of de-professionalization (when the medical knowledge is more easily accessible to people). On the other hand, these authors (especially Broom) propose a different view of the matter, questioning the de-professionalization theory (we will deepen this in the next section). We can notice how in the last years there has been a wide debate regarding a presumed loss of power of doctors over their knowledge and working conditions. While one concept relates to organizational and managerial issues, reducing the control that doctors had over their work, the other mirrors an environment where *lay knowledge* is more accessible to the ones who are not supposed to keep it. This means that, with time passing, people can get more and more medical information in easier ways, thus undermining the classic conception of physicians as keepers of a sort of *rocket science.* Having said this, which are exactly the changes in medicine that made scholars talk about de-professionalization and proletarianization?

2.3. CHANGES IN THE MEDICAL ENVIRONMENT

The first relevant change that has been occurring since the beginning of the 80s is a sort of bureaucratization of the medicine, as we mentioned above in Pear's study. A terrain which once was solely managed by physicians has started to be controlled by others, even by people who do not have the scientific background to do so. This, we assume, might cause frustration in doctors' lives and identities. Furthermore, other elements can be listed as an increasing bureaucratization of the medicine and that is not necessarily due to a presence of non-doctors in the medical world. As an OEDC 1996 report pinpoints, an increasing attention to cost-curbing strategies and the need for a higher accountability of doctors caused a dramatic raise of incentives and rules to change the way how general practitioners and specialists work. We can notice that other elements have to be kept in consideration by doctors when they work: cost cutting is a pressing need and this calls for a high level of attention. Lewis et al. (2003), in their study about Australian GPs, stress how one of the major constraints is a sort of *routinization of experts* and how their work was subjected to governmental control, worrying more about cost-cutting issues than about the patient care. Two consequences will be interesting to analyze with our empirical data. The first one is to what extent being a doctors nowadays also means being a manager inasmuch as financial aspects are increasingly more relevant. Second, we would like to understand whether an attention to financial issues could endanger the primary aim of doctors i.e. to provide the best cure for the patient. Could these two apparently opposite forces eventually clash?

Another aspect that has to be analyzed within what we called *bureaucratization* of the medicine is the increasing presence of medical guidelines. According to Field and Lohr (1990) they are "*…systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances".* Timmermans and Kolker (2004), studying the rationale of guidelines, stress how the basic idea is a shift from pathophysiology to epidemiology with a quantitative and population-based fashion of analyzing illnesses: guidelines are still elaborated by members of the medical profession, this dispelling all the doubts regarding an intrusion of managerial prerogatives. What we pointed out means that in this case, according to the authors, we are not experiencing a physicians' loss of autonomy (Freidson's claim would still work) but a change of focus, setting the elaboration of guidelines on the so-called *evidence-based medicine* (ibi). Timmermans and Kolker also point out that a risk could be to view the increasing use of medical guidelines as a sort of standardization with the aim of reducing practitioners' variation but, as we will see later, with a deeper analysis the situation might be different. We also need to mention that guidelines found several oppositions, especially regarding their sources and their goals. Among others, it has been argued that money is the real driving force (Zinberg, 1998) or that in the last years they have become plethoric, obsolete and somehow too much influenced by experts' dogma (Schwenk, 2009). Undoubtedly, going through the literature we noticed how medical guidelines have dramatically increased in the last years, and we interpret this as one of the elements which could contribute to the loss of physicians autonomy. It is a fact that what thirty years ago was complete freedom is now strictly regulated by rules that come from the top. Is this having any effect on doctors' identities?

As we noticed in the previous part, the challenge for physicians' autonomy can come from a governmental and organizational side. On the other hand, the patient himself can be a "threat".
Several scholars (Hardey, 1999, Broom, 2005) have studied how patients are more and more informed about issues which once solely belonged to physicians: *lay medical knowledge* is becoming easily accessible because of the Internet and because of an information society. Moreover, the spread of CAM (complementary and alternative medicine) dramatically increased the options for consumers, leading towards a consumerist model of health care (Broom, 2005). According to Hardey (1999) the increasing of the Internet amongst patients caused a challenge to old hierarchical ways of information giving: the result could be a lower trust in doctors. We can notice how classic and paternalistic relationships between physicians and their clients are facing a radical change. A supposed stable order is somehow reversed: people are more informed, they look for information on the Internet and they question what in the past was an unilateral flow of information. The patient is therefore becoming a cultured person who can be seen as a threat for practitioners' esoteric knowledge.
According to quite recent surveys, a percentage between 60 and 80 % of people living in the US used Internet to find information regarding health issues (iCrossing, 2008). A relevant element is that, according to Fox (2006) only 15% of the seekers state that they always check the date and the source of the information that they find: this could open a wide debate concerning the reliability of online knowledge.
According to Slattery (2008) online information can cause confusion and anxiety since it is a hard job for non-doctors to be able to distinguish symptoms and causes and Kim and Kim (2009) showed how a constant online research can mirror a lack of trust in physicians' skills while the overall effect on doctors' perceptions is neutral (both positive and negative). Nwosu and Cox (2000) also showed how physicians (in their study mostly specialists) perceive that the Internet may damage the doctor-patient relationship and that an Internet usage training was needed in hospitals. The literature studies about the use of the Internet in the relationship doctors-patients are several and they show both pros and cons, depending on the

utilization that people do. The following table can show which are the major providers of health information in the US:

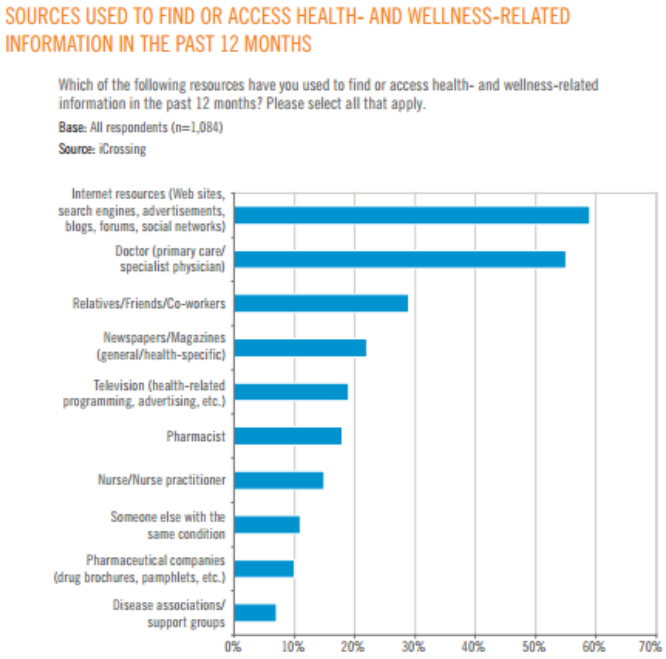

Figure 1. From Kahn et al. (2008)

We can see how in a panel of 1084 respondents, almost 60% of them stated that the Internet provided them with the biggest amount of information in comparison to other channels as doctors, press, television and other medical actors. Regarding the sources of the increasing patients knowledge, as CAM and consumerism, we do not have space here to deepen a wider body of literature and it is not our main goal to study the reasons of these issues. What we are interested in is to provide the reader with a general picture of the medical environment, to mention which are the most relevant changes, to understand why do they foster the de-professionalization debate, to analyze which are the major critiques and solutions and, last, to use the empirical data in order to find out whether these changes had an impact on doctors' perceptions and identities.

As we have briefly analyzed, according to a vast body of literature a process of de-professionalization or proletarianization is occurring since a long time, the two being slightly different but also strictly connected. As Lewis et al. (2004) clearly stress, the two major forces leading towards these processes are patients and bureaucracies (institutions, governments…). People are becoming more and more informed with *lay knowledge* about medicine; consumerism and alternative treatments are endangering the medical power and bureaucracy with both institutional and medical guidelines are reducing physicians' autonomy, like they were sort of *employees.*

Sic rebus stantibus, we need to mention some critiques to the de-professionalization thesis, in order to see the other side of the coin and analyze our data in a way which is open for debate.

2.4. CRITICISM TO DE-PROFESSIONALIZATION AND PROLETARIANIZATION THEORIES

Navarro (1988) more than twenty years ago already understood that the on-going corporatization and commodification of medicine could be a threat for physicians but on the other hand he differentiated the process of losing autonomy from the one of proletarianization: according to him the term can be *politically misleading* inasmuch as the history has shown that medical profession very rarely carried on changes called by the labor movement. We can see how we cannot categorize doctors as a mere part of the working class which is led by progressive forces in order to obtain more rights and privileges. As we have noticed before, the profession itself relies on a sort of *élitarian halo* that makes it special and "closed" and we understand how the term *proletarianization* does not seem to fit the situation that we are analyzing.

According to Filc (2006) it is a fact that medical knowledge is more accessible to people but this is why *"…the profession is constructing new ways of defining its cognitive basis so as to protect its monopoly over skills"* and the main tool for that aim is the focus on *evidence based medicine* which is creating a sort of *stratification* of medical profession, both considering knowledge and other issues as cost savings and rationalization. The author, in his critique of the de-professionalization theory, argues that the shift towards a more managed health care does not mean that the classic physicians' values (as altruism and autonomy) would disappear: on the other hand new systems based on a *formal rational* way can be characterized by values and ethic as they rely on equal access and financing by progressive taxation (he provides the example of Great Britain and Israeli healthcare services). As we can notice, it is argued that what is occurring is not a de-professionalization while a shift of focus to new ways of understanding medicine which do not necessarily imply a loss of autonomy and power. Is it really like this in doctors' identities and interpretations?

Lewis et al. (2003) agree that GPs (in their study on Australian doctors) are threatened by financial constraints and a more *knowledgeable* patient but this could not be expressed by a general discourse of de-professionalization while, in order to have a full understanding of the situation, micro levels in the workplace have to be considered: physicians still strongly consider themselves as professionals while some changes are undoubtedly occurring, especially regarding an increase of workloads and morale oscillations. We can notice how the de-professionalization thesis should not be generalized to higher levels: even though a loss of autonomy is undoubtedly occurring, we do not have the elements to state that such a phenomenon in medicine is taking place.

Going even further with the critiques of these theories, we can find how the scenario can be interpreted in different ways which entail a sort of *adaptation* to modern times. Broom (2005) acknowledges how a process of transformation is necessary and he interprets it as an *enlistment* where the Internet informed patient should not be conceived as a threat for the doctor but instead an opportunity to adapt to the current situation with the aims of increasing the dialogue and improving the decision making process. Timmermans et al. (2004), as we mentioned above with their evidence-based focus, interpret these changes as a *reconfiguration of the medical knowledge:* our analysis should not start with a focus on quantity (what physicians gain or lose) but on quality (analysis of the shifts of knowledge and autonomy). Furthermore, Lewis et al. (2003), drawing upon the notion of *re-professionalization,* shift the focus to a sort of constant *renegotiation* of professional power. We need to stress how to renegotiate something does not necessarily imply that a loss is occurring: modern changes mean that there are new challenges for shareholders and stakeholders and what is needed is a capability to question the situation in order to adapt to a different scenario. This calls for a needed flexibility and open minded attitude of physicians: they have to realize that if they want to deal with new challenges they have to entail the possibility of changing

perspectives and renegotiations of power. A more knowledgeable patient means that he can question doctors' diagnosis: physicians will have to accept that and re-define their job according to new basis. Nevertheless, a higher pressure from bureaucratization, routinization, cost-cutting strategies and evidence-based guidelines can also be a threat for physicians and their capability of facing change is strongly tested: are they able to *enlist* this scenario in their routine?

A seminal paper which can help us to connect the literature related to the changes in the medical environment and the de-professionalization thesis to the identity literature and then to our empirical part has been written by Watson in 2008. According to the scholar, it is relevant to link what he calls *managerial circumstances* to "*broader societal or political-economy level structural circumstances and transitions"* in order to understand how people's identities relate to societal and historical events. Strictly speaking, we interpret his ideas in a way that links what happens in people's minds to an external side: the society.
This is to show that perhaps the focus that allows us to perceive change as a possible path relies on an external perspective where people's actions are set and explained. As the proletarianization and de-professionalization criticism suggests, we need to entail the possibility of a shifting focus which is open to new conceptions of medicine.

Furthermore, Watson goes on showing how people act according to a three-step process (as we can see in Figure 2.) where a discourse is identified and a self-identity is created through an identity work that involves the presence of a *social identity.* In the example that Watson analyzes, his case study is a manager who has incorporated into his self-identity various elements of external and social "managerial identities" and not, as old identity studies suggest, a manager who simply has a managerial identity: this identity work takes place in a changing, ambiguous and various context, where people are often questioned and have to strive between different and sometimes contrasting discourses in order to fuel their identities.
Our analysis has been done to connect the personal creation of the self with influences coming from the social world. In the same fashion, we can broaden our analysis and understand how professionals (in our case doctors) have to deal with different discourses coming from a social world and how they foster their notion of the self with a continuous dialogue between an internal and an external perspective. We position physicians following Watson's framework, seeing how they engage in an identity work that *"bridges self identity and wider discourses":* during the process of framing their self-identity individuals also deal with social identities (Watson, 2008). These discourses, in our point of view, are the ones which come from social, institutional and political areas and which create and nurture people's self identities. We therefore have to connect what physicians think and how they perceive their work to wider discourses and not limit our focus to a mere incorporation of unilateral influences. We would like to interpret what is happening (Internet, consumerism, bureaucratization, routinization…) to the historical context: doctors are therefore engaging in an identity work whose features come from the needs of the time when they live and not, as de-professionalization theories suggest, from sudden influences which threaten their status.
We showed how our interpretation of the literature, drawing upon identity theories, is criticizing proletarianization and de-professionalization theories, interpreting these changes as necessary adaptation to modern times instead. What has to be answered yet is how this is conceived in practice i.e. whether our respondents, a symbolic panel of doctors, interpret the changing world as a threat for their identities or not.

Figure 2. A 'three step' view of the relationship between managerial and other discourses and self-identities

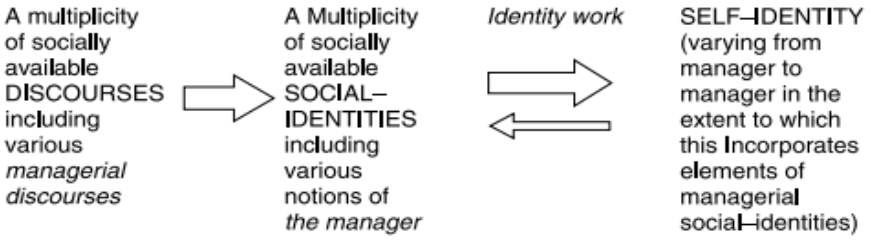

Figure 2. From Watson (2008)

SUMMARY OF OUR ASSUMPTIONS

During the theoretical part we developed several assumptions or hypothesis that we aim to study with our empirical data.

We acknowledged that several changes have occurred in the medical environment and we expect that these changes could have impacted on physicians' identities and attitudes. These changes can be categorized as belonging to two different phenomena: a de-professionalization (changes related to an empowered patient and to a shift of medical knowledge from the doctor to other actors) and a proletarianization (changes related to an increasing use of medical guidelines, cost-savings and appropriateness measures and a progressive clustering of physicians into Medical Homes).

In the wake of past studies which considered the impact of modern times' innovations on professionals' (managers and consultants) identities and possible frustrations or self-esteem oscillations, we want to analyze whether this could also be the case for our target i.e. physicians.

Considering that the environment has profoundly changed (Internet, cost-saving policies, increased bureaucracy, spread consumerism) we are now trying to relate what we studied in the literature to empirical findings by posing the following questions:

1. a) Are physicians' identities threatened by being increasingly questioned by the patients? (related to a "patient empowerment")
   b) In other words, is a "de-professionalization" actually occurring?

2. a) Is the status of physicians as professionals being threatened by recent changes in the medicine environment such as bureaucratization/routinization, grouping in new forms of organization and economic pressure?
   b) In other words, is a "proletarianization" actually occurring?

3. EMPIRICAL PART

3.1. THE INTERVIEWS

The target of our study, as we mentioned, are physicians, and we decided to focus on this kind of professionals for several reasons.
First, analyzing the related literature, we found a lack of studies regarding physicians' identity side. As we have deepened above, most of the papers that we analyzed rely on data gathered in economic organizations, especially studying managers. Second, we would like to study whether a statement carried on by Alvesson (2004) is still applicable or not: he stressed how professionals in "harder" science-related fields are less questioned than professionals who work in "soft" fields as managers or consultants.
We would like to analyze to what extent the multiplicity of changes in the "popular culture" has the power of questioning what doctors say and which are the possible future scenarios. Third, still related to the changes in the medical environment, we are strongly interested in understanding whether doctors can experience any frustration or identity oscillation because of a more and more "chaotic" environment.
We are fascinated by apparently conflicting issues between an élitarian, closed and esoteric knowledge and a daily work routine which calls for dialogue, understanding and a sort of empathy for the best cure of the patient (regarding this last element, see Del Canale S. et al., 2012, about the relationship between physicians' empathy and diabetes' cure).

We contacted 20 professionals operating in the medical field in three countries: Italy (15), Sweden (4) and US (1) and 19 of them answered agreeing to be interviewed. Concerning the professionals in Italy and US, we got their emails through a primary care physician who, having a role of coordinator in his health unit, was keeping contact information of his colleagues. Regarding the physicians in Sweden, we asked for their collaboration through hospital helpdesks in Skåne region. Among them, there are general practitioners (11), specialists (6) and bureaucrats/administrators (2). The interviews conducted in Italy took place in Emilia Romagna region (Parma) while the ones conducted in Sweden in Skåne region (Malmoe and Lund). All our respondents have graduated in Medicine except one who has conducted pharmacist studies.
After having carefully analyzed the data that we gathered we decided to focus only on the interviews taken in Italy as the sample was not wide enough to allow comparisons between the two countries. We therefore studied a final number of 16 interviews, eliminating 3 of the professionals (1 did not answer) and adding to the 15 taken in Italy the one conducted through Skype with a professional operating between the US and Italy as a policy developer.
The age span of our interviewees was between 45 and 66 years and the average age was 54 years; 14 of the interviewees were male and 2 female.
Our questions were related to a starting point of approximately twelve years ago. This means that we tried to evaluate physicians' opinions regarding changes starting from a bit more than a decade. This decision comes from the understanding, through the literature, that the changes we are focusing on have started to be relevant for the medical professions from that period on.

The majority of our respondents has been chosen for the very specific particularity of their work which involves a direct and personal contact with patients. More in detail, the reason why general practitioners are way more than other kinds of doctors is due to their characteristic as "gatekeepers" between patients

and the health service. Indeed, they are the first professionals people address to in the case of need (we only considered a consultation for normal issues, not urgent problems for which emergency services exist).
On the other hand, specialists usually have to deal with more specific issues that have already been somehow skimmed: the dialogue with the patient is still relevant but, in our opinion, not as influential as the one with GPs. The relationship that therefore GPs and, to a lesser degree, specialists have with their clients is for us a necessary starting point in order to understand how is nowadays conceived the relationship doctor-patient and to what extent modern influences can affect physicians' identities.
Nevertheless, our aim was not to study the difference in attitude that GPs and specialists could have: we looked for a general picture which could consider the two categories indifferently.

Moreover, we decided to interview a small percentage (2 people) of those kinds of professionals who elaborate health politics and have a task of control of efficiency regarding costs and outcomes. We have to point out that, even between general practitioners and specialists, we found some of them having commitments related to the administration and organization of health units or cost control. This was to clarify the background of our respondents and to show that our results entail a various combination of elements within the medical profession.

Last, as we mentioned in the beginning, we also conducted some "group interviews" in order to appreciate the exchange of opinions of different components of the same professional category.
Two general practitioners have therefore been interviewed together, as they worked in the same Medical Home and the scheduled time would have fit better in this way. After that interview one of them, being particularly interested in our research, asked if she could have joined us to the next interview to discuss with us more in depth. We therefore re-scheduled the following interview (that was supposed to be with a policy-maker physician alone) together with the doctor who asked us that additional intervention.
We found it extremely relevant inasmuch as we could gain precious insights from the "free" dialogue (even if a limit was set by the interviewer) of two different kinds of professionals, who showed us how reality can change according to the perspective that is considered. Since the policy-maker physician has been interviewed for the first time during this second group interview, his contribution has been counted as one of the 16 doctors interviewed, while the doctor interviewed for the second time with him has not been counted twice. Nevertheless, the more "dialogic" part of the second group interview has been transcribed in the Appendix as it was not relevant for our conclusions.

We used the tool of the semi-structured interview i.e. a basic list of questions has been elaborated but, on the other hand, its order could slightly change and be more flexible according to particular needs of the respondents (Saunders et al., 2007 p. 312). We followed this path in order to be able to adapt the questions to different kinds of people. This does not mean that we did not follow a logic but we tried to make questions following a natural "flow" of the interview. Since we were not looking for quantitative and objective data, we were not interested in direct and omni-comprehensive questions. What we were trying to look for was how physicians perceive their role in a changeable world: this is why what interested us the most were ideas, feelings, emotions, fears related to the topics that we initially settled.
Our work is an identity study whose aim is to understand how physicians see themselves and to what extent their role is changing (*if* it is changing) and how do they interpret the changes in their field, in order to set the basis for future challenges within the profession. This is the reason why we had to catch their *inner* conceptions and think whether that was reflecting a shift in their definitions as professionals or not.
During our interviewing process we basically followed the framework set by Sveningsson and Alvesson

(2003) who state that if the study aims to unravel people's deep conceptions it is necessary to *"…Listen carefully to the stories of those we claim to understand and to study their interactions, the discourses and roles they are constituted by or resist…*(and to carry on open-minded efforts) *to explore the more vital aspects how people define and re-define themselves".*

All the interviews have been conducted and recorded in doctors' offices in order to make them comfortable during their answers. We subsequently re-listened to them, transcribing the parts that could be relevant for our study. They all took place between during July, August and September 2012.
The average length was 20-25 minutes per interview and the interviewees have been guaranteed anonymity.
The complete list of the questions that we followed can be found in the Appendix in section 6.

In order to better understand our analysis, it is now needed to briefly describe the Italian healthcare system, the scenario where we conducted our interviews. In Italy there is a Nation HealthCare Service created in 1978 which provides universal coverage to all Italian citizens for free or at a minimal cost and the 21 Regions are in charge of the service delivery through a geographical network of health units (France et al. 2004, Lo Scalzo et al. 2009). Regarding general practitioners, they are self-employed but they are paid on a per capita basis (following a government rule that limits to 1500 the number of patients that doctors can enroll); furthermore residents in most of the regions have to chose a family doctor in order to get care from the health service (France et al. 2004, Lo Scalzo et al. 2009). As we noticed in a study conducted in early 90's, almost all Italian primary care physicians were single handed and employed staff as secretaries or nurses was very rare (Pringle, 1991). We will notice in our interviews that this trend has been progressively changing, at first starting from early 2000's with increasing spread of "group medicine", then more recently with the increasing creation of Primary Care Units as *Case della Salute* (*Medical Homes*) with a sort of clustering of doctors and other health professionals (nurses, social workers, out-of-hospital specialists) in order to share the knowledge and provide a more efficient cure to patients**.** This element is quite symbolic if we consider that, when that article has been written, in another country as the UK the percentage of "independently" working doctors was only 15% (Pringle, 1991). We therefore can state that Italy experienced in the last fifteen years a big change in the way primary care medicine is organized.

Before going through the transcription of some relevant excerpts, we need to explain the reason of our choice. At first blush, we will notice different and contrasting opinions. Both positive statements (when physicians did not experience troubles) and negative ones (when some fears appeared) are mentioned.
Our rationale was to give space to both the opinions (transcribing some that we thought being particularly interesting) and, in the end, to show how the troubles that our respondents met have been solved.

In order to treat the data in a scientific way and make the reader understand the distribution of positive and negative reactions to the questions, we grouped the answers in two tables (one for each part).
More in detail, we analyzed and grouped our answers according to a "Yes , No or I don't know" criterion, where it is showed both the number of physicians who met problems relating to the changes that we analyzed and the number of the doctors who experienced identity oscillations.

3.2. DEPROFESSIONALIZATION? A KNOWLEDGEABLE PATIENT AND THE IMPACT OF THE INTERNET

In the first part of the interview we touched upon the topic of an increasingly informed patient about medical knowledge i.e. to what extent people who come to consultations hold a sort of *lay knowledge*.
We asked when has this phenomenon started, if it was increasing in the last period and which were its supposed developments. We particularly stressed the hypothesis that this kind of information mostly got through the Internet could question physicians' knowledge and therefore be a threat for their autonomy and for the doctor-patient relationship.
Besides a mere objective analysis, our focus had the aim of understanding our respondents' conceptions about these changes and whether they could perceive them as a threat or not. Moreover, we tried to deepen our interviewees' attitude regarding their feelings, the role they take and the view that patients have about them once they have to face these issues. According to the de-professionalization theories, as explained for example in Broom (2005), we tried to understand whether an increasingly accessible medicine to the layperson could endanger its esotericism or not.
The following are some of the answers that we decided to show as relevant, related to questions 1-3 (see the Appendix).

Physicians' reactions (both GPs' and specialists') and interpretations of the raising of the Internet for the search of of medical knowledge are various and apparently contradicting.
On the one hand, we noticed several positive comments regarding an acceptance of Internet as a relevant option before and during the consultations. Besides, doctors realize that the seeking of medical information in the web is dramatically increasing even though that is not such a "ground shaking" tool.

> *"My first reaction is a listening to patients' claims. I would even accept a questioning, trying to contextualize it"(Luca, GP)*

> *"Patients' needs adapt to current technologies: 10 years ago to TV shows and nowadays to the Internet. I therefore see it as a normal thing and not like a revolution" (Roberto, GP)*

One the other hand, this element can cause some negative effects on physicians' understanding.

> *"It can be terrible: most of the time it is knowledge which is not filtered by any culture. I conceive it as connected to fear: if the patient went to look for information on the Internet it means that he is most likely terrified because of his health condition. It can be ill-omened" (Simona, GP)*

> *"The first reaction is of bother and annoyance because people don't know this field. It's like if I tried to build a car following instructions found on the Internet. Most of the information is publicity material: apparently stunning news pumped by media and transferred to normal people who most of the times don't have the tools to get them or to understand the difference between discovery and application" (Paolo, GP)*

A shared idea concerns doctors' role and autonomy. Our respondents agreed that doctors are not the only keepers of medical knowledge anymore because of a variety of influences. It seemed that sometimes roles were even inverted in order to better understand patients' claims.

> *"The conception of doctor as a master does not exist anymore. Past generations were accepting everything and believing him as he was God on earth while nowadays there is a relationship that…ok, I would not define as equal but…relying on a constant discussion of what we do" (Roberto, GP)*

> *"I am not scared of losing power: the truth also belongs to others. I am not a young doctor so I rely on an old tradition where there was the doctor and then…the doctor. Perhaps there is a loss of autonomy but I am not scared of that: this is the game! The patient's empowerment means that he knows more than in the past and this is an incentive for me to keep myself updated" (Carlo, GP)*

> *"We can't deny the fact that patients are our employers! Yes,* (joking) *we live thanks to these 1500 desperates!" (Simona, GP)*

At first blush this could hide the fact that their role was questioned and their autonomy could be reduced by Internet and by a more knowledgeable patient. But going deeper in our analysis, our respondents showed a strong sense of dominance and belonging to the profession and that permitted them to draw a line between their role as doctors and the questioning of patients. The "intrusion" in the terrain where they work was not therefore seen as a fact that could endanger their professionalism and reduce their autonomy.
Thus, we noticed that this "loss" of power had not relevant effects on doctors' autonomy during the consultations inasmuch as all of them (16) eventually invoked the element of *role* as a stabilizer.

> For example, after our question *"Did you experience an increase of more cultured/knowledgeable patients?",* we have been corrected: "*If I can, I'd rather say a more informed patient" (Giulio, Cardiologist)*

> *"I honestly don't care much about this questioning, because I do eventually command. My patients know that and together we discuss about our matters" (Pietro, GP)*

> *"My personal reaction to an exaggerated informed patient is often negative: medicine has to assume a role respect. This model has to be the basis for the doctor-patient relationship. I can even adapt that model with a degree of partnership or even empathy but I do believe that we need dominance on the basics" (Paolo, GP).*

> *"When people enter my studio with a pile of printed paper my first reaction is that they want to steal your job! If you needed to build a house, would you read a book about mathematical calculations before addressing to an engineer? (Domenico, GP)*

> *"Some patients introduce their selves as colleagues! In these cases we need to use the 'broken-tape' technique: repeating the same concepts with different words" (Sandro, GP)*

We noticed that apparently it seemed that power and autonomy were threatened by the Internet but deepening our respondents' thoughts we could understand how they are used to "draw a line" between their knowledge and the various criticisms. The question that we tried to answer during our interviews was: how do physicians solve this conflict? We found out that even though opinions regarding the spread of "lay knowledge" were different, the mechanisms that doctors used in order to deal with these issues were basically the same i.e. dialogue and partnership. This requires a constant open-minded attitude and does not create particular problems for physicians' identity.

> *"Patients are exactly like us but we have a capability that they don't have and we offer them this capability. I believe in therapeutic alliances: the doctor has to inform, suggest solutions and share them with patients. Indeed, prescriptions are not imposed from the top but their rationale is instead that they are 'therapeutic suggestions' (Sandro, GP).*

> *"When I am with patients I think 'with a loud voice' with them: I talk a lot and I try to explain my inner thoughts" (Luke, Specialist)*

> *"Patients usually accumulate several information but they do not have the culture to put them together. They just got in touch with one single variable and our work is to contextualize and integrate it with more variables" (Giulio, Cardiologist)*

> *"My role experiences a sort of splitting because when a patient enters and starts to criticize and to claim his 'knowledge' the first reaction would be to argue with him. But in the same way as parents educate children, we don't have to criticize them but we have to make them more aware: they will be doctors of themselves for 365 days a year" (Giulio, Cardiologist)*

> *"The authority degree passes through the patients involvement, suggesting them therapeutic options and deciding together with them"(Paolo, GP)*

> *"Our role has to be the one of a guide; the thaumaturge doctor doesn't exist anymore" (Luca, GP)*

As we pinpointed earlier, the excerpts in our empirical parts are showed in order to provide the reader with a broad and various picture of how our respondents answered. Nevertheless, in order to build a scientific frameworks to analyze the results, we need to list how the answers were distributed.
We therefore grouped our answers according to two criteria:

1) Have our interviewees experienced any trouble with patients' questioning?
2) Has the questioning ever had the power of threatening their identities/lowering their statuses?

The answers to these criteria have been reached by us re-elaborating the physicians' answers.
Troubles were interpreted as concerns for an increasing phenomenon of patients who came to doctors' offices with lay-knowledge found on the internet and the fear that this tendency could be dangerous.
On the other hand, the second criterion has the goal of understanding whether doctors were affected by that or not. The aim was understanding whether a sort of de-professionalization was occurring.
It goes without saying that physicians who did not face any trouble according to the first grouping, also did not show an "eroded" identity (even if biases in the answers could have been possible).

Table 1. Is De-Professionalization taking place?

	YES	NO	I DON'T KNOW
HAVE YOU EXPERIENCED ANY TROUBLES WITH PATIENTS QUESTIONING?	8	6	2
HAS THE QUESTIONING EVER HAD THE POWER OF THREATENING YOUR IDENTITY/LOWERING YOUR STATUS?	0	14	2

Results reached through the analysis of the data collected with the interviews

As we can notice from Table 1, more than half of our interviewees (8) did experience some troubles during the consultations, in terms of patients questioning what they were stating. Nevertheless, results are rather clear saying that the great majority of the physicians (14) did not face relevant problems regarding a reduction of their self-esteem or status as professionals. We will show later which is the reason of this apparently contradicting result.

3.3. PROLETARIANIZATION? THE QUESTIONING OF PHYSICIANS' AUTONOMY IN A BUREUCRATIZED ENVIRONMENT

In this section we analyzed practitioners' conceptions about the changing medical environment.
While the first part was mostly related to patients (but still from a physician's perspective), this part regards the issues due to governmental/regional policies in order to increase efficiency.
We tried to understand whether doctors were seeing themselves questioned by recent changes in the environment or whether they thought that their role was changing according to different situations. Moreover, we wanted to find out if different discourses (Sveningsson and Alvesson, 2003) were shaping physicians' identity work in a changing world. Nevertheless, we were also interested in studying to what extent the *identity work* is present within this particular category of professionals that, as it has been stated by Alvesson (2004), is less likely to experience identity oscillations and questioning for its "hard science" idiosyncrasies.

We particularly focused on three main areas and their impact on identities: the increasing use of guidelines, economic pressures and the rising of new kinds of organization (*Medical Homes).*
For each sub-topic we showed both positive and negative opinions and their impact on physician's identities. As the excerpts will clarify, this is to show that even if negative opinions were presents, the great majority of our respondents eventually solved their troubles in a positive way i.e. their statuses and identities as professionals were not eroded nor threatened, according to their prestige as professionals and the esoterism of the knowledge that they own.

The following are a sample of meaningful answers related to questions 4-10 (see the Appendix).

The first relevant area concerns medical guidelines based on evidence based medicine, as we have noticed they are spreading in a significant way in the last decades: the great majority of physicians showed a positive attitude towards them and did not meet relevant issues in their utilization.

> *"As the word suggests, guidelines should be a guide: they are a useful, updated and reliable instruments which have to be considered educative rather than coercive. Nevertheless they have to be related to every single patient and situation and this depends on the doctors' capability" (Luke, Specialist)*

> *"Guidelines represent the necessary shift from an empirical and gut-based medicine to an evidence-based medicine built on science, repetitiveness and sharing of knowledge between experts: most of the times they are elaborated by prestigious and authoritarian associations" (Paolo, GP)*

We have not noticed any opposition to the increasing use of guidelines, even though we perceived that sometimes the most relevant issues are the need of a deeper elaboration of *relational* guidelines, the recognition that often other interests are involved (as the ones of pharmaceutical companies, health organizations or even political interests) and the urgency of a constant updating regarding new scientific studies and consequent guidelines.

> *"We need relational guidelines! At the beginning institutions did a huge mistake imposing guidelines from the top: we never had a proper relational elaboration of them" (Sandro, GP)*

> *"Of course there are other interests! Most of the times guidelines are sponsored by pharmaceutical companies. Especially in the US, medical institutions employ the best doctors and get incredible amounts of money from pharmaceutical companies that have a stake in the guidelines' development" (Pietro, GP)*

> *"There are several cons: who is controlling the controllers? They can be influenced by pharmaceutical companies' strains or by personal opinions. Choices are often questionable" (Paolo, GP)*

> *"I sometimes have the feeling that something is kind of addressed. I am a bit losing my trust in people who are managing us. I don't want to talk about politics but…I do not trust everybody" (Luke, Specialist)*

In our study we were strongly interested in studying physicians' perceptions and we tried to go deeper in our analysis, analyzing whether these changes could have the power of undermining physicians' identity as professionals.

> "*I am the doctor and I eventually do what I want" (Pietro, GP)* (This kind of answer was very common)

> *"For instance, TSH is a test which is conceived as superfluous in most of the cases. But if a patient arrives, he says that he is always tired, he is dizzy and so on. I tell him to do a blood test but… TSH is a*

test that can hypothetically be useful and.. Well, I don't care if it's not in the standard procedure and I suggest him to do it anyways" (Simona, GP)

Pietro, GP, has posted and underlined with a fluorescent marker an A4 sheet of paper which states: *"The guideline Alfa* (made up name) *states that the molecule Beta lowers glycaemia better than others. Doctor Pietro* (with his surname) *is not convinced and doesn't want to prescribe it to Mr. Y who absolutely wants it. After some time, studies show that this molecule was actually lowering the glycaemia level but it was also increasing mortality. The drug is therefore recalled and suspended"*

A topic which is strictly connected to guidelines is the cost-cutting or saving of resources. It is a current issue which involves the ability of the doctor to both prescribe the best drug or test for the patient and save money inasmuch as the health care service has a budget which calls for a so-called *appropriateness* of its resources' utilization.

"Cost-cutting has started to be pressing in the last 5-6 years and even more after the 2008 economic crisis and after Italy last year's spending review. During the 80s and the 90s prescriptions were totally free and I could give whatever I wanted to patients. It's a hard task but we live in an era of limited resources" (Paolo, GP)

"Whoever operates according to an agreement with the healthcare service is a person who got a license to work for it. That means both focus on health and the right management of the resources he has. This money comes from citizens' taxes and their first right is that it will be spent in the right way" (Lorenzo, Specialist and Health Politic)

"We spoiled our citizens. Regions spend 80% of their money in health services. Besides, 40% of ticket free patients (if your income is below a certain level you don't pay the fee for every specialist visit or clinical test) use 70% of the resources. Is everybody sick? (ironic) . *If we don't think about appropriateness our system will go bankrupt! (Pietro, GP)*

"We need to consider the spreading of generics. Their rationale comes from a great idea: drugs whose patents are expired cost half price so…I'm sorry, pharmaceutical companies (laughing). *The contents being equal, I prescribe the cheapest one! But often there is a positive or negative margin of 20% that could be relevant for the patient or their efficiency has not been proved yet. So, generics can be tricky" (Simona and Giovanni, GPs)*

"Have you ever heard about the 'end of the year prize'? Doctors' costs have to follow an average in order to get a monetary incentive. It has been called 'prize for the reduced variability of the health unit'. Basically, the less you spend the more you can gain. That money is calculated according to the average doctors' annual spending in the health unit. The problem is that doctors who spend less see doctors who don't save money as enemies because they will eventually get less! (Sandro, GP)

"The monetary incentive, even if you save a lot, is not very high. But still, it can be a dangerous mechanism. Bureaucrats have often chosen parameters that are far away from the best cure for the patients i.e. nowadays you are rewarded if you save money, without needing to prove whether the saving created a harm or not" (Giulio, Specialist)

Once again, we tried to relate the impact of these changes to our respondents' perceptions. Can this urgent need, that once did not exist, of considering the costs, lower doctors' autonomy? Can they feel their role as trapped between two aims i.e. both providing the best service for the patient and making the system save money? Regarding this debate, we found several and contrasting opinions. The great majority of our respondents acknowledged the existence of those 'revolutionary' changes but the impact on personal behaviour and ways of working was different.

"It's hard to combine a saving ethic with an ethic which is, in my opinion, in a higher level: the one which tells you to cure patients in the best way you can" (Paolo, GP)

"*It is frustrating. I'm between two 'fires': condescend with the patient and please the institutions. 5 years ago I could allow patients to do any kind of test or prescribe any medicine but now I think a little bit about that and I say 'Is it really necessary? Wouldn't it be better to save resources for the moment when that person will really need help?' (Luca, GP)*

"Because of the economic crisis, the default risk and the fear of losing their jobs, people's trend to somatise dramatically increased. They come to me more often, they demand more exams because they are scared: this is more than the 50% of my consultations! The challenge is that you can't just tell them 'go out, you are only an anxious'. It's hard for me to act within this environment" (Simona, GP)

"Some years ago a ministerial 'note' eliminated the refund for a medicine to lower cholesterol level. A patient that I was following did not have such a high cholesterol value in order to get that medicine for free. What should I do in these cases? I thought he should have taken it anyways but on the other hand I needed to follow a law. I tried to explain him how the situation was and told him 'Well, I suggest you to take it but you need to pay for it'. He got completely mad at me saying 'Should I beg for prescriptions?!?'. He eventually changed his GP. I lost other patients for similar reasons". (Simona, GP)

"I sometimes receive the famous call from controlling institutions that tell me that I am spending too much. I fight everyday but I act according to my ethic. If I have to chose, I chose to get the call. Nevertheless I suffer when I go to sleep and I know I haven't acted in the best way possible. Either the human error or the system don't allow you to be calm. We would need to get off work and detach from troubles but I do practice my job in other ways…" (Giulio, Specialist)

"I have troubles standing the continuous patient's questioning regarding bio-equivalents: we often have discussions because of the brand gap they have to pay if they want the original medicine. It has been a huge change in the last years and the healthcare service, regardless of the producer, only refunds for the cheapest one" (Giovanni, GP)

"I don't see a big change: I agree to the need of saving money if we can. That would means to allocate resources in a different way. If I follow the so-called 'science and conscience' I don't usually meet big troubles (Luke, Specialist)

"It can maybe be a bit frustrating to deal with people whose main aim is to save but I am the doctor and I will eventually be the 'prescribing agent'. A physician who is aware of each drug's relevance will always win against a control" (Paolo, GP)

"I don't feel any pressure. I never had to renounce to a better cure according to a saving need. Never. Never. In our daily work any kind of illness can be cured without struggling for this conscience problem and the best cure has to follow the appropriateness" (Roberto, GP)

A recurring topic between our interviewees was the interpretation of some rules and procedures as the so-called *defensive medicine*. This kind of acting expresses, according to the Guardian (2005), the fact that doctors have one eye on the law court instead of both on their patients: its aim is mainly to reduce doctors' troubles in the case they would do something wrong. We understood how this way of doing medicine is dramatically increasing. A more informed patient claims for more and a doctor's safety net would be to take refuge in what laws and guidelines state, thus acting according to a defensive medicine.

"Defensive medicine can be confused. For instance, if ones has the diabetes, it is likely he will have, in the long run, ocular issues (diabetic retinopathy). Primary care physicians' task is to send a diabetic patient to periodical tests in order to avoid these complications. We need to educate for a better self management". (Lorenzo, Specialist and Health Politic)

"Defensive medicine is not necessarily bad. It fosters you to talk: it is important to share the choice you make with the patient because it won't eventually create you troubles. These issues are more relevant in hospitals where we are slowly going towards a private conception of the medicine, like the US model where insurances don't pay for some choices and you therefore need to justify them" (Paolo, GP)

"A tendency which is unfortunately increasing, according to the defensive mechanism, is that if a doctor meets some troubles, he can't be sued if he demonstrates that he followed some specific guideline. I have to tell you… I can't really share this way of acting. It's not my philosophy. Guidelines cannot be an impoverishment of our capabilities". (Luke, Specialist)

"A mistake is to live saying 'I act not to go to jail or not to be questioned by the patient'. If you look at it in that way…yes, it might save you from some complaint but you don't give your contribution to the cure" (Giulio, Specialist)

"Our society brainwashed patients with this supposed 'right to health'. It's insane! One can only give the 'right to cure'. A person with a chronic disease can get better but he/she can't recover. The problem has been dangerously shifted. Besides, in the last years they did a campaign against us. They talked about 'bad health management' but…have they ever said what's the percentage of errors related to what is done in the right way? When associations do this propaganda, you create a problem in how the patient sees you and you build up expectations that have no fundament!". (Annamaria, Specialist)

The *clustering* of doctors in Medical Homes is another phenomenon that we deepened. We interpreted it as a relevant change in the medical practice, inasmuch as independency and autonomy of the physician (seen once as single-handed) can be endangered by the grouping of professionals. Surprisingly, we found out that, even though there are some fears, the shared understanding is positive and it is seen as an adaptation to modern needs. The great majority of doctors therefore did not experience a loss of power nor a questioning of their identity as professionals. Even the ones who had some fears eventually realized how this change was needed, despite of some possible negative scenarios. The common features are the need of dialogue between colleagues and other operators within the group and a struggle to keep the doctor-patient relationship alive.

"Why to keep riding horses when we have Ferrari? The clustering is not mandatory but we do hope it's going to be the standard setting. It's necessary: society has changed and we need teams that provide services for a 2012 patient. The single-handed man with his wife answering the phone was OK in 1980" (Roberto, GP)

"The transformation from a single man to groups is global. Hospitals are for emergencies and 'territory' for prevention. Doctors need to reconsider their role: it is not easy because when they started they were 'soloists' and they have troubles in sharing what they do with their colleagues" (Viktor, Health Politic)

"Medical Homes have to be created according to a cultural resemblance of doctors, not because of an economic incentive. The pro is a constant exchange of knowledge and expertise between colleagues that need to have more dialogue. Doctors should see in their colleagues the 'specialist' that they are not in that precise moment. Besides, the doctor-patient relationship which is typical of our system (Italian health care service) *won't change. But if for instance one day a patient's GP is not there, he can go to his colleague" (Lorenzo, Specialist and Health Politic)*

"Doctors' clustering is an efficient and new way of working. Professional integration between doctors, nurses, secretaries and social workers is necessary. Besides, the very fact of working together can stem their efforts to threaten our role" (Roberto, GP)

"As they said in the past, 'unicuique suum'. Some tasks shouldn't be performed by complex and expensive people as doctors. I would never tell a nurse how to cure a skin ulcer because she knows how to do it better. On the other hand that nurse shouldn't tell me how to remove a stomach. Integration between professionals it's the way to go and Medical Homes can only have positive effects" (Lorenzo, Specialist and Health Politic)

"People are linked to their doctor. Medical Homes are not, for the moment, giving us the results we were expecting. Patients come and claim to find their doctor all the times: they have troubles realizing that they could find skilled persons to temporarily substitute their physician" (Domenico, GP).

"I am really scared that with the increasing clustering we will lose the special doctor-patient relationship" (Enrico, Specialist)

"The risk is that if too many people take charge of the patient, doctors could lose their power. I am not defending my privilege but the decision should be in physicians' hands. The relationship should be patient-doctor, not patient-Medical Home!" (Carlo, GP)

Concluding, a frequent reaction, when our respondents were asked whether they were experiencing a sort of de-professionalization/proletarianization or not, was as follows. Our category of professionals, even though it has to deal with revolutionary changes, is reacting quite well to them and did not show particularly relevant identity troubles. As we will analyze in the discussion, physicians (both general practitioners and specialists) are enlisting a necessary change in their conception of the work and they seem willing to adapt to modern times. The power that they still have undoubtedly plays the biggest role in that. Even though several doctors showed concerns, fears and scepticism, they eventually relied on their autonomy and power both towards patients and bureaucracies.
We need to point out that this "summing-up" question was asked in the end of each interview, in order to affect the answer the least possible.

"We sometimes have to face hard moments but things go eventually well... The power that we had 30 years was not acceptable. Things need to be contextualized" (Giovanni, GP)

"I am not in crisis. I only have to adapt. If I look at the old picture of the countryside doctor with his little leather bag…it's not like this anymore. The power we had was not acceptable. I feel like a doctor who is fitting the current situation" (Domenico, GP).

"The problem belongs to the individual. The solution is not letting the system deprofessionalize yourself and support a role that, despite what regions or other organizations tell you, is still unique. Each doctor has to work with enthusiasm. I love to read scientific articles and I spend a lot of time doing that. The constant updating is my solution not be deprofessionalized" (Luke, Specialist)

"The doctor-patient relationship can be endangered by several factors. If the doctor is able to ride on these factors he will never lose his authority. The 'ipse-dixit' era is over: we need a continuous knowledge updating" (Paolo, GP)

"De-professionalization is an ambiguous term. I think you need to be stronger and even more professional. You can't not have clear ideas. I conceive it as a stimulus to study and to enter in patient's life to help him" (Giulio, Specialist)

"If you had interviewed me 20 years ago I would have said the same things. I don't feel a loss of autonomy. The way I cure my patients is the same as before. On the other hand patients do see us in a different way: this Medical Home is not my solo studio of 10 years ago. The fear is to become bureaucrats or employees but I think that we need to adapt to new ways of doing our work: if we succeed to shift to this new track we can save the relationship doctor-patient.I would say that with this power we can have an even more authoritarian role!" (Roberto, GP)

As we have done for the first part regarding the de-professionalization topic, we grouped our answers related to the likelihood of a proletarianization in the second part of our data analysis.
"Yes", "No" or "I don't Know" answers refer to the fear or not that medical profession could be extended beyond physicians' control. More specifically, we interpreted as positive answers widespread concerns about a too high routinization of the tasks, an unnecessary control from the above (mainly institutions) and a suffocating economic pressure for cost-saving aims. Moreover, regarding the identity side of our analysis, we studied whether, eventually, those concerns could have the effect of eroding doctors' power and status as a professionals. The aim was understanding whether the so-called "proletarianization" phenomenon, related to an identity side, was present.
As we mentioned above, while in the empirical part we decided to transcribe some meaningful excerpts in order to appreciate the variety of our interviewees' answers, these data (and Table 1's data) have been elaborated considering all the answers that we collected. They therefore mirror the complete spectrum of physicians' understandings and will allow us to reach our conclusions.

Table 2. Is Proletarianization taking place?

	YES	NO	I DON'T KNOW
HAVE YOU EXPERIENCED ANY TROUBLES with medical guidelines?	2	14	-
HAVE YOU EXPERIENCED ANY TROUBLES with cost-cutting/appropriateness policies?	5	11	-
HAVE YOU EXPERIENCED ANY TROUBLES with new forms of organization (Medical Homes)?	5	10	1
HAS THE ECONOMIC and/or INSTITUTIONAL STANDARDIZATION /ROUTINIZATION EVER HAD THE POWER OF THREATENING YOUR IDENTITY/ LOWERING YOUR STATUS?	1	15	-

Results reached through the analysis of the data collected with the interviews

As we can notice from Table 2, most of the respondents did not meet serious troubles in dealing with what we interpreted as being the most relevant changes in the medical environment. More in detail, working with medical guidelines seems to be a problematic issue only for 2 doctors, economic and appropriateness pressure does not create relevant problems for 11 physicians and new organizational structures do not represent a problematic issue for 10 of them. Regarding the identity side, according to the great majority of our interviewees (15), the new medical environment does not have the power of undermining the identities of the "knowledge keepers".

4. DISCUSSION

It is here useful to repeat our questions (or assumptions) in order to analyze them carefully. We asked:

- ✓ a) Are physicians' identities threatened by being increasingly questioned by the patients? (related to a "patient empowerment")
  b) In other words, is a "de-professionalization" actually occurring?

- ✓ a) Is the status of physicians as professionals being threatened by recent changes in the medicine environment such as bureaucratization/routinization, grouping in new forms of organization and economic pressure?
  b) In other words, is a "proletarianization" actually occurring?

DE-PROFESSIONALIZATION

Regarding the first part of our first assumption, we noticed how recent scenarios involve a continuous action of patients questioning what doctors state. Patients go to physicians' offices having already a so-called "lay knowledge" regarding the issues they are dealing with. This mostly comes from the widespread use of the Internet which is providing the people with a wide source of knowledge whose reliability is not, however, necessarily high. Our respondents' reactions to this phenomenon are apparently contradicting but, when it comes to the identity and status discourse, they follows a unique path.
Regarding physicians' understanding, approximately half of them (6) showed a positive attitude with an enlisting of patients' claims between their work activity while the other half (8) underlined how this phenomenon is causing some problems as a feeling of annoyance because of the lack of trust from the patients who carry on these actions.

Analyzing this first part of our interviews and relating them to the identity literature that we studied, we can reach interesting findings. We can notice that a knowledgeable patient does not have the power to threaten or endanger physicians' identities: in fact the great majority of the interviewees (14) did not show any significant impact of patients' questioning on their identities. More specifically, even though a widespread questioning of doctors' diagnosis is going on, it has no power of lowering their status as professionals nor their self-esteem. Once our questions were trying to deepen physicians' ideas regarding a supposed loss of power, they did not show any relevant doubt, relying on what we called a "power discourse". We agree with Alvesson that people (in our case doctors) cannot distance themselves from identity (the questioning does not create dramatic troubles). In other words, the fact of doctors being questioned does not cause such a high threat that can make them reconsider "who they are". We think that the reason relies on professionals' prestige and autonomy which 'nurtures' their identities.
The demonstration is that, even though some of our respondents showed concerns, they eventually solved their troubles stating that 'they were the doctors' and trying to adapt to new scenarios (partnerships) instead of feeling threatened.

Our respondents agreed that nowadays expectations are different and that their mindset must entail a *role reconsideration* according to changed scenarios. Nevertheless it is needed to acknowledge that this does not have the power of inverting the roles. Physicians do stress that they will eventually act according to

their discretion which comes from years of education and experience. What once was a stable and fixed element is now adapting to modern times: the old image of the doctor as sole keeper of knowledge does not exist anymore. Basically, questionings and critiques are considered as part of the routine inasmuch as the basic relationship doctor-patient is carried on relying on professional's decision-making power.
Nevertheless, when Ashfort and Mael talk about *amalgam of identities* and Alvesson et al. introduce the concept of identity as a *struggle*, where professionals "fight" in order to make sense of the changing world and experience role conflicts, we found a minor resemblance with the literature. Our respondents do re-consider their role, they have dialogue with patients, they feel as if the outside world has new tools. But on the other hand we acknowledge that the doctors that we interviewed are not destabilized by the internal fight of different roles: their self esteem is not lowered and the different *discourses* that interplay during their work do not have the power of 'de-professionalize' them. This partly fits past studies (Alvesson et al., 2003 for example) that interpreted identity as a struggle, even though the final result is not a frustration as we hypothesized.
Our findings undoubtedly fit with Freidson's theories of doctors' dominance: this element does not seem to have changed because of a more informed patient. Besides, Faber's (2002) argument regarding the *exclusion* of others from the esoterism of medical knowledge seems another element that strengthens a situation where doctors, even though questioned, are still the main keepers of medical knowledge.
As we mentioned above, claims and 'questionings' do exist and our respondents seem to have found a solution in order to adapt to new scenarios. The solution that our interviewees involve in front of an increasingly knowledgeable patient is based on a constant *partnership.* Dialogue, therapeutic alliances, education to be *'doctors of themselves'* are the most common features. This, in our opinion, helps to acknowledge the need of a role reconsideration (inasmuch as the hierarchical respect is carried on) to make a step towards a better understanding and cure of the patient.

Regarding the assumption that a de-professionalization is occurring, we can understand how our empirical data did not support it. Having defined this phenomenon as a situation where medical knowledge is more easily accessible to people, causing a shift from the "ownership" of knowledge from professionals to non-doctors, that would have meant both an increasing skeptical behavior towards what doctors say and a consequent feeling, from the doctors' side (the perspective of our work), that their role was losing importance. The elements that we enlisted in the previous sections, relying on great majority of respondents' (14) who did not show serious problems in the maintenance of their status as professionals, did not support the assumption of an hypothesized on-going de-professionalization. The "mystique" of the medical profession is therefore not endangered.

PROLETARIANIZATION

In the second part of our interviews we mainly concentrated on three issues: the increasing use of medical guidelines, the prescription appropriateness/cost cutting attention and the raising of new organization forms.
The shared understanding of medical guidelines between doctors (both specialists and primary care physicians) is positive. Guidelines developed on *evidence-based medicine* are undoubtedly interpreted as a helpful tool in order to improve their capabilities and consequently their outcome for 14 of the doctors that we interviewed: we did not find serious elements which could show scepticism or fear. Nevertheless, doctors do believe that this tool spread dramatically in last decades and that it could sometimes have

'directed' their path but this is almost never conceived as a limit because their knowledge allows them to understand when they can ignore a guideline and act according to their responsibility.

Once the focus shifted to a connected discourse i.e. appropriateness and cost-curbing strategies, our results showed much more disagreement. Our interviewees did agree that a world where resources are limited calls for a wise management of the health care service with the aim of keeping its universality and free access, features that make free healthcare services (in our case, the Italian one) an admirable example in the world. We also noticed that there is widespread agreement about a revolutionary change in the last 7-8 years and especially after the 2008 financial crisis. A relevant implication can be the urgent need that doctors start to act as managers: as a general practitioner pinpointed, '*we have to consider not only the relationship risk-benefits but more and more the cost-benefit one'.* Medicine is therefore asking for new skills and in our study we did notice that doctors acknowledge that and try to do their best in their daily routine in order to act responsibly.

Nevertheless, cost cutting strategies fostered a mechanism which has been highly criticized and that made us notice conceptual disagreements. The so-called 'end of the year prize' entails that the more a doctor saves (regarding drug prescription and medical tests), the higher the money incentive will be in the end of the year. We noticed how this mechanism can create a vicious circle where saving is not directly related to a better cure, hypothetically rewarding a doctor who can save money regardless of the results.

Another element that triggered a strong debate regards the widespread use of generic medicines. To save can mean being able to evaluate whenever a test can be avoided, in order to keep resources for a future problem or for people who need them more, but can also mean prescribing the cheapest medicine if the active principle is equivalent. This is not always simple and we found several oppositions to a business which is dramatically increasing and which is not always reliable: in fact the spread of generics, as our respondents stated, can go out of control and increase a consumerist approach which does not necessarily stand on scientific basis. While some of the doctors did not experience troubles in prescribing generics, others did and that could cause troubles during their relationship with the patient. A doctor even raised en ethical problem: while *brand* drugs are usually produced within the country's firms, bio-equivalents are sometimes imported from China or India and this could cause, in the long run, "*a threat for our employees' jobs and a questionable quality…(do we completely trust Chinese medicines?)".*

When we talked about discordance we meant a common contrast regarding the way in which cost cutting strategies are interpreted. While most of our respondents (11) did not show any trouble in applying an appropriateness discourse and prescribe '*thinking economically'*, other doctors seemed to confirm one of our first assumptions. At the beginning of our paper we raised the problem whether doctors could be 'in the middle' of two contrasting forces: on the one hand to save money as much as they could and on the other hand to provide the best cure for the patient. We noticed that this issue creates a sort of frustration in some of our respondents: they engage in role conflicts with patients who claim for more prescriptions and they do realize that a new scenario where resources are limited is causing dramatic clashes that they can barely limit. Meaningful indicators are patients who question their doctor's power in providing them the drug they need or who even think about changing their primary care physician.

Furthermore, defensive medicine also created relevant dissonances. On the one hand, some doctors pictured a scenario where following what guidelines state does not create particular problems but on the other hand some of our interviewees raised ethical issues. They showed how this kind of medicine whose main aim is to 'defend' from being sued entails a distorted perspective and how they cannot really share a philosophy that does not involve personal capabilities: to risk and act according to doctor's 'science and

conscience' should not stand on a defensive mechanism. In other words, this kind of medicine, according to some physicians, mostly relies on the maintenance of the category's personal interests and privileges.

Another relevant change within the Italian medical environment is the current *grouping* or *clustering* of doctors. In this section we are strictly referring to primary care physicians in Emilia Romagna region, Italy, where policies were first encouraging "physician clustering", then fostering the creation of "Medical Homes".
We found out that the general attitude is positive: 10 of our respondents acknowledged that the single-handed doctor of the past is not a relevant character anymore and we need a strategic organization that can readily answer to the society's changing needs. In order to provide an '*integrated management of the patient*' the so-called *Medical Homes* should be developed according to a 'knowledge sharing' logic where both physicians and other professional characters (nurses, secretaries and social workers) can mutually gain insights and aim to a constant empowerment. Nevertheless, we found some conflicts that questioned the *rationale* of this organizational idea. The logic of these Medical Homes is that whenever a patient (who still belongs to his general practitioner) does not find his doctor available, he can address to another physician within the organization, according to an integrated management logic. Some of the doctors (5) were scared that the basic element of physicians' work i.e. the patient-doctor relationship would be endangered by a bureaucratic construction that could eventually distance the patient: the more complicated and 'bureaucratic' the organization is, the more complicated will be for the patient to keep his trust for the doctor.

Relating the findings of the second part of our interviews to the literature we analyzed, we can reach important insights both about the impact on identity and about the proletarianization debates.
A doctor who has to deal with cost-cutting policies and could be somehow 'trapped' between them or a doctor who has to deal with an increasingly more bureaucratic environment where he is not the single-handed *thaumaturge* anymore can, at first blush, be interpreted as "proletarianized" (according to Broom, when the medicine is extended beyond the control of the medical profession).
We found out that professionals' identities are nurtured by several *discourses* (in the wake of Alvesson and Watson), that could be the 'cost-saving' discourse, the 'patient-oriented' discourse, the 'institutional doctor' discourse or the 'empathetic doctor' discourse. In other words, different elements constitute the way how physicians approach to patients or to their work in general. We noticed how they are ready to split or change their roles according to situations: they do try to understand what institutions, organizations and patients need. Their attitude is therefore open to debate and re-consideration of their roles.
When it comes to guidelines, they can be somehow conceived as a limitation to their autonomy, calling for the need to consider some paths which do not only rely on professional's autonomy. When it comes to cost-saving policies, they often strive to balance the patients' requests with limited resources. When it comes to bureaucratic 'grouping' they show fear that their patients could see them in a different way. Their identities are therefore not unilateral and fixed but they are shaped by different forces. Linking identity issues to the professionalization debate, we could state that at first blush a sort of proletarianization might occur because of the number of problems that our respondents have met in the three categories that we analyzed: medicine could be interpreted as extended beyond doctors' control (conceiving control as the most relevant characteristic as a physician's identity). Nevertheless, we also have to consider other factors.

Firstly, when doctors talked about these changes during their work, less than one third of them showed troubles in dealing with these situations: some of them did not even consider them as revolutionary (these data, discussed above, are summed up in the first three lines of Table 2.).
Secondly, regarding a deeper analysis which entails an identity consideration in terms of status and power, even though some doctors experienced doubts and identity 'oscillations', almost all of them (15) eventually solved their internal issues according to their identity status as professionals, not showing relevant problems (this is referred to the last line of Table 2.).
We therefore noticed that professional autonomy is not threatened:

- ✓ regarding guidelines, they are eventually conceived only as a guide (the control is maintained)
- ✓ concerning cost-cutting aims, the *appropriateness* logic and the understanding that resources are limited help them to solve the problem (their autonomy as 'prescribing agents' is therefore kept)
- ✓ regarding the grouping in Medical Homes they do understand that modern times need different skills and organizing forms (the control is again maintained)

These data, summarized in the last column of Table 2, express the result of the interviews that we conducted about the proletarianization phenomenon. They consider the final impact of all the three categories that we listed (guidelines, cost-saving policies and new organization forms as Medical Homes). More in detail, we deeply analyzed the insights that we had considering the previous three categories all together, being helped by the final question (see the Appendix) which was directly asking whether our respondents were feeling their status eroded. In the case that concerns in the three categories were not present, it goes without saying that it was directly interpreted as a "no impact" situation on identities. Besides, in the case that doctors showed some fears, we analyzed them deeper, understanding that, after having all considered, for the great majority of them (15) they were not relevant issues. We understood how, once again, the "power discourse" can allow physicians to keep control on a situation that seems unstable. Our interviewees therefore solved the issues that they meet according to a maintenance of their status as professionals.

We can therefore conclude that these changes do not have the power to make physicians 'proletarianized': medicine in the last years does not seem to have been extended beyond the control of medical profession, at least not regarding an identity side (which was the main focus of our study). All our interviewees (except one GP) eventually solved the troubles that they had according to a "power" logic, not showing relevant identity oscillations or status threats.
Role reconsiderations, frustrations, doubts and concerns do exist but they do not endanger doctors' identities which still highly rely on their knowledge. We can apply again the conception of identity as a *struggle*: roles, situations and questionings stimulate professionals' identity work but that does not lead to any frustration or dramatic identity oscillation as we hypothesized: doctors do not distance themselves from their identity as professionals. In other words, we noticed the interplay of different discourses that come from the multi-faced character of modern times: these discourses fuel and limit the identity work but we did not find relevant impacts on identity in terms of frustration. Freidson's and Faber's claims about a professional dominance and distinctiveness therefore seems to keep playing a relevant role within the professionalism debate. Moreover, this also seems consistent with Alvesson's claim that professionals operating in 'hard' science-related fields are less questioned and maintain a high level of prestige, comparing them to consultants or managers. Being a doctor therefore entails a lower degree of questioning or, at least, a lower self-esteem decrease.

Modern changes, in this part related to a proletarianization debate, therefore do not have a relevant impact on physicians' identities and do not cause emotional exhaustion or frustrations in such a high degree that could endanger their statuses as professionals.
Nevertheless, they do have an impact. We followed Watson's framework which relates occurring changes to a particular societal or historical moment, in order to prove that physicians' identities and attitudes have to be understood as fitting to new conceptions of medicine and adaptation to modern scenarios.
Talking about proletarianization might therefore be misleading: what is occurring instead is a widespread understanding that society's needs are changing and new ways of doing medicine have to be enlisted.
Our respondents, even the most skeptical ones, showed how they could not escape from what patients and institutions were asking them and this was conceived as a stimulus to ride the current situation and even reinforce their professionalism. Patients' and institutional pressures are therefore elements that can sometimes provoke doubts and troubles but they eventually provide doctors with a constant challenge to prove to what extent their autonomy can adapt to modern times. Partnership and dialogue with patients, colleagues and institutions seems to be the strategic response that physicians adopt in order to adapt to change. In a certain way, an even more interesting scenario can be hypothesized: terms as re-professionalization have been mentioned during the interviews, confirming that a proletarianization or a de-professionalization is not something which our respondents are experiencing.

Summarizing our assumptions and the data the supported or rejected them, we noticed how:

1) A patient with a lay medical knowledge is a common feature that we found in all our interviews (16).

   More than half of our respondents (8) experienced some troubles in dealing with an empowered patient during the consultation but, eventually, the great majority of them (14) did not see their identity or status as eroded by that, relying on a power and prestige discourse.
   A de-professionalization phenomenon, according to an identity perspective, has therefore not been found.

2) The increasing use of medical guidelines, a widespread attention on cost-saving and appropriateness measures due to economic pressure and the rising of new organization forms (*Medical Homes*) are acknowledged by all our interviewees (16) as being hot topics nowadays.

   While guidelines elaborated on *evidence-based medicine* do not highly interfere in physicians' work (only 2 respondents met relevant problems), both cost-saving policies and *Medical Homes* do create some issues to doctors (one third of them experienced some problems in adapting).
   Nevertheless, eventually, considering the overall impact of these changes on our respondents, 15 on 16 doctors do not see their statuses as lowered by that, according to a "power" logic.
   A proletarianization phenomenon, related to an identity side, is therefore not noticed here either.

5. CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Medicine is a complex field to study: its main characteristics do not solely involve professional or organizational issues but also ethical ones. We believe that because of this unique feature the medical profession has a relevance which goes beyond the surface: studying how doctors work and what their feelings are has constantly to be related to a higher issue i.e. the acknowledgement that people's lives are at stake.

As we understood during our study, there are undoubtedly several changes occurring within the medical environment: they are mostly due to both a more informed patient and more demanding institutions.

Physicians increasingly have to deal with patients who find information on the Internet and question their diagnosis. Guidelines try to 'lead' doctors towards efficient and standardized actions. Cost-saving rules somehow limit the extent to which physicians can prescribe medicines or allow patients to test. Grouping in organized forms of offices are transforming the once single-handed conception of medicine. Increasing consumerism, generic drugs and alternative medicine are providing the patient with different options. Since some decades we are therefore experiencing several and revolutionary changes. We hypothesized that these changes could have a relevant impact on physicians' identities, perhaps in terms of self-esteem decrease or oscillation.

We found out how these issues have been apparently interpreted in a different ways but, eventually, with a common understanding.

Our respondents showed that they engage in active efforts in order to improve the way they work and how they are seen by patients, colleagues and society. When they operate, their identities are shaped by different discourses which change according to the situation. We can state that most of our interviewees carry on an *identity struggle* in order to make sense of their work. During their identity work they also experience troubles, fears, misunderstandings and doubts that could, at first blush, mean that their identity is threatened by modern changes. Nevertheless, differently than past studies on other professional categories (mostly managers and consultants) this identity struggle is not that relevant and, most of all, it does not have the power of eroding physicians' identities. Even when our respondents showed some troubles during their work routine, the great majority of them eventually solved these troubles according to the authoritarian side of their identity.

Freidson's claim of physicians' dominance and Alvesson's concept of *professionalization* therefore seem to be confirmed by our study. Furthermore, we found an interesting contradiction. All of our respondents agreed that doctors are not viewed anymore as *thaumaturges* and sole keepers of the knowledge.

But, on the other hand, they solve their internal conflicts drawing upon a power logic ('*I am the doctor, we eventually do what I say*), thus apparently leading again to the idea of a professional as master of both patients and knowledge.

The de-professionalization and proletarianization thesis have been widely criticized, showing how doctors instead struggle for an adaptation or enlistment of new opportunities in their work, setting their *rationale* in historical and institutional frameworks. Surprisingly, we noticed how modern changes can even strengthen medical profession, inasmuch as physicians need to understand and involve new and challenging scenarios, sometimes even hypothesizing a *re-professionalization.*

Last, we would like to stress economical implications of our study. Being a doctor means, nowadays more than ever, also being a manager. Economic needs have never been as present as in the last years and physicians need to strive between a limited-resources system and the claims of a more demanding patient.

This patient is living in a world where influences are providing him with more information and where recent events (as the financial crisis and a consequent uncertainty about the future) make him somatize the stress, stimulating a constant and interesting challenge for the physician.

In a broader perspective, we tried to study whether economic and institutional forces could level human capital resources. We acknowledged an on-going bureaucratization and routinization of professionals' tasks and one of our hypothesis was a possible standardization of our target in the economic environment. Nevertheless, we did not find relevant evidence that could support this assumption. In fact, while the overall organization of the medicine is changing because of the features that we widely discussed, our interviewees, who represented a sample of the medical human capital resources, are not particularly affected by those changes. This means that the physicians that we interviewed do not see themselves as leveled or "proletarianized", keeping a high degree of control on what they do. Now more than ever, Friedson's claim of professionals' dominance is undoubtedly true and it also helps to reinforce physicians' status with the enlistment of a necessary change during their work routine.

Last, during our study we conducted interviews in two countries but we could not make a comparison between different healthcare services because of the unbalanced quantity of data, hence the decision of focusing on a single country (Italy).
It would be interesting in the future to compare the two healthcare services (the Swedish and the Italian one) which incorporate several differences. It would be challenging to study whether their differences can be related to cultural idiosyncrasies. For instance, in the Italian system patients are linked to general practitioners while in Sweden they are usually not. Can this element have an impact in how changes are interpreted and in how identities are affected?
Furthermore, we did not study in detail differences between primary care and specialist cure. It could be possible that GPs, who have to follow patients from the very beginning, experience at a higher level some issues that would appear more 'skimmed' to specialists.

6. APPENDIX

6.1. List of basic questions asked to physicians during our interviews.

- ✓ Does it happen/what would you think if it happened that patients come to your office with knowledge found on the Internet?
- ✓ Does it happen/what would you think if it happened that patients question your diagnosis according to what they have read on the Internet?
- ✓ How would you describe the relationship that you have with the patient? Dominance/control? Partnership?
- ✓ Have you ever met any problem in accepting/applying medical guidelines?
- ✓ Have you ever felt that your terrain was controlled by others?
  - Pharmaceutical companies?
  - Non physicians?
  - Institutions with cost cutting goals?
  - Institutions with bureaucratic/organizational goals?
- ✓ What do you personally think about the current clustering of doctors in Medical Homes?
- ✓ Have you ever had any problem concentrating on cost-cutting/prescription appropriateness?
- ✓ Can the saving logic clash with a different logic i.e. to provide the best cure for the patient regardless of its cost?
- ✓ Considering what we said, do you personally think that the medical profession is losing some of its power and dominance?
  - On patients?
  - On institutions/organizations?
  - On drug prescription?
  - On the organization of your work?
- ✓ Considering what we said, do you think that your status as professional has been eroded by these recent changes?

6.2. Additional Interviews

Among our interviews, we conducted two focus groups with two physicians each time s in order to get an idea about internal dynamics and attitudes towards the profession. We found challenging the different approach that our respondents had and we could appreciate their reasons in supporting or criticizing some of the recent changes. We are now transcribing part of the second focus group in an excerpt where S. is Simona, female, a 54 years old general practitioner who experienced a relevant struggle regarding the fear of recent changes and her relationship with patients and L. is Lorenzo, male, a 55 years old doctor who was working as a specialist and is now involved in the elaboration of Health Policies and control of physicians' actions. We will provide the reader with an interesting picture about an empathic and "worried" physician versus a colleague of her who may understand her fears but has now to act according to his role of "service provider", relying on a long-run organizational discourse.

(Regarding defensive medicine):

S: Defensive medicine is defensive not towards myself but towards patients' requests
L: Not at all, it is towards insurances, the judge and your professional union!
S: No, who will eventually create troubles? The patient
L: Absolutely not. It's always the lawyer
S: Called by the patient!
L: No, it's very unlikely. Patients are sent to lawyers by 'Patients' Rights Associations' whose only aim is to wait for our mistakes
S: But it's the patient who goes to those associations!
L: You are wrong. Those associations literally sit in doctors' waiting rooms and they listen to complaints. They even financed a TV campaign which said 'If you think you had a bad health experience in the last 10 years, you are still in time to sue your doctor'. How do you think an average patient would react if he thinks his wound hasn't been cured properly?
S: That's why you need a good relationship and a sort of empathy with your patient
L: Is there a better feeling than the truth?
S: Please, Lorenzo! 70% of my issues are nonexistent somatised problems that I need to care about!
L: Watch out, I am now interviewed as a 'services developer'. I do understand your issues but anxious patients don't lead to legs' losses or blindness!
S: But still, I have to deal with them! There is a need of listening and dialogue and we don't have time for that because there are bigger problems. But still, these somatisations are 70% of my consultations! What to do?
L: Are you sure that doctors should solve that? I think there is a mistake in doctors' understanding of roles
S: Maybe, but patients still somatise!
L: The modernization and democratization of medicine that we are experiencing needs a long time and can only be accomplished with more responsibilities and modern methods.

(Regarding new forms of organizations and doctor-patient relationship):

L: Nowadays nurses are closer to patients than doctors are
S: Of course, because they are the first ones a patient can find! You need to pass 57 walls to reach the doctor
L: No, because it's easier to be intimate with them. Doctors are still 'distant' people
S: It depends on their attitude! The bureaucratic and organized evolution of health systems as you are picturing (especially regarding Medical Homes) *creates distance and separation! The presence of secretaries and nurses creates gaps! The more the patient is far away from the doctors, the more the patient will see the doctor on a pedestal!*
L: We have different perspectives and I believe that new organizations could foster a professional integration with another aim: to distinguish professional roles. A doctor who knows how to be a doctor allows the nurse to be a better nurse and vice versa.

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