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Guest Editor's Introduction

Recent years have seen significant changes in the governance of public services, in particular in the provision of education and health care. These changes are built upon the idea that quality and efficiency will improve from a combination of incentives, agency, regulation, and provider competition, which New Public Management prescribes. Along with these changes, however, professional concerns are voiced. Many professionals claim that the new systems of governance will have the opposite effect of manifest intentions—they are believed detrimental to the quality of professional work (Lægreid & Christensen, 2011).

The extent of regulation and control of the professions is an important element of this discussion. How detailed should regulation be, and how much control of individual professionals is required? Since the balance between professional autonomy and governmental restriction is a question of discretion, there is room for disagreement. Eliot Freidson's change of perspective on this question is noteworthy. In his first account, published in 1970, he was concerned about doctors' "unrestricted" autonomy, and argued in favor of the need to control their power for the sake of societal interests (Freidson, 1970). Thirty years later, his perspective shifted dramatically. He now argues that the medical profession, as well as other professions, experience too little autonomy and may end up between a rock (bureaucracy) and a hard place (the market) (Freidson, 2001).

In this special issue, we focus on the medical profession. Many recent studies have found that medical doctors in Western countries are warning that the systems of governance are threatening the quality of care (Lægreid & Christensen, 2011; Makdessi & Halmin, 2013; Wyller et al., 2013), and a number of studies document an increase in stress, burnout, and reduced professional satisfaction among doctors (McKinlay & Marceau, 2011; Shanafelt et al., 2012).

If researchers are right in their claim that doctors are increasingly discontent in the new health care system, or perhaps even alienated as some writers suggest (McKinlay & Marceau, 2011), the significance for performance is of crucial interest. Frustrated, stressed, and alienated doctors are not a likely recipe for high quality care. As seen from the societal and patients' point of view, it is crucial that the conditions for high quality medical care are optimal. If the system counters this, doctors, patients, and health authorities share a common interest in changing the system.

However, despite the many concerns and despite postulated relationships between system factors, professional satisfaction, and the quality of medical care, research in this area is still insufficient. This is partly due to the lack of high quality empirical studies, and partly the result of disciplinary boundaries. The majority of research on doctors' health and professional satisfaction is carried out by the doctors' themselves and to some extent psychologists. The majority of studies regarding health care organizations and systems, on the other hand, are performed by social scientists. Further, research on the quality of medical treatment is seldom

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related to system factors.

The papers in this volume of *Professions and Professionalism* are the result of an attempt to transcend disciplinary boundaries and expand the research on, and our understanding of, the relationship between social context, professional satisfaction, and quality.

The Institute for Studies of the Medical Profession in Oslo hosted a symposium in June 2014, where a number of international experts delivered commissioned talks on various aspects of this topic. The speakers from that conference have since converted their presentations into scientific papers, all of which (except the commentaries) have been submitted for external peer review.

Each of these papers addresses different aspects of our topic. The papers by Olaf G. Aasland and Ruth McDonald provide general reflections from two different perspectives, both of which are sociologically inspired.

Olaf G. Aasland provides a reflection on why doctors complain strongly about stress and burnout, while at the same time belonging to the healthiest segment of the population. Building on the sociology of professions, in particular the concept of de-professionalization, he argues that the situation can be interpreted as a case of cognitive dissonance: Doctors' traditional conception of their role as "professional artists" has been threatened by changes in modern health care systems. This adds a cognitive dimension to the traditional moral perspective. Inconsistencies between the doctor's different roles, such as being the patient's advocate but also considering societal responsibility, are traditionally seen as role conflicts, leading to moral stress. Aasland further suggests that there may also be a mismatch between the traditional conception of the doctor's role and what is needed in 21st century global health care.

Ruth McDonald argues that much of the discussion in sociological literature applies a black and white, or binary, perspective on the different issues. Examples are the distinctions between medicine and management, or "powerful" versus "powerless" professionals. The lack of nuances, she claims, hinders appropriately understanding the field. An implication of her argument is that the claimed contradiction between current systems of management and professionalism is an oversimplification that stands in the way of a thorough understanding of social mechanisms.

It seems obvious that satisfied doctors would perform better than their dissatisfied counterparts. The connection is, however, not well documented. Lawrence Casalino and Francis J. Crosson discuss this relationship in their paper titled, "Physician Satisfaction and Physician Well-Being: Should Anyone Care?" Casalino and Crosson claim that high quality studies on the relationship are few and argue that more and better studies are needed. Nevertheless, the few existing studies have found that dissatisfied doctors are more likely to experience stress and burnout and are less likely to take good care of themselves. These factors lead to diminished professionalism, which in turn leads to reduced performance. Therefore, we should be concerned if doctors are professionally dissatisfied, since this condition will likely lead to suboptimal, or even harmful, medical care.

Peter Angerer and Matthias Weigl also discuss the relationship between professional satisfaction and quality in their paper: "Physicians' Psychosocial Work Conditions and Quality of Care: A Literature Review." They present the results of a systematic literature search conducted in Medline and PsychInfo. Twelve studies were included, and the evidence provides preliminary support for the connection between content and quality. In line with Casalino and Crosson, however, the authors argue that more studies with stronger methodological designs are needed.

These methodological challenges are further discussed by Thomas Konrad in his paper: "Measures, Methods, and Models of Doctor Satisfaction: Future Research Challenges." He provides an extensive overview of the many ways in which doctor satisfaction is studied. He points to the fact that different measures, methods,

and models not only reflect different theoretical approaches, but also different political agendas and ideological values. This is an important reminder. Research on medical care and the doctors' role involves many stakeholders: patients, politicians, managers, and the doctors themselves. Each stakeholder has, in principle, a common interest—high quality health care—yet the interpretations and perspectives on quality and how to secure quality will most likely vary between them.

Acknowledging the differences in perspective also requires being clear about the definitions of the concepts, including "professional satisfaction" and "quality." The papers by Konrad, Angerer and Weigl, and Casalino and Crosson discuss facets of satisfaction. Magne Nylenna, Oyvind Bjertnaes, Ingrid Sperre Saunes, and Anne Karin Lindahl contribute to the clarification of medical quality in their paper "What Is Good Quality of Health Care?" Based on a broad review of definitions, they extract the following dimensions: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity. The authors argue that studies of the relationship between doctors' satisfaction and quality of care, as well as studies of system features and quality, need to take a variety of definitions into account.

The relationship between satisfied doctors and quality of work is only one aspect of what we would like to know. Another aspect of the topic is the features of medical practice about which doctors complain. Francis J. Crosson and Lawrence Casalino present and discuss the results of a study of American doctors, which was recently conducted by the RAND Corporation (Friedberg et al., 2013). The study found that the most important reasons for dissatisfaction are closely related to the doctor's feeling at the end of a working day that s/he had been able to provide good care for the patients. Thus, time, pace, and professional autonomy were among the crucial factors. Further, frustration regarding electronic health records ranked high among generators of dissatisfaction.

The identification of specific factors that cause frustration or dissatisfaction is important in order to understand how the shaping of an organization can foster or hinder professional satisfaction and quality. The balance of professional autonomy and societal control is a core question, as illustrated by Freidson's change of perspective.

Marx Exworthy discusses two ideal typical accounts of medical control from the theory of professions, with reference to the British health system. One way of considering control is in terms of open and direct control, called the "iron cage" in this literature. Another type of control, "the gaze," is of a more subtle type and refers to control that can be exercised through becoming part of a social culture and internalized by its actors. Trust in professional self-regulation relies on the latter type of control, while reporting requirements or financial incentives are examples of the first. Clearly, one type of control can transform into another, as the so-called crowding out effect demonstrates (Frey, 1994). Financial incentives can "crowd out" an initial (e.g. patient centered) motivation; to be transformed into a motivation of maximizing financial gain.

At the symposium, all talks were commented on by active researchers in the field. Three of the commentaries are published in this issue. Jenny Firth-Cozens takes Casalino's and Crosson's paper as her starting point, and discusses the relationship between doctors' satisfaction and the quality of their work. She concludes that satisfied doctors are a prerequisite for high quality care.

Donald Light argues in his commentary that promoting collaboration between the different stakeholders in health care, such as managers and doctors, is a promising way to improve doctors' satisfaction as well as the quality of health care. He presents empirical examples of such collaboration, from British Columbia, Utah, and Idaho, and argues that successful collaboration alleviates dissatisfaction and alienation among doctors.

Finally, Per Arne Tufte discusses the concept of causality in this research field. A majority of the studies regarding relationships between doctors' satisfaction, the

quality of their work, and how this is affected by system factors tend to ignore the distinction between correlation and causality. Tufte suggests that a stronger focus on the causal mechanisms would improve our understanding.

Together, the collection of papers in this issue contributes to pushing this research a step forward. For the time being, it is clear that we should not draw strong conclusions. More rigorous studies are required in order to make conclusions about the relationships between features of health care systems and doctors' professional satisfaction, as well as the relationships between context, doctor satisfaction, and the quality of their performance. It is my wish, however, that compiling perspectives from medical research on how doctors look upon and experience their own practice and perspectives from "strangers at the bedside" (Rothman, 1991) can be mutually beneficial.

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