

TRANSFORMATION OF PROFESSIONAL AUTONOMY OF MEDICAL  
PROFESSION UNDER HEALTH TRANSFORMATION PROGRAM IN  
TURKEY

A THESIS SUBMITTED TO  
THE GRADUATE SCHOOL OF SOCIAL SCIENCES  
OF  
MIDDLE EAST TECHNICAL UNIVERSITY

BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR  
THE DEGREE OF DOCTOR OF PHILOSOPHY  
IN  
THE DEPARTMENT OF SOCIOLOGY

MAY 2023



Approval of the thesis:

**TRANSFORMATION OF PROFESSIONAL AUTONOMY OF MEDICAL  
PROFESSION UNDER HEALTH TRANSFORMATION PROGRAM IN  
TURKEY**

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## **ABSTRACT**

### **TRANSFORMATION OF PROFESSIONAL AUTONOMY OF MEDICAL PROFESSION UNDER HEALTH TRANSFORMATION PROGRAM IN TURKEY**

**ÇORBACIOĞLU AKSAK, Gül**

Ph.D., The Department of Sociology

Supervisor: Prof. Dr. Fatma Umut BEŞPINAR

May 2023, 310 pages

This study aims to examine the transformation of professional autonomy of the Turkish medical profession under Health Transformation Program (HTP), a comprehensive health reform that began to be implemented by Justice and Development Party (AKP) as soon as it came into power in 2003. The program entails changes in the organization, financing and delivery of healthcare services which had profound impact on the context and conditions of work of Turkish medical profession. This research aims to address how autonomy of the medical professionals as a group and medical professionals as individuals are affected in the context of HTP in Turkey, using concepts of political, economic and clinical autonomy. Through an analysis of in-depth-interviews conducted with 23 medical specialists working in private and public sectors in Ankara, it examines the subjective perceptions of professionals on the three dimensions of autonomy with regards to profession's relationship with the state, market and the public. Findings of the study present medical professional perceive political, economic and clinical dimensions of autonomy as intertwined that all three dimensions of autonomy as declining under the conditions of Health Transformation Program.

**Keywords:** sociology of professions, medical profession, professional autonomy, healthcare reforms, Health Transformation Program

## ÖZ

### SAĞLIKTA DÖNÜŞÜM PROGRAMI ALTINDA TÜRKİYE’DE HEKİMLİĞİN MESLEKİ BAĞIMSIZLIĞININ DÖNÜŞÜMÜ

ÇORBACIOĞLU AKSAK, Gül

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Bu çalışma Türkiye’de Adalet ve Kalkınma Partisi (AKP) tarafından 2003 yılında uygulamaya başladığı kapsamlı bir sağlık reformu olan Sağlıkta Dönüşüm Programı (SDP) altında tıp mesleğinin mesleki bağımsızlığının dönüşümünü ele almaktadır. Bu program sağlık hizmetlerinin organizasyonu, finansmanı ve sunumunda değişikliklere yol açmış ve Türkiye’de tıp mesleğinin çalışma ortamı ve koşulları üzerinde büyük etki yaratmıştır. Bu araştırma bir grup olarak tıp mesleğinin ve bireyler olarak hekimlerin mesleki bağımsızlığının SDP bağlamında nasıl etkilendiğini, siyasi, ekonomik ve klinik bağımsızlık kavramlarını kullanarak incelemeyi hedeflemektedir. Ankara’da özel sektör ve kamu sektöründe çalışan 23 uzman hekimle gerçekleştirilmiş derinlemesine mülakatların analizi ile bağımsızlığın üç boyutunun mesleğin devlet, piyasa ve kamu ile ilişkilerini üzerindeki etkilerinin hekimler tarafından nasıl algılandığını incelemektedir. Araştırmanın bulguları, hekimlerin siyasi, ekonomik ve klinik bağımsızlığını birbiriyle bağlantılı olarak algıladıklarını ve üç bağımsızlık boyutunun da Sağlıkta Dönüşüm Programı’nın yol açtığı koşullar altında azaldığını göstermektedir.



**Anahtar Kelimeler:** profesyonel meslekler sosyolojisi, tıp mesleđi, mesleki bađımsızlık, sađlık reformları, Sađlıkta Dönüşüm Programı

## ACKNOWLEDGMENTS

I would like to express my deepest gratitude to my supervisor Prof. Dr. Fatma Umut Beşpınar for her support, patience and tolerance throughout this very long process. I am also grateful to my examining committee members Prof. Dr. Kezban Çelik, Prof. Dr. Ayşe Gündüz Hoşgör, Prof. Dr. Reyhan Atasü-Topçuoğlu and Assoc. Prof. Dr. Çağatay Topal for their attention, valuable contributions and criticisms.

I also would like to thank TÜBİTAK for the financial support they granted me through programs 2211-A and 2214-A, which made this study possible. I am grateful to University of York Department of Sociology and Prof. Dr. Sarah Nettleton for hosting me through the latter, contributions of which has been an invaluable part of this research. I would also thank Sündüs Aydın for all her help and friendship and Prof. Dr. Ayşe Saktanber for her mentorship throughout the years.

I am grateful to my parents Candan and Dr. Abdullah Çorbacıoğlu for always supporting, encouraging and believing in me. I would also like to thank my parents-in-law Eser and Rükneddin Aksak for their invaluable support throughout the years. My husband Çağan Aksak has made the difficult process of writing this thesis fun; he has always been there in every way even though he was also burdened with the same difficult task.

My daughter Aylin has accompanied me at the final stages of this thesis; she turns 1 year old as it is coming to an end. The difficult and stressful days will also be a nice memory with her presence. I dedicate this thesis to her and loving memory of my grandparents Dr. Abdülkadir and Müfide Çorbacıoğlu, who are the original influences for this study, along with my father.

Finally, I would like to thank all medical professionals who accepted to participate in my research, those who have enlightened me through informal conversations and correspondence and all healthcare workers who always work tirelessly under difficult conditions.

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## LIST OF ABBREVIATIONS

AKP	Justice and Development Party
AMA	American Medical Association
ATO	Ankara Chamber of Medicine
BMA	British Medical Association
CT	Computed Tomography
DP	Democrat Party
ECG	Electrocardiogram
ENT	Ear Nose Throat
GSS	General Health Insurance
HTP	Health Transformation Program
IMF	International Monetary Fund
KHK	Executive Order
MRI	Magnetic Resonance Imaging
OECD	Organization for Economic Co-operation and Development
ÖSYM	Student Selection and Placement Center
SABİM	Ministry of Health Communication Center
SGK	Social Security Institution
SSK	Social Insurance Institution
TMA	Turkish Medical Association
TUS	Exam for Specialization in Medicine
UK	United Kingdom
US	United States
WB	World Bank
WHO	World Health Organization
YÖK	Council of Higher Education



## CHAPTER 1

### INTRODUCTION

This study aims to examine the transformation of professional autonomy of the Turkish medical profession under Health Transformation Program (HTP), a comprehensive health reform that began to be implemented by Justice and Development Party (AKP) in Turkey as soon as it came into power in 2003. The program entails changes in the organization, financing and delivery of healthcare services which had profound impact on the context and conditions of work of Turkish medical profession. This research aims to address how autonomy of the medical professionals as a group and medical professionals as individuals are affected in the context of HTP in Turkey, using concepts of political, economic and clinical autonomy.<sup>1</sup>

HTP reflected the main principles and premises of reform initiatives in health systems and healthcare services around the world at the end of 1980s and the beginning of 1990s, which has been called by Klein (1995, 223) the “international epidemic” of health reforms. These reforms were mostly responses to increasing healthcare expenses through privatization, managerial practices and limiting public spending. In a similar vein, the main goals of HTP were

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<sup>1</sup> Parts of this research have been published in the following:

Çorbacıoğlu, Gül. 2021. “Tıbbi Görüntüleme Cihazları ve Hekimlerin Mesleki Bağımsızlığı: Çelişkili bir İlişki”, *Sosyoloji Araştırmaları Dergisi*, Vol: 24, No: 1; 18-44.

Çorbacıoğlu, Gül. 2020. “Tıbbi Görüntülemenin Hekim-Hasta İlişkileri Üzerindeki Etkisi: Ankara’da Çalışan Uzman Hekimlerin Deneyimleri”, (ed. A. Turhanlı, A. Aydınoglu, M. Şahinol) in *Türkiye’de STS: Bilim ve Teknoloji Çalışmalarına Giriş*. İstanbul: İstanbul Teknik Üniversitesi.

Çorbacıoğlu, Gül. 2017. “Şiddet ve Değişen Hekimlik: Türkiye’de Sağlık Çalışanlarına Karşı Artan Şiddetin Şiddet Algısı ve Hekimlik Pratikleri Üzerindeki Etkileri”, (ed. G. Yenimahalleli Yaşar, A. Göksel, Ö. Birler) in *Piyasa Hakimiyetinde Sağlık ve Sosyal Güvenlik*. Ankara: Nota Bene Yayınları.

identified by Ministry of Health as effectiveness, productivity and equity (TC Sağlık Bakanlığı 2003, 4). It aimed to achieve these three principles by implementing its main elements which were administrative and financial autonomization of public health care organizations; promotion of private investments in health care especially through public-private partnership; a general social health insurance; family medicine scheme; a Full Time Act which restricts practice for medical professionals working in public organizations; a new payment scheme for medical professionals based on performance. The role Ministry of Health has become the coordinator and supervisor of services rather than the provider, as the affiliated organizations have now become autonomous in their budget. They have also become subject to a new public agency by which they are appointed managers who are not medical professionals. Private sector has been promoted and allowed to expand through tax advantages, investment incentives and other amenities, resulting in expansion of private insurance companies and outstanding increase in the number of private healthcare organizations. Consumerism, managerialism, assessment of medical performance by financial determinants became main principles in healthcare services. The desired outcome of cost control and customer satisfaction has led to efforts by state agencies, hospital managers and patients to intervene in medical decisions by controlling and influencing medical practice. These implications of the reform program affected every aspect of medical professionals' lives from their volume of work to their salaries. Understanding the consequences of these changes for political, clinical and economic autonomy of the medical profession is important since professional autonomy has been embraced by the medical profession itself as its most prized value and privilege. It is also viewed by scholars of Sociology of Profession as the distinctive characteristics that sets Professions apart from other occupations.

Professions have been seen as significant actors in society in the Western world, which led to a plethora of literature on their history, definition and social, economic and political roles in society since the early 20<sup>th</sup> century. They are characterized as groups distinct from other occupations due to their guild-like

structure and affiliations, strong value identification of their members, socialization processes and significant power in society and in their domain of authority. Most of the focus of theorization efforts on professions were based on United Kingdom and United States, which gave the literature a certain direction that involved comparing different cases to abstraction that emerged from these two cases. Considering the history of its institutionalization, its qualities and the values attributed to its work, medical profession was viewed as the ideal (as well as idealtypical) profession. Scholars have argued that the most important and prized quality of professions was absolute professional autonomy, which implied the freedom to control conditions and content of their work, including financial matters, macro policies, other occupations working in the same realm, independent from any intervention of any other actor. According to these explanations, professional autonomy was achieved by support of the state and trust of the public, but at the same time allowed the profession to be independent from their influence. Early theories focused on social role of medical profession and what they argued to be its inherent characteristics, such as altruism to explain its distinct position in society and in relation to other social groups. After 1960s, attention was directed more to explaining and dissecting power of medical profession, simultaneously stemming from and allowing its autonomy. Professional dominance approach that focused on its ability to control all aspects of its work and neo-Weberian approached that prioritized market closure and cognitive exclusiveness were the most influential explanations to understanding the profession and its autonomy.

As healthcare systems have started going through reforms around the world after 1970s, sociological interest in medical professions has increased one more time, this time also leading to studies of the profession in other parts of the globe, primarily in Europe, Soviet Union, Eastern Block and Scandinavia. These cases have presented a different picture of the medical profession, especially with regards to its relationship with the state. They presented that fully autonomous professions with absolute autonomy is not a universal case and that in fact medical professions may develop in very close relationship and become part of

bureaucracy (as in the cases of Germany, France and Scandinavia) or practice under the mandate of the state which controls all its affairs (Soviet Union and Eastern Block). The awareness of differences in trajectories and characteristics of the professions coincided with the growing literature on changing healthcare systems around the world. By 1970s, the changing ideological and economic environment in both developed and developing countries have resulted in changes in health systems, which had profound impact not only how health systems are organized, financed, delivered and governed, but also on the relationships between actors involved in this realm. Increasing health care costs and pressure on public expenditure was one common underlying driving force behind these reforms. Other challenges have been corporatization of healthcare organizations, advancements in medical technologies of diagnosis and treatment, aging population, consumerism and as a result, increasing public expectations and demands (Stevens 2009; Green and Thorogood 1998; Robingson and Stiener 1998; Blank and Burau 2004). Along with these developments, medical profession has been accused of swelling up health care costs and public expenditure through varying clinical decisions and expensive treatments. Professional autonomy has been singled out as a privilege that enabled this kind of discretion on the part of the medical professionals. The policy changes that aimed to achieve cost containment in late 1970s and early 1980s, shifted to efficiency in 1990s, concurrently trying to constrain professional autonomy (Whiteford and Nixon 2000, 442; Blank and Burau 2004; 89-92).

The policies were a reflection of the global shift towards neoliberal ideology in developing and developed countries in 1980s. Within this framework, public services were framed as inefficient; efficiency would be attained through privatization of state-owned companies and industries, deregulation and liberalization of sectors that rely on government control, and cutting back public expenditure, including in healthcare. In many developing countries, underlying motivation for similar reforms was the compliance to International Monetary Fund (IMF) and World Bank's to conditions that demanded restructuring and liberalization of public and finance sectors, in exchange for lending and

restructuring debt. “Structural Adjustment Policies”, as these prescriptions were called, required that spending on public services such as health are cutback and privatized.

These changes led to questions regarding the power of medical profession in the healthcare system. Since the cost-efficiency and productivity efforts in many healthcare reforms required increased accountability and control of the medical profession, its professional autonomy was inevitably curtailed. The theorization efforts then turned to explaining how professional autonomy was affected as a result of changing organization, financing and delivery of health care system. They examined repercussions of consumerist approaches to service delivery, increased access to information by the public, advancement of medical technologies, managerialization and bureaucratization of healthcare organizations. They discussed how to explain changing autonomy of the medical profession. This allowed new perspectives on medical professions to flourish. Different approaches focused on different dimensions of change. Proponents of deprofessionalization argument focused on information, technology and relations with the patients, while proletarianization argument focused on corporatization and bureaucratization of healthcare. Finally, dynamic system approaches have emerged which aim to explain professions in relations to other actors involved in the healthcare domain.

Dynamic system approaches, fundamental principles of which this study draws on, views profession and professional autonomy as dynamic concepts that are products of historical relationship between different actors in society and therefore is subject to constant change and are in flux. The increased interest in professions in non-Anglo-American contexts has shown that ideology of professionalism and professional autonomy is constructed as a result of social, political and economic relationships in a given society at a particular historical context. Profession and its autonomy should be examined by locating them within a web of relationships, allowing to observe autonomy as a result of change in the characteristics of these relationships, negotiations, conflicts,

alliances between actors throughout history. These analyses did not take the profession as the beginning point, but rather these relationships and the processes, since they considered the importance and influence of countermovements by other actors against the profession in the given domain.

Abbot's ecological approach (1988), Light's countervailing powers approach (1995, 2000, 2010), and Krause's explanation of transformation of guild power (1996) are examples that emphasize the necessity of studying professional autonomy as a result of complex factors that are shaped in particular historical contexts and interaction of social forces. State, public and market emerge as three other important "countervailing powers" in the domain of healthcare and medicine since 1980s, that challenge the dominance of medical profession in this area. According to Light (1995), the dominance of medical profession that has been sustained for most of 20<sup>th</sup> century, led to reactions and countermoves by others that have interest in the same domain to aim at redressing the (im)balance of power. Medical profession' autonomy had been based on the implicit social contract between state, society and profession that required the profession to regulate and monitor its members. However, new techniques for evaluation, surveillance and routinization creates control over professions, therefore, theories of profession that are based on absolute autonomy as fundamental characteristic of profession require a reevaluation.

These approaches have also helped highlight the relationship between the state and the profession in understanding the changes to professional autonomy, importance of which is ignored, minimized or viewed as nonconfrontational in Anglo-American models. The state has a bigger role in some countries with regards to training, employment and regulation of the medical profession. Regulations that legitimize the medical profession as the authority and autonomy to practice, prescribe, examine and operate are part policy making, which, even when the medical profession may have influence, ultimately rely on state mechanisms and government actors. In some cases, medical profession is granted an important political role that requires it to be closely affiliated with the state, or

function as a part of state apparatus. I argue that in while it is important to focus on interaction of medical profession, state, market and public to understand the transformation of professional autonomy under HTP, profession's relationship with the state takes precedence in this analysis as it has profound consequences for shaping its relationship with the markets and the public in Turkey. This is due to state's fundamental role in regulating, organizing and providing healthcare services in Turkey and medical profession's status that is legitimized by state, roots of which can be traced to the modernization and nation building efforts in late 19<sup>th</sup> and early 20<sup>th</sup> centuries. Therefore, in order to understand the extent of political, economic and clinical autonomy of the Turkish medical profession under HTP, the transformation of its relationship with the state, followed by the market and the public should be examined.

In Turkey, the efforts to reform healthcare began in 1980s and 1990s which aimed to privatize and commercialize the health care system. Like in many other countries in the developing world, these reform efforts were promoted by World Bank, IMF and World Health Organization (WHO) (Belek 2012). However, these plans had not materialized until Justice and Development Party (AKP) came into power in 2003. Comprehensive reforms took place in organization, financing and delivery of healthcare system, under HTP, which had profound impact on medical profession's conditions of work, social status and relations with other actors in society.

While it was neoliberal ideology that characterized health reforms around the globe as well as in Turkey, what marked AKP's efforts was its "neoliberal populist" regime, accompanied by increasing authoritarianism. Neoliberal populism has appeared in different parts of the world in the past two decades, from United States (Merkley 2020) to European Union (Onbaşı 2018), mobilizing support from masses in different parts of the world, including Brazil (Ricci and Venterulli 2023), India (Rogenhofer and Panievsky 2020; Gürsoy 2021), Israel (Rogenhofer and Panievsky 2020), Thailand (Gürsoy 2021) and Pakistan (Yılmaz et al 2022). This approach to governing included gaining mass

support of groups of people previously excluded from political and economic processes through social policies and an anti-elitist and anti-intellectualist discourse that targets the educated, economically more privileged through.

Özdemir (2020) argues that AKP's partly particularist and clientelist social policies that have benefited poor and socially excluded groups helped Erdoğan and AKP gain popularity among these fractions of society, at the expense of its neoliberal policies hindering benefits from formally employed. These targeted social policies were designed to "balance the discontent of neoliberalism" for the poorer sections of society (Boyras 2018, 2). Coming together with its populist anti-establishment discourse, it gained mass support from the underprivileged population that largely formed the unemployed or informal working class (Özdemir 2020, 16-17). Populist regimes promise representation to those sections of society that have been underrepresented as political actors, through a discourse that creates antagonisms between the so called "elites" and the "disenfranchised". In this case, AKP signalled itself as the true representative of the latter, who are comprised of conservative, poor, vulnerable mostly rural or newly urban population. The duality between social positions and values of the "greedy" "corrupt" elites comprised of secular, educated, urban population and "common pious people" that are socially, economically and culturally excluded from "seats of power" were highlighted. The elite in this discourse includes various groups such as those related with the state through civil service, bureaucracy of politics, economic elite such as industrialists or certain professional groups, or cultural elite such as academics and journalists (Ağırtan and Kuhlmann 2019, 1413). Professional groups, including the medical profession is seen as part of the status quo, ensuring the reproduction of the system that excludes the vulnerable as outsiders, working against the "people", although they are also the group that provides a fundamental public service that is needed most by the same section of population they are pitted against by AKP's rhetoric. Neoliberal policies such as HTP were accompanied by populist discourse that aims to discredit professional groups such as medical professionals in AKP's efforts to restructure social, economic and political spheres of society.



While various studies have assessed HTP and its repercussions, many were written by economics or public health scholars, focusing on economic dimensions of organization and delivery of HTP (Sönmez 2011; Bulut 2007; Pala 2017; Yenimahalleli Yaşar 2017; Bilaloğlu 2015; Belek 2012; Elbek and Adaş 2009; Hamzaoğlu 2013; Aslanoğlu 2012; Arslanoğlu 2013; Elbek 2015).

On the other hand, medical profession in specific did not constitute much attraction from a social science perspective in Turkey. The literature on sociology of professions have recently been developing, with studies on teachers (Durmaz 2014; Buyruk 2015) and lawyers (Akbaş 2011). In the recent years few studies on health occupations have also been published (Ünlütürk Ulutaş 2011; Acar 2010; Güler 2012; Köksal 2012; Üçkuyu 2012; Soyer 2012; Adaş 2013; Elbek 2013; Başkavak 2016). These studies lack three features that this study aims to cover: Most have a political economy perspective, only few have a sociological lens; they do not focus specifically on the medical profession but rather on all healthcare workers (or in one case, only on surgeons); and they do not examine professional autonomy. Professional autonomy was generally addressed as an issue of concern by medical professionals themselves as an ethical issue (Ankara Tabip Odası Sağlık Politikaları Komisyonu 2011). This study aims to fill these gaps, by taking HTP as the context and examining the Turkish medical profession and its professional autonomy as a distinct case. It will draw on the dynamic system approach by studying the transformation of professional autonomy against the backdrop of its changing relations with the state, market and the public, what Donald Light calls “countervailing power” in the realm of health (Light 1995; 2000; 2010).

Main research questions that will be addressed by the research are as follows: How did the extent of professional autonomy change after HTP from the perception of medical professionals? What are consequences of the changing extent of their professional autonomy on their daily working lives? How do their relationship with the state, the healthcare services and professional labor markets and the public have impact on professional autonomy? Do medical professionals

experience political, economic, clinical dimensions of professional autonomy as independent or interrelated values? How does the unique case of transformation of autonomy of Turkish medical profession and the specific configuration of social forces that drive this transformation diverge from other explanations in the literature? Is the professional autonomy of the Turkish medical profession distinct from other explanations in literature which tend to view it as an inherent quality or an absolute value that is attained independently from the state and other actors in society?

In order to answer these questions, first a historical background will be provided as an insight to Turkish medical profession, the foundations and extent of its autonomy. This historical background ensures that the analysis on effects of HTP is placed within the specific social and historical context and presents the historical transformation of its relation with other actors in society who have a stake in how the financing, delivery and organization of the healthcare services are structured. In this sense, publications of Turkish Medical Association (TMA), Chambers of Medicine, historical accounts, memoirs and biographies of Turkish medical professionals were crucial to understanding the transformation of status, identification of its members, the public perception and the relationships of the medical profession in Turkish society.

Then the research questions will be answered by using qualitative approach, through analyzing semi-structured in-depth-interviews conducted with 23 medical professionals who are specialists working in Ankara. The field study for this research was conducted in Ankara between July 2013 and February 2014. In order to understand how respondents experience the transformation of their professional autonomy by comparing before and after implementation of HTP, it was important to interview medical professionals who have been practicing as specialists at least for 10 years at the time of interviews. While 11 respondents worked in private health care organizations in form of Private Medical Centers with no inpatient care facilities and larger Private Hospitals, 12 worked in public health care organizations that varied from hospitals affiliated with Ministry of

Health, to Training Hospitals and University Hospitals. The analysis of findings from this field work will be divided into three groups: Professional autonomy as a result of profession's changing relations with the state, followed by relations with healthcare and labor markets and with the public.

A qualitative research method is chosen for this study as it allows the researcher to get close to participants as possible, access and accurately interpret the complexity of their views, perceptions and subjective meanings they have adopted as a result of their experiences. A significant aspect of this research is presenting how respondents subjectively perceived their autonomy in the face of objective work conditions. Therefore, in-depth-interviews helped provide an insight into feelings and sentiments attached to changes in status and control, processes of negotiation, bargaining and corner cutting in daily work life practices. Qualitative approach also allows examining the different levels of perceived autonomy based on differences among organizational settings and different kinds of decisions medical professionals have to make. As the profession is becoming more stratified, differentiated and heterogeneous due to variations in organizational structure, specialization and employment conditions, subjective perceptions are important to studying whether and how shared professional culture, values and ideology, professional autonomy being the foundation of all, are maintained.

The chapter following this brief introduction will define the theoretical and conceptual framework of the study. For the conceptual framework, the main concepts that will be used in the study, namely professional autonomy and its political, economic and clinical dimensions will be defined. Different scholars have used various terms to define these concepts. These different approaches will be presented, concluding with the particular definitions that will be used in this study. This will be followed by presentation of theoretical debates on profession, focusing on professional autonomy. These debates in the Sociology of Professions correspond to developments that have taken place in healthcare and medicine throughout the 20<sup>th</sup> century. In order to give context to why certain

theories have found proponents at a particular time frame, these developments will be taken into consideration as the vast literature on professional autonomy is presented.

The next chapter will present a historical account of Turkish medical profession, and its interaction with state, market and public, relationship with three actors that forms the foundations of its autonomy. The chapter will take late Ottoman Empire period of 18<sup>th</sup> century as the beginning point, since the modern medical institutions and profession have been established during this time period. It demonstrates a continuation in the early Republic period, when the state and the medical profession were almost intertwined, which presents a relationship that differs from those in United States and United Kingdom, which most theories of professions as modeled after. The historical account will explore the historical trajectory of institutionalization and extent of clinical, economic and political the profession has, which will be helpful in understanding how the present situation is different compared to prior to implementation of HTP.

The fourth chapter will explain the methodological approach used in this study. It will explain why a qualitative method has been chosen to conduct this research, as well as the specific problem of study. The field work, respondents, interviews will be described, followed by explanation of why reflexivity is important for this study and which additional sources were used. The chapter will conclude with the limitations of the study.

The next three chapters will present findings of the field work. In line with the theoretical approach of dynamic systems this study employs, the chapters are organized in a way that allows each chapter to discuss the profession's relationship with one countervailing power. They explain how this specific relationship has affected professional autonomy and its particular political, economic and clinical dimensions. The first of the three chapters will provide an analysis of medical profession's relationship with the state, examining the respondents' perceptions of how AKP governments impact profession's

relationship with the other two countervailing powers of public and the market and its professional autonomy. Final chapter will discuss profession's relationship with the market(s). The markets that are addressed in this study are the market for healthcare services and the market for medical profession labor market. The third chapter will discuss how the public's perception of the profession has changed with HTP, its implications for doctor-patient relationship on a daily basis and how this relationship affects professional autonomy.

This study's significance lies in its presentation of the Turkish medical profession as a distinct case in how a specific constellation of relationship with state, market and patients institutionalize and transform its professional autonomy. It examines how this transformation comes about as a result of wider social, political and economic developments. It aims to understand whether the three dimensions of professional autonomy, namely political, economic and clinical, are perceived as separate or inextricable by individual medical professionals. It also aims to contribute to the literature by presenting a particular case in which the profession has developed in close relationship with the state which grants it profound authority and power in society, but not as much in terms of autonomy.

## **CHAPTER 2**

### **THEORETICAL AND CONCEPTUAL FRAMEWORK: SOCIOLOGY OF PROFESSIONS AND THE MEDICAL PROFESSION**

This chapter will provide a conceptual framework and a theoretical background to the inquiry into transformation of professional autonomy of the Turkish medical profession under HTP. Theoretical explanations and conceptualization of professional autonomy based on Anglo-American medical profession have dominated the literature on professions and medical profession throughout 20<sup>th</sup> century. They have mostly emphasized the profession's independence from and authority over the state the public, some also stressing the vitality of support of these actors in legitimizing autonomy. Since the last quarter of the 20th century, the market has also joined the state and the public in the analysis of professions, as the third external force that has contributed the changes in structure, organization and social position of the medical profession. The profession, which traditionally had the sole authority over issues of health and organization of medical practice, is now only one of the four Countervailing Powers that dominates the realm of healthcare. This has profound consequences on its professional autonomy. A historical examination into formation and the extent of professional autonomy of the Turkish medical profession presents that it has institutionalized within a very close relationship with the state and the public, having a very significant role almost "within" the state and under its mandate, rather than as an external, autonomous actor. In this study, I aim to present an analysis into changes in profession's autonomy by placing it within this broader framework of relationships with the state, the public and the markets of professional labor and healthcare services. This will be carried out against the historical backdrop of the institutionalization of this autonomy within the same broader web of actors in society. Through these efforts, this study aims to point out how Turkish medical profession's autonomy differentiates from the

dominant theoretical and conceptual explanations of “professional autonomy” based on Anglo-American medical profession.

First, in order to contextualize this study’s approach within the landscape of sociological literature on professions and professional autonomy, a historical background will be provided to the institutionalization of medical profession in United Kingdom and United States, on which most theories of professions are based on. This will be accompanied by the debates on the concept of “profession” in different contexts, specifically a discussion on the differences between Anglo-American and European conceptualizations. Then, the concept of professional autonomy will be defined in this context, with its three dimensions, political, economic and clinical, which are crucial for this study. Finally, the vast theoretical literature on professions, focusing on the medical profession, will be reviewed, taking into account the social, economic and technological developments that affect the context and conditions in which the medical profession is practiced and located in society. The historical sequence of this review will present how these developments have affected the shifting focus, explanations and significance of theories and debates on autonomy of the medical profession throughout the 20<sup>th</sup> century.

### **2.1. “Profession” and “Professional Autonomy” as an Anglo-American Concepts**

The emergence of the concept of “profession” is useful to understand the separation implied between the profession and other occupations. While, according to Krause the professions are the product of universities and have existed since then (Krause 1996, 13), according to Johnson, the growth of professions has been the defining characteristics of the industrial society (1972, 9). This distinction stemmed from the qualities they embodied, their social status in society, their place in the division of labor, the values their work claimed to maintain, their service ideal, the body of knowledge they possess and the long training they have to undergo to attain that knowledge, and most importantly, the

autonomy they have over the domain of their practice. The traditional professions, namely law, medicine and clergy had always been seen as being different from other occupations historically. Justice, health, faith and technical progress were universal ideals that were seen as values promoted by these professions, which would benefit the well-being of society. Altruism constitutes one characteristic that is attributed to these professions in relation to these values. However, as will be presented, this was approached with skepticism later in the 20th century, with their integration into the capitalist economy and increasing relations with the market. Nevertheless, from the late 19th century into the first half of the 20th century, these professions were still seen as operating within a space in society, which Freidson (2001) called the “Third Logic”, independent from and unfettered by both business and bureaucracy, due to their service orientation, monopoly over esoteric and theoretical body of knowledge for which they attain a long training and license to practice, and the complex and uncertain nature of the services provided which cannot be controlled and assessed by outsiders. It has been seen as an alternative to the profit-oriented, egoistic market forces and bureaucratic conduct of quantifiable and standardized work based on previously set regulations and rules (Turner 1995; Light 2010; Larson 1997; Freidson 2001). Until the 20<sup>th</sup> century, professionalism has developed mostly as independent of capitalism, since most professionals worked under the patronage of aristocrats, and were not involved in a capitalist exchange in a free market. Their services were not commodities in a free market open to all, but rather, they had fixed patrons who they provided their services to. Therefore, the early professions had a more “medieval flavor, rather than capitalist” (Derber et al 1990, 119). This traditional view of professionalism as opposed to values of the market and bureaucracy has started to transform as capitalist and bureaucratic corporations became more dependent on professional knowledge, as states started to become mediator providers for their services, and as the client base for professional services started to shift from aristocrats to urban middle classes at the end of the 19<sup>th</sup> century (Derber et al 1990, 120).



The words that exist to describe professions (and their connotations) in different languages present the diversity in the underlying connotations, contexts and the extent of independence they have had throughout the history in these different contexts (Crompton 1990; Burnham 1998). Crompton argues that while the word “profession” has moral connotations in English, in French it is a “descriptive term translating as ‘occupation’” (1990, 149). This is related to the historical process in which professions and occupational associations in Britain and United States had an important degree of autonomy over their work, knowledge, recruitment and codes, whereas the professions in France had emerged through creation of ‘grand ecoles’, under the sponsorship of the state. On the other hand, in Germany, the concept to describe the English profession is “Beruf” which is a “Lutheran notion of calling, which turned into an idea of inner vocation when secularized during the 19th century” (Jarausch 1990, 2). While in these other languages it does not denote a difference between vocation or occupation, in English the word “profession” denotes a separation from other vocations and occupations in these societies; it is a concept used to denote a superior existence with regards to status, control, power in society and in division of labor. Crompton also argues that the particular status of “the professions” in Britain and United States is the consequence of this history, and that it is now widely accepted that Profession is not a universal concept in sociology, but rather a specifically Anglo-American one. But it would be admissible to say that the amount of Anglo-American literature on both the professions in Britain and United States, as well as work written by British and American scholars on the professions in other geographies, have led to the perception of the concept of “profession” as a universal concept (Crompton 1990, 149-150).

The dominance of Anglo-American subject matter and theoretical perspectives in the literature on sociology of professions, and on the medical profession in specific, has led the Anglo-American model of institutionalization to be used as the yardstick to assess the extent and quality of professional autonomy. The characteristics and historical development of professions and recent changes taking place in them have been discussed mostly through the examples of British

or American professions, whose features are in fact specific to the social, political, cultural and economic context of the societies they are located in. Professions in other developed and developing and industrializing have not come under scrutiny as often as their Anglo-American counterparts, however the studies where they have been the topic of such investigation have been important to show the diversity among the different professions in different societies.

The peculiar historical narrative on the development and institutionalization of American and British medical professions strongly emphasizes their autonomy from other actors in society, most significantly from the state. While it has later been claimed by several scholars that this is partially misleading narrative, the profession in these countries played an evidently important independent role in establishing and institutionalizing their legitimacy and autonomy in their area of work. In United States, American Medical Association (AMA), which has been established in 1848 has become the most important arbiter in medicine, lobbying for and ensuring the power of the profession in matters that pertaining to itself and issues of healthcare. The amount autonomy held by the profession over matters of extent of healthcare services, licensure and credentials required to practice, medical training, supply of professionals, were the reasons why the first half of 20th century has been called the “Golden Age of Medicine” in the United States. The institutionalization of medical profession in the United Kingdom also coincides with the second half of the 20th century. Industrialization has led to emergence of urbanized middle classes which led to expansion in the market for medical and legal services (Johnson 1972, 52). Medical profession, which had previously practiced under the patronage of aristocrats, institutionalized into an organized profession. The aim was to control and limit the number of practitioners and eliminate the quacks which were threatening public health as well as the reputation of the profession. Here, Royal College of Physicians, originally founded in 1518, and the British Medical Association (BMA) founded in 1832, acted as authorities that determined standards for qualification and regulation of professional practice and conduct (Berlant 1975).

Although they have been enlightening for paving the way for theorization of the social, cultural and economic positions professions occupy in society, the overwhelming emphasis on Anglo-American context in theoretical and empirical literature in the sociology of professions have created several problems for analysis of professions in other societies. The emergence of the organized medical profession in the United Kingdom and United States as institutions that hold immense autonomy from the state, have affected the way early 20th literature conceived the founding dynamics of the professions, and their transformation.

Beginning with the early work on professions, some key features have been highlighted as characterizing professions, used by scholars of sociology of professions for distinguishing professions from other occupations. Although different approaches among these scholars have led to disagreements on these key features, on their ontological existence and on whether they are normative or constructed, “professional autonomy” has been agreed upon as the most important pillar in distinguishing certain occupations as professions. While it may be debated how this autonomy is achieved or where/when/from which factors they have originated from, Anglo-American models historically and empirically demonstrated that medical profession is characterized by a high level of professional autonomy, which has caused this concept to be placed at the center of debates on the rise and decline of profession. The Anglo-American model of professions (those professionalized from within), according to McClelland (1990) have usually been placed at the opposite polar of the Continental professions (those professionalized from above). The Anglo-American literature, the dominant narrative is based on American and British medical professionals having achieved autonomy independently, although some scholars have objected to this by arguing that it is mistaken to imagine Anglo-American professional autonomy as constructed through full independence from the state (Krause 1996; Abbott 1991; Light 1995).

While earlier studies emphasize far too much autonomy from state and qualities of professions that are viewed as “intrinsic”, rather based a product of social relations. Then the late twentieth century Anglo-American studies have focused mostly on the internal organizational changes of the profession, or Elston (1991,61) put it, “seize on one aspect of change and draw general conclusions about overall rise or fall, ignoring other, countervailing tendencies” (quoted in Baggott 2004, 53). They do this by placing the medical profession in the center of their analysis and ignoring or weakly establishing the relationship with other actors in the domain of health care, namely the state, the market and the public. Most have not paid sufficient attention to all external factors and actors that play a part in the working lives and organizational changes in the profession and the relationship of the internal organization with other areas of professional life at the same time. Therefore, they lack a full comprehension of how these changes may in turn bring about transformation in the relationships between the profession and these other actors involved in health care. While diverse, overwhelming majority of work on professions continued to have a definitive static, unified definition of “professional autonomy”. It is described almost as an absolute, normative, intrinsic quality which emanates from the historical narrative that the profession is has established itself and institutionalized independently, regulating itself in a guild-like manner and has full financial and organizational authority over matters in health.

On the other hand, it has mostly been argued that European professions have developed through close interaction with and from within the state. Looking into the professions in Scandinavia, Latin America, Eastern Europe, North Africa and Middle East have also demonstrated the pitfalls and dangers of trying to conceptualize professions located in different societies without studying the particular historical background and social, political and cultural relationships between actors in a particular society; and context within which the professions institutionalize in.

In a similar vein, I argue that the traits, the content of work, the responsibilities, the relationships the medical profession builds with society can change as the result of wider economic, political, social developments. This may also affect its most prized value, autonomy. I argue that unlike what has been claimed by Anglo-American body of work, “professional autonomy” is a dynamic, ever-changing concept, in parallel to the dynamic framework that is shaped by the relations between itself and other countervailing powers that are involved in the realm of medicine and health care. Through the Turkish case, I argue that it is mistaken to point at a dichotomous and absolute concept of autonomy, that professional autonomy is not absolute and it fluctuates on a continuum as a result of impact of many different factors and interactions with different actors. Its clinical, economic and political dimensions may be located at different places on this continuum at certain times in history. Therefore, it is more fruitful to view the concept of professional autonomy as fluctuating condition that is the result of everchanging relations between different actors within a particular social, economic, political context.

## **2.2. Establishing Professional Autonomy**

Autonomy implies the profession’s “authority and freedom to regulate themselves and act within their spheres of competence” (Wilensky 1964, 138). There are three dimensions of authority that enables autonomy, which are reflected in different emphases by different theoretical standpoints on professionalism and the changes it faces in the second half of the 20<sup>th</sup> century. The first dimension is the authority the profession holds over the public and the patients. Haug and Lavin, who examine changes in the doctor-patient relationships that challenge professional authority, define the concept as “public acceptance of the right of the physicians to direct the interaction in therapeutic encounters and instruct patients in appropriate treatment behaviors” (Haug and Lavin 1978). This authority allows the medical professionals to conduct their work in the manner they view suitable in accordance with their clinical judgement. The second dimension is the authority the profession holds over other

occupations in the health division of labor, to direct and evaluate other's work, without being subject their direction and evaluation (Freidson 1970b). This allows the medical professionals to be exempt from external assessment, controlling and regulating their own work. The third dimension is the authority the medical profession has over the governments on matters related to health policy and medicine. The theoretical, esoteric body of knowledge the profession claims to possess legitimizes the claim that they are the experts to make appropriate informed decisions on organization and delivery of health care services, as well as definitions of health and illness, the patient and the needs of the patient (Illich et al 1977). This final authority allows them to have a say over policies and practices that will affect their content and context of work. Therefore, professional authority encompasses the power that makes professionals' advice obligatory to follow, by the state, the health organizations, and the public. It involves being able to dictate particular definitions of reality, meanings and values as valid and true (Starr 1982, 2).

Major (Anglo-American) scholars of professionalism in the second half of the 20<sup>th</sup> century have unanimously pointed at the special theoretical and esoteric body of knowledge and linked skills as the basis of professional authority. Larson (1977) emphasized importance of cognitive exclusiveness and a unified training in establishing a market monopoly for professional services, while Abbott (1988) stressed the significance of an abstract system of knowledge in jurisdictional boundary disputes in the system of professions. However, a cognitive base that incorporates a theoretical body of knowledge or technical competence are is not by itself sufficient to attain professional authority. In order to achieve the position of sole authority on this specific area of practice, legal authority of competence is necessary. Eliminating competitors and ensuring the profession as the only legitimate provider of the services requires achieving monopoly over practice. Larson (1977) and Freidson (2001) underlined the priority of market closure to establish monopoly through credentials over a knowledge and skills. This monopoly requires legal protection by the state. State support and sanction is also fundamental to development of "allegedly"

independently formed Anglo American profession, just as much as the Continental professions that have developed through organic links to the state. State legally supports and sanctions for professions to institutionalize their authority through licensure and credentials.

While state support is necessary to obtain market monopoly and legal privileges, it does not guarantee that the public is going to consume the product or consult the services of the professional group. The state may extend legal protections for monopoly of practice to the profession, but it cannot force the public to consume them. The profession is granted the right to control key aspects of the market and work conditions through licensing, in exchange for fulfilling the public expectation to provide high standards of practice. They are also allowed discretion in exchange for fulfilling the expectation that they will serve the public with a service orientation, rather than their own financial or political interests (Sullivan 2000; Freidson 1970a; Freidson 1970b; Larson 1977; Light 1995; Elston 2009). Any profession that wants to achieve autonomy in society has to convince the public that it is trustworthy, and will conduct its practice with the best interest of the clients in mind. The necessity of trust stems from an asymmetry of knowledge and skill between the profession and public, in which the information and means of healing are only accessible to trained and licensed practitioners. This implies a power inequality between the patient and the doctor, which becomes a relationship that is open to exploitation, if the doctor pursues his/her own self-interest. The patient is vulnerable against the doctor who holds the information to his health, which is transcendent value for the individual's existence (Starr 1982). Therefore, the public needs to be persuaded that the professionals are not only properly trained and credentialed, competent to respond to clients' problems, but that they do so in a trustworthy, ethical way in a way that takes into consideration the client's best interest. The patient needs to be persuaded that the professionals act ethically and can be trusted to provide highest quality service. The relationship between the public and the profession has been often conceptualized as a "social contract" which depends on trust and mutuality of dependency and obligation (Cruess and Cruess 2008; Sullivan 2000;

Allen et al 2005). The social contract is a mix of implicit, explicit, written and unwritten roles of conducts for professional behavior and duties (Crues and Crues 2008, 583). It includes legislation on health care, licensing and certification, code of ethics and the Hippocratic Oath.

In order to persuade the public on its trustworthiness and altruism, the profession must maintain a unified public identity in the eyes of the public (Hafferty and Light 1995). The individual doctors gain authority to access patient through their confirmation as members of a group with monopoly over practice, which is impossible by constructing an institutionalized public identity. A formalized and codified education that ensures the standard training and socialization of the members is one aspect of this unification (Larson 1977). The modern university system has enabled a systematic scientific foundation to reinforce their claims of competence over a theoretical, esoteric body of knowledge and skill and helped standardize the professional training. Symbols such as a standard curriculum, degrees and diplomas therefore does not only help determine clear boundaries of the area of jurisdiction, but also to create an image of “professionalism”, a status of authority in society (Brosnan 2015). However, according to Larson, who emphasized importance of “production of producers” for market closure, the professional training should be standardized and codified to an extent that will enable uniformity among practitioners, it should not be too standardized in order to avoid easy access and routinization (Larson 1977, 31). Maintenance of “mystery” of the knowledge, and establishing a “scientific” base for this knowledge has established public’s trust in the professionals’ competence, based on objectivity and impersonality (Derber et al 1990).

The second aspect of establishing a unified public identity is the institutionalized means of organization for the profession, most important of which is the professional association. While associations are not specific to professions, they are necessary for them to project a unified and credible identity which help reinforce a homogeneity among members. This unified image of profession as a corporate body is also important in its political struggles with the state, which, if



persuaded of profession's credibility, will not only create market protections, but also will grant authority over terms and practice to the association (Freidson 1970a, 33). Associations are established with the claim of undertaking social control of its members (Pavalko 1988, 111). They promise self-regulation of its members, which assures the public and the state of its ability to discipline and dismiss members who are unethical and incompetent. Therefore, a unified, homogeneous identity of a group that is trusted to be competent to train, license and regulate its own members, also transfer this image of trustworthiness and competence to its individual members, members' autonomy will be recognized by members of the public who face them individually in the examination room. The associations also negotiate with the state the right to determine the "supply" of "the producers", which is an important part of maintaining professional authority, since limiting the number of those who are credentialed to practice (and therefore hold the authority) will ensure the financial rewards and social status promised to each member can be protected. The guarantee of individual members' socio-economic mobility and status is closely related to the authority and prestige the professional group holds in society (Sullivan 2000, 673). Therefore, professional authority depends on the group's recognition as a collectivity, as corporate body. The individuals are recognized, attributed status and authority as "members of a collectivity that has objectively validated their competence" (Starr 1982, 12). The public trusts and consults individuals as a result of their belief in the merits of the profession as a collectivity and that these individuals apply the standards shared by the community.

### **2.3. Conceptualizing Dimensions of Professional Autonomy: Political, Economic and Clinical**

The differences among theories on professions emanate from their explanation of the content of and the ways in which this autonomy is achieved. While early theories have argued that professional autonomy is an inherent, natural characteristic of professions, the approaches that became more dominant in the second half of 20<sup>th</sup> century examined how autonomy was achieved as a result of

processes of struggle and negotiation with other forces and actors in society. Debates taking place in this period have also revolved around factors that affect professional autonomy in a changing environment of organization of medicine and healthcare, as well as the consequences of these changes on the profession as a corporate body and individual professionals. Collective autonomy is gained through professional authority in society, through state's legitimizing support and public's recognition of professional competence in a specialized theoretical area of knowledge and claims of altruism and service orientation. The distinction between collective and individual levels of autonomy is important because autonomy is possessed by individuals as an extension of virtues and privileges of the group they are members of. This autonomy spills over to the amount of autonomy that will be attributed to the member of this professional group. Therefore, individual and collective levels of autonomy are separate but intertwined (Funck 2012).

Therefore, a two-level analysis is required in order to evaluate the change in profession's autonomy. First is a macro level that explains the power of collective political autonomy, an assessment of how much autonomy the profession has against the countervailing powers of state, market and public in the domain of medicine and healthcare. This requires a historical perspective in which the institutionalization of medical profession as a social, political and cultural authority in society and how it has gained (or lost) autonomy in interaction with these other powers in society.

The second is a micro level analysis which examines the impact of change in collective professional autonomy on the subjective work experiences of the individual medical professional. This analysis will enable an understanding of how the individual professional evaluates the impact of changing context, content and conditions of work, and whether all individuals experience dimensions of autonomy equally.

While professional autonomy can be distinguished as collective and individual, literature further elaborates on what these categories entail. There are different definitions and categorizations of individual and collective autonomies (Funck 2012; Elston 1991; Freidson 1970a; Freidson 1970b; Freidson 1988; Gabe et al 2004; Schulz and Harrison 1986; Evetts 2002; Krause 1996). While these studies have put forward different terms to refer to collective or individual autonomy, there is a consensus over what the contents of these categories involve. The literature can be summarized into 3 categories of autonomies: Political autonomy, which refers to collective autonomy and clinical autonomy and economic autonomy, which refer to types of individual autonomies.

Political autonomy consists of profession's ability to control collective regulation of medical training, licensing; discipline and social control of members (self-regulation). It enables elimination of competitors from the domain of medicine and healthcare services. It also includes the profession's right to make policy decision on health, as the legal experts on matters of healthcare and medicine (Elston 1991; Schulz and Harrison 1986; Gabe et al 2004, 174). It is usually the professional association that is the main actor of collective autonomy (Abbott 1988; Johnson 1972). While earlier theories of profession argue that it has dominance over and holds the ultimate autonomy over these matters, later approaches recognized the disputes between two actors in establishing healthcare services and policies, therefore professional association's role in negotiating and bargaining with the state and market to protect profession's right to self-regulate, self-assess and self-determine the conditions and context of work.

Individual autonomy refers to dimensions that correspond to two aspects of medical profession's content and context of work on a daily basis: Economic and clinical autonomy. Economic autonomy includes individual professional's ability to determine the remuneration and fees, control of volume of work, distribution of resources, number of patients, terms and conditions of work (Elston 1991; Gabe et al 2004, 174; Harrison and Schulz 1984). Clinical autonomy includes professionals' ability to control technical aspects of work. It implies the ability to

judge the quality of and plan the content of one's own work, to make decisions on diagnosis and treatment, beginning with patient's admittance to discharge (Elston 1991; Freidson 1988; Harrison and Schulz 1984; Funck 2012). This includes decisions such as which tools, tests and techniques to use, what medicine to prescribe, when and how to operate on a patient and duration of hospitalization.

There are different approaches to how absolute professional autonomy and its different dimensions are, as well as which dimension is the most indispensable. Although many observers argue that individual and collective autonomies are intertwined, some argue that one dimension is more important for the profession than others. What Elston (1991) defines as "clinical autonomy", is defined as "technical autonomy" by Freidson; he argues that this is the most important for a profession to maintain its dominance. He makes a distinction between socio-economic autonomy and technical autonomy, arguing that even one profession loses socio-economic autonomy, being restrained by the state or organizations, it is important that the individuals still maintain ability of decision making over the technical content of work, meaning over decisions on patients. In a similar vein, Evetts (2002) argues that maintaining individual autonomy is more important for the profession to maintain collective autonomy. However, in this study I argue that one cannot discuss the three dimensions of professional autonomy separate from each other. The clinical autonomy of an individual professional which refers to the decisions the professional will make on the condition of a patient will be bound by the kind of services s/he can provide, the resources available to him/her, the time s/he is allowed to spend on a patient, the pharmaceuticals s/he can prescribe. Therefore, the decisions that are going to be made will not only have consequences for the patient, but also for "responsibility of community and distribution of resources" (Sandstrom 2007, 3). I argue that it would be misleading to only emphasize the importance of autonomy as a relationship that is limited to one that is between doctor and patient, and to the technical content of work. I also argue that its control over the technical content of work is also connected to the extent of its political autonomy, the ability of profession as an

organized group to control matters that are to their own interest and concern to its members. These concerns may be related to guarding boundaries of their domain from the competitors, controlling conditions of pay, work and qualification. Professional associations are important vehicles here that enable negotiations with other actors, as well as reinforce the professional identity of their members. Apart from political autonomy, the improved social and economic status and “hope of collective mobility” of the professions like medicine is “directly dependent on the authority and prestige” in their respective fields (Sullivan 2000, 673). Collective status of the profession is significant to understand the status of individual profession in society. It is important for legitimacy in the eyes of the state and the public, as well as the sphere of autonomy that is granted to the professional in terms of regulations and opportunities on fees, salaries, volume of work, and the resources that are available to him or her. Therefore, unlike Freidson argues, socio-economic (in other words, political and economic) autonomy of a professional is connected to his technical (clinical) autonomy.

The debates on which dimension of professional autonomy is indispensable to the professional has also been accompanied by discussions on whether professional autonomy is an absolute concept, meaning whether the group or the individual profession holds either full autonomy or none. Evetts (2002) argues that no profession in history ever had unfettered autonomy as the “its ideal typical interpretation” in theory. She also argues that “discretion” would be a better concept than autonomy to define the privileges the profession possesses over issues that pertain to its work. She also puts forward that unlike most of the historical narrative, the profession had always worked under conditions that combines external regulation as well as self-regulation, for which “acquired regulation” would be a better definition (Evetts, 2002, 347). They monitor themselves to a large extent, however there have always been other authorities and institutions that oversee them, such as Ministries or Departments of Health. While this may be seen as an encroachment on professional autonomy for those who argue for the extent of autonomy as an absolute concept, Sandstrom (2007,

14) argues that some kind of restriction for professions would actually work for the advantage of the profession, by preserving the claimed altruism, and preventing exploitation of self-interests.

I agree with scholars who put forward the claim that professional autonomy is not an absolute concept. I argue that it exists in a continuum, on a scale in which it varies depending on power struggles, conflicts and negotiations between actors in a specific realm. I go further by arguing that the three interrelated dimensions of professional autonomy, political, economic and clinical, may also exist in different extents across time, societies, based on how healthcare services are organized and structured which is a consequence of web of relations between profession, state, market and public. They may also vary in terms of how different individual professionals experience them, depending on work conditions, interests, specialties, in health system where there are different kinds of organizations and market dynamics.

Following this argument, in this study I will present how collective and individual autonomies and dimensions of political, clinical and economic are interrelated, but also interdependent, fluctuating through profession's changing relationship with state, market and public, the other actors who also seek to dominate the medicine and healthcare domain. I will also present that in terms of Turkish medical profession, autonomy has never been absolute, but rather historically fluctuating and dynamic as a result of medical profession's place in the domain of health in relation to competing actors, institutions and organizations that want to determine boundaries of medical profession's autonomy and conditions of work, and that these different dimensions may be experienced by individual professionals.

#### **2.4. Context and Sociological Theories on Professions**

To understand how sociologists have explained the development of professions and professional autonomy that distinguishes professions from other

occupations, a more general assessment of the literature on the sociology of professions is required. This review is also necessary for the fact that since the earliest sociological analysis of professions, the medical profession has often been used as a model for what a “profession” is, how it is defined, their qualities, traits and history has been utilized as a model for explaining how a profession is distinct from other occupations. As Gabe et al (2004, 163) argue, “...across the substantial body of literature on the sociology of profession..., there has been a general consensus that, if any occupation warrants being called a ‘profession’, it is medicine.” Therefore, to be able to understand professions, it is impossible to overlook the history and theorization of the medical profession. Medicine has its own distinctive history, but is “part of larger movements of the rise of the professionals in general” (Coburn and Willis 2002, 378). The aim of this chapter is to trace historically the theoretical work on the sociology of professions, with emphasis on the medical profession. In the center of the theoretical debates lies the concept of professional autonomy, its meaning, how it is achieved, maintained and (whether it is) lost.

#### **2.4.1. Earlier Theories on Professions**

Views of Emile Durkheim, one of the most fundamental classical sociologists, on the occupational groups and division of labor in society have been influential in the first half of 20th century. Durkheim pointed at the sociological importance of the professions as a mediatory level between the individual and the state. He emphasized the ethics of the professions represented the moral basis for the modern society, dissolution of which it would prevent. Division of labor would create organic solidarity in society, through their shared values, which were altruistic in nature, and that they were committed to service and community welfare (Turner 1995, 129). The function of professions in society and their assumed moral and altruistic characteristics according Durkheim, are influential for Functionalist and Traits approaches to professions, which were the dominant perspectives in the early 20th century writing on the topic.

Early sociological writings on professions indicated certain traits and qualities professionals should possess, which make them different from other occupations. According to Carr-Saunders and Wilson (1933), professions possess particular “traits or attributes most often including an esoteric body of knowledge, a code of ethics, and an altruistic orientation” (Coburn and Willis 2002, 380). Traits approach points out that occupational group becomes a profession when it demonstrates an altruistic interest in serving the public. (Carr-Saunders and Wilson 1933; Marshall 1939; Parsons 1939). This later expanded to include key professional traits which can be listed by Goode (1969) as code of ethics, prestige, high income and education (Randall and Kindiak 2008).

Carr-Saunders and Wilson were concerned with 'professionalism', “the standards that professions should follow, standards that had developed at one point for one profession and at a later time for others.” (Burnham 1998, 73). They recounted law and medicine first and foremost among others. These central attributes included expert knowledge, technical autonomy, service ideal and altruism towards others, codes of ethics and specialized long training. Carr-Saunders and Wilson also thought that professional associations played a very important role in a profession’s existence and that professions were one of the most stable elements in society, an idea similar to one that has been put forward by Durkheim.

Another writer in the traits approach, William J. Goode listed features that emphasized the community aspect of professions, referring to it as a unified group. He claimed that a profession controls its training and entrance to profession; requires a long education; requires a high standard of behavior; enjoy high prestige in society, and a high income; shapes the legislation related to the profession (1957, 195). Each profession is a community with common values, a common sense of identity, common role definitions for members and non-members, a common language (1957, 194). It has power over its members, and social control over many aspects of society. He argues that that the professions cannot be evaluated independently of the society, and that the advantages a



profession enjoy “rest on evaluations made by the larger society, for the professional community could not grant these advantages to itself. That is, they represent structured relations between the larger society and the professional community” (Goode 1957, 196).

These traits identified by these scholars were mostly common-sensical or normative notions which were assumed to be superior to those embodied by other occupations. They listed certain traits that should be embodied by a profession, they compared occupations to assess whether or not it met the criteria to be defined as a profession. These definitions of profession and professionalism had a “fairly high level of abstraction and did not attempt to move beyond conceptualization to causal explanation” (Gorman and Sandefur 2011, 278).

According to Saks, compared to traits approach, functionalism “presented a more theoretically coherent account, seeing a relationship between profession and society” (Saks 2012, 2). Criticism brought to the traits approach is that their descriptions of the professionalization process and the traits seem disconnected from the relationships professions build with the society and external factors that they may encounter in their development. Coburn and Willis also argue that the reason why trait approach was superseded by structural functionalism was that “Parsons and others in the functionalist tradition explained professional, and particularly medical, power in terms of the potential within the professions to exploit the patients (clients, etc.) financially, sexually and otherwise” (Coburn and Willis 2002, 380). This potential is usually ignored in normative traits explanations. According to functionalism, this professional power would explain an ‘implicit contract’ between ‘society’, and the professions, through which the profession were given autonomy in exchange for self-regulation (Coburn and Willis 2002, 380). This approach pointed more at the external, particularly societal factors that have explained why professions possessed the attributes assumed by the writers.

A prominent figure in the functionalist approach, Talcott Parsons argued that the profession's function in society is the social control of deviance. He stated that "[i]t seems evident that many of the most important features of our society are to a considerable extent dependent on the smooth functioning of the professions." (Parsons 1939, 457). Profession's function of social control depends on respectability in society which relies on the fact that they are perceived as ethical and altruistic by society. Parsons is aware that altruism for professionals is not merely fully self-dedicated service to clients, but in reality, it also stems from its exact opposite. Parsons questions the dichotomy between altruism and self-interest, saying that it is in professionals' self-interest to be altruistic, since altruism and service to clients will keep the profession respected and trusted in society. The asymmetry of knowledge between the professional and client necessitates this trust.

Critiques of traits and functionalist approaches have started to become vocal, especially towards the 1960s. They criticized traits approach for taking the traits of an "ideal profession" as given, without much analysis into the realities of the professional life and what these values have entailed. Gabe et al (2004, 165) argued that professional rhetoric about altruism and adherence to professional ethics was being taken at face value and that insufficient attention was being paid to what professionals actually did. This model of professions paid insufficient attention to power relations and historical circumstances that shaped the development of professions. Overall, both traits and functionalist approaches are criticized for presenting a homogeneous picture of professions –which was inaccurate-, for disregarding historical, national, social and cultural differences, and for being ahistorical and uncritical. They presented professions as "relatively homogeneous communit[ies] whose members share identity, values, definitions of role and interest" (Bucher and Strauss 1961, 325). They focused on cohesion of a given profession and ignored deviations, conflicts nor differing interests within it. Parsons assumes a harmony of interests between individuals and society; and takes the honorability and reliability of a profession as given. He has a normative definition of profession which overlooks the complexities and

conflicts in the relationships between the profession, clients, society. As Berlant argues, his theory is not a descriptive, but a prescriptive one (Berlant 1975, 42). While he considers the social structure and the relationship between the professional and the society, he sees them as smoothly functioning mechanisms that are based on assumed cohesive, superior characteristics of the profession.

Those that criticized the functionalist and traits approaches to sociology of professions after 1960s were perspectives that were “more interested in power, how it was acquired and how it was maintained” (Gabe et al 2004, 165). Although the realities of medicine have always comprised dualities and contradictions, the medical profession has been seen as self-sacrificing and scientific and in the possession of knowledge and expertise (Coburn and Willis 2002, 377). The theoretical frameworks which have taken the basis of autonomy as assumed ethical and altruistic characteristics and possession of scientific expertise, have been replaced by those which questioned and aimed to dissect it. Instead of viewing professions as inherently superior occupations that were detached from time and place; theories that were developed from 1960s onwards analyzed professions and professional autonomy in certain historical, social and political contexts. They viewed professional autonomy as a result of “strategies and tactics used by occupational groups to gain control over the market for their services, or to gain state support for occupational self-regulation” (Gabe et al 2004, 165). There was an increasing skeptical interest on how these certain occupations ‘achieved’ the status of a profession collectively.

#### **2.4.2. Changing Healthcare Environment, the State and the Medical Profession Since 1970s**

Transformation in healthcare systems around the world beginning in 1970s paved the way for a bigger interest in medical profession. In 1950s and 1960s, governments’ focus was on equity and access in health. This corresponds to a time period that is called the Golden Age of medical profession, in which advances in scientific medicine, and in parallel the autonomy and authority of

medical profession was at its peak (Gorman and Sandefur 2011). Since 1960s, all societies face similar challenges, first one being the increasing health care costs and pressure on public expenditures. Aging population, advancements in medical technologies of diagnosis and treatment, increasing expectations and demands from medical care were other factors. Also, medical profession's autonomy which was viewed as unfettered has been accused of swelling up health care costs and public expenditures by varying clinical decisions and expensive treatments. Cost-efficiency efforts in the neoliberalizing developed countries coincided with compliance to IMF and World Bank conditions that demanded restructuring and liberalization of public and finance sectors in developing countries, resulting in healthcare reform efforts that aimed to cut spending on public services and privatize them (Ağırtan 2007). As the neoliberal ideology becomes the prevalent framework for restructuring health services, cutting costs while increasing efficiency and effectiveness of service, and enhancing patient participation and satisfaction became a common concern for policy changes and reforms. Application of managerial principles in organization and delivery of services, decentralization of authority over provision and governance, and incorporation of private actors into the financing, provision and governance of health services became common practices.

This includes introduction of managerial principles, summarized as “New Public Management” into planning and delivery of public services. The prevalence of the principles and their practices in public services has become a point of interest in the literature of health care systems (Hunter 1994). New Public Management implies adopting similar models of managements in the public and private sectors, splitting services into smaller units, splitting the purchaser and the provider of services, and provision through contracts to increase competition, imposing performance and accountability incentives through quantifiable measurements, and an emphasis on patients as “consumers” (Leicht et al 2009, 585; Boston et al 1996, 26; Dopson 2009) One implication of application of managerialist principles through New Public Management has been a shift in accountability of professionals, who previously were the central authority in

decision making in health affairs (both on basis of daily practice and on a policy making level). They became accountable to managerial control, as one their unprecedented authority and autonomy was seen as a reason for health care costs to skyrocket (Bury 2009, 14; Gabe et al 2004, 212). Objectives of efficiency, cost control and productivity has resulted in efforts by managerial cadre to standardize delivery of services so that professional performance could be assessed by outsiders based on quantitative indicators. As non-professionals do not have the knowledge and skills to evaluate the quality of medical practice, standardization and routinization enable external control and assessment through volume of work.

Another shift that took place as a result of health reforms has been the transforming role of governments in financing, delivery and governance of health services. In Europe, Britain and developing countries, with the rise of neoliberal ideas, the state who was previously been seen as responsible for financing and provision of the public services, had increasingly come to seen as the problem itself. A decrease in the role of government and in public services was mandated to obtain efficiency, effectivity and cost control. Introduction of private sector and market logic into the public sector, privatization and deregulation have brought forward a blurring line between public and the private sector, and the idea of government as the sole director of these services on a national scale (Pierre and Peters 2000, 3). Involving private sector actors into financing and delivery of services implied that government would now become the buyer of the services and not the provider. Services would be provided by contracting delivery out to private actors, by increasing copayments by “consumers”, and allowing private insurers to participate in the system (Hancock 1999, 68). Public services that were traditionally identified with central state control, hierarchical bureaucratic organization were thought to be more efficiently managed through decentralization and with cooperation of different agencies and stakeholders both from the private and public sector. The state would become the “enabler” while “steering not rowing” the system (Osborne and Gaebler 1993; Pierre and Peters 2000). It would not be providing the

services, but instead directing and regulating provision through other actors in public and private sector. The paradox of this governance approach is that, while changes made by governments were framed as “minimizing the role of the state” and loosening government control, these changes actually required central political direction from the governments themselves (Bury 2009). Pierre and Peters (2000) argue that governance is still state-centric, since the state is still the only political actor capable of directing, giving meaning and objective to cooperation between different stakeholders involved in the system. The shift from “government” to “governance”, transferring authority to local governments or private sector to implement organization, financing and provision of services is not a decline of state, but rather a “transformation” of state power based on constitutional, legal-rational powers to one based on coordination of cooperation between public and private actors and interests (Pierre and Peters 2000). While it is “steering at a distance”, it actually “enables” this cooperation. A degree of cautiousness is required when arguing that governments are willingly losing control, leaving it to the market through privatization and deregulation or weakening their authority by decentralization. What should be considered is how much power the state still attains throughout the system, and how meshed it is with private sector and the market. While state’s role in financing and provision may decrease, its responsibility in organization and regulation may actually be strengthened.

One of the important developments in the second half of the 20<sup>th</sup> century has been the rise of large healthcare organizations as employers of medical profession (Elliott 1972; Stoeckle 1988). They replaced the idea of a solo-practicing, self-earning professional. Changing demographics of the professions, with increasing number of women and people from different racial backgrounds entering into a profession which used to be primarily dominated by white, privileged males (Witz 1992; Riska 2010) also an important development. Modern healthcare services have also become technically, financially and administratively more complex. This has led to emergence of new occupations based on expert knowledge but lacked autonomy, service orientation and

prestige, such as technicians or nurses. This started changing division of labor in medicine (Iedma and Scheeres 2003; Liberati 2017). These developments complicated the existing definitions of professions, and specifically for the medical profession, the reorganization of health services in line with the principles of the market. Skepticism towards professions have been reinforced especially with the increasing third-party involvement, which came in the form of encroachment of states, corporations and clients on health services. These new involvements led services to be reorganized in line with principles of consumerism and commodification of health.

McKinlay and Marceau (2002) identify developments in health systems as a shift from “medical dominance” to “corporate dominance”, which implies an increased domination of financial and industrial interest in the financing, organization and provision of health care, compared to the dominance of medical profession in on health policies until 1970s. Light (2000) describes the same process as shift from provider driven to buyer driven. Calnan and Gabe (2001) described a shift that materialize during the same process, a shift from professional decisions and preferences to that of the users.

Under “regulation” of states, health care systems have been reformed, in most of the developed and developing world since 1970s, to reflect a realm of health services that are defined more by an emphasis on increased external monitoring and evaluation of professional activity, consumer choice and individual responsibility, accommodated by competition between and within public and private sectors, and decentralization of authority to local governments, agencies and institutions. These developments have profoundly affected the theorization efforts since 1970s. They examined the impact of these developments on autonomy of the medical profession. Theories and arguments focused more on how professions gained and maintained their autonomy and power, rather than taking them at face value.

The literature in sociology of professions after 1970s faced a dilemma: There was growing suspicion towards the idea that professions were inherently ethical, altruistic occupations which worked selflessly towards the benefit of the society. It started to be questioned whether the seeming altruism was a façade hiding their aims to achieve their self-interests. This led some approached to view professions as “exploitive monopolies”, which were motivated by the individual professionals’ desire of income and authority (Coburn and Willis 2002, 380), However, at the same time, third party intervention, financial leverages in form of corporate profits or cost-control, increased rate of salaried employment have also triggered the question whether professions were on a “decline”.

### **2.4.3. Power Approaches and Dominance of Medical Profession**

In his influential work on the profession of medicine in United States, Freidson claims that he suggests a “model for the analysis of the professions in general, consulting professions in particular”, which he utilizes medicine as a model for the former (1970a). His seminal work on professional dominance is a point of reference for many studies on professions and medical profession as reference. Scholars have debated its limitations or the changes that have taken since, some arguing its claims are still valid, others arguing that they have lost their explanatory power. He also holds a central place in the conceptual and theoretical framework of this study since, as will be presented, his definition of profession and analysis of medical profession relies on professional autonomy and control as its main characteristic.

Freidson’s thesis of professional dominance is based on his perception of medical profession as the most important single element of social structure of medical care (1970a, 77). Instead of individual experience and attributes of physicians or “profession as collection of individuals with special knowledge and ethical orientations”, his level of analysis treats the structure of organized medical care as important (1970a, 77). He discusses the profession as a special form of occupation, with certain legal powers and ethical implications, which has



a special position of dominance among the occupations that provide health care. He argues that “the foundation on which the analysis of a profession must be based in its relationship to the ultimate source of power and authority in modern society – the state”, since, profession’s power is based on “legally supported monopoly over practice” (1970a, 83). Elites are also important in the source of professional status, since a profession gains and maintains its position through support and patronage of a social and political influence of an elite segment of a society which has been persuaded of value of its work (1970b, 72-73). The profession has gained its officially and publicly respected authority through convincing the public of its value; and this state-sanctioned autonomy it possesses and the “institutionalized expectations of societal trust in the occupation’s claims” become the defining characteristics of a profession (Gabe et al 2004, 174). This leads to the dominance in medicine, which sets the profession apart from other occupations in health sector, and the guarantor of which is the state through legal means. Although his level of analysis can be described as one of macro-organizational, he leaves out broader socio-political and historical context in explaining how these relationships were founded. In other words, he does not problematize the relationship between the profession and the state or the public.

Freidson argues that the main characteristic that distinguishes the profession from other occupations is that they possess the control of conduct and content of their work, as well as others in their domain. Other important distinctive features of medical profession are that doctors are freed from regulations by others, they are only accountable to peer review, as opposed to review by non-physician authorities or other organizations. The professions possess a sort of esoteric knowledge and technical skills that one can only achieve through long and hard training. The medical professional, for example, is in the possession of specialized, expert knowledge, which leads to asymmetrical power relations with people s/he has to practice his/her skills and knowledge on. In order to persuade the public of its value, and maintain the trust of the clients with whom they have this asymmetric relationship with, they should be able to maintain their

autonomy and control. That is the only way they can channel their complex knowledge and skills into healing power. Profession has the autonomy maintains the right to determine criteria for credentials and license to practice for their own members, through which they have the sole say on who will be eligible to work, under what conditions and ethical codes. It also enables them to stay free of external regulation, evaluation and encroachment of other occupations (1970a, 134)

These provide the medical profession a different, privileged status in the structure of relationships with other health occupations in the division of labor and the patients. Most importantly, Freidson calls medicine “the only occupation” that is truly autonomous, and it is this autonomy that is “sustained by the dominance of its expertise in the division of labor” (1970a, 136). The difference between medicine as the dominant profession and others (nurses, technicians, other health care workers) reflects the existence of “a hierarchy of institutionalized expertise” (1970a, 137).

While other scholars were debating the “decline of professions” in throughout 1980s, Freidson insisted on arguing that medicine was still the “dominant profession” in the domain of health care. In 1988, in his new afterword to his other book *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, which was also originally published in 1970, Freidson wrote that since 1970s, there has been changes in the American medical system, such as a new legislation on physician payments by insurance companies and, a variety of administrative mechanisms for monitoring medical decision making (1988, 385). However, he argued that although individual practitioners may be losing some of their technical autonomy, medical profession as a corporate body is still dominant (1988, 388). He foresaw a division within the profession, arguing that there will be a gap between the managed and managers; physicians who become administrators and those rank-and-file physicians who have to work under their peers. Increasing external regulation of medicine, although under which medicine will sustain its dominants status as a collectivity, will lead to increasing

division of medical profession within itself, Freidson argues (Freidson 1970a). There may be changes in the organization, production and delivery of medical services, or the work conditions of individual doctors; however, according to him, there's no reason to believe that the medicine's status of dominant profession will change (Freidson 1984).

#### **2.4.4. Social closure, Market Monopoly and Expertise**

Another theoretical approach to profession that addresses the power of professions is the Neo-Weberian approach which seeks to explain how professions gain and maintain their power in society. It explains the root of the professions and their distinction from other occupations within a process of 'market closure', through which professions carve out a privileged place for themselves by creating legal boundaries that protect insiders and exclude outsiders from practice. This usually takes place under the sanction of the state (Saks 2012). This approach views a dynamic world of "macro-political power and interests, in which occupational groups gain and/or maintain professional standing based on the creation of legal boundaries that mark out the position of specific occupational groups" (Saks 2012, 4). Professions gain a protected position in society, which is linked to higher income, status and power through their position in the market place. It is argued that this is made possible through higher educational credentials. Licensure and education are tools to exclude outsiders, in which the very specific quality of the nature of this knowledge or expertise, such as complex medical knowledge acquired through long education, carries importance.

According to Larson (1977), a profession collectively achieves its status by monopolization of market. The power theories have 'unmasked' earlier work as ideological; which led them to view profession not as fixed and timeless concept, but rather as a product of historical and political processes through which they have constructed intellectual and organization domination over certain aspects of

social life. Abbott argues that this ‘unmasking’ has reached its peak with Larson (1988, 5).

According to Larson, a profession, a relatively new social phenomenon which is the product of modernization, is characterized by its control over the market for its expertise (Larson 1977, xvi). The intention of her work is to explain how the professions come to possess this market power. The marketable expertise the professionals have are intangible scientific expertise; professionalization is “collective assertion of special social status” and “a collective process of upward social mobility”, through which the members translate their scarce resources in the form of special knowledge and expertise into social and economic rewards, while sustaining an inequality in the system of stratification (Larson 1977).

She argues that the two dimensions of the process, market control and social mobility, are inseparable. These also sustain an inequality which holds the members of the collectivity, the profession, in a position which enables them to achieve and maintain high social status and income. However, the professions do not achieve this alone. She argues that professions’ monopolization of market depends on the interventions by the state, which, however, is a two-sided dynamic process. The state is also dependent on the professions’ independent “capacity to govern as well as legitimating its governance” (Johnson 1995, 16). She argues that Freidson’s emphasis on autonomy is important, however that this autonomy is “only technical and not absolute” (Larson 1977, xii). It is not sufficient in itself for their privileged status. The state-sponsorship is necessary but not the only ingredient in sustaining the power of the professions; professions are protected by the state and their position is secured by the political and economic influence of the elite that is linked to the state (Larson 1977, xii). Freidson’s analysis is important for Larson, because it shows that the autonomy is gained as the result of a process (Larson 1977, xii).

State-sponsorship can eliminate competitors, but cannot force consumers to consumer products produced by a certain profession. So, it is insufficient by

itself. What is necessary also is the unification and standardization of the professionals who possess this knowledge. In the case of medicine, for example, Larson argues that “[m]edicine’s privileged position with relation to the state was perfunctory, therefore, until the profession succeeded in unifying itself around demonstrably reliable production of producers. This process which I have called the negotiation of cognitive exclusiveness, was inseparable from the production and progress of medical knowledge” (Larson 1977, 24). What she calls the ‘production of producers’, which implies the development of a cognitive basis that provides the profession with monopoly over services, and thus the market share, income and status, are very important in maintaining their claims. The production of producers should be standardized, and the universities carry major importance for this process. Elimination of other ‘producers’, which implies competing professionals or occupations, is very important for a profession to be trained and socialized to gain the market monopoly. The state support for professional education and licensure, which is significant for exclusion of competitors, carries great importance.

Freidson’s emphasis on professional dominance as professional autonomy and autonomy as technical content of work, according to Larson, is a limited explanation. She argues that the discretionary power, which is possessed by professions, goes beyond this technical autonomy. It derives from a monopoly of competence legitimized officially by state, as well as a credibility with the public. Even if the profession had the technical control over its work, it would be ineffective without market monopoly and public recognition, according to Larson.

#### **2.4.5. Professions as an Actor in Capital Accumulation**

The Neo-Marxist scholars of profession have written extensively on the medical profession since they perceived the medical profession as not only a dominant force in health care, but also as carrying an important place in the capitalist society. They argue, as many others before them such as Freidson and Larson,

that the medical profession is strongly linked with the state. However, different from the power theories, they do not only aim to explain how the medical profession rose to power and to a dominant position within society and health care, but also analyze the contribution they make to the economic and political functioning of the capitalist system and the accumulation of capital. Neo-Marxist approach criticizes others for failing to locate the profession within the context of capitalism, and for ignoring the role the medical profession plays in capital accumulation (Gabe et al 2004, 166). They question and often deny the functional and ethical character of the profession, while emphasizing their power and market control (Turner 1995, 130). They criticize professional dominance and Neo-Weberian approaches for perceiving the state as simply and “enabler” of professions’ status in society, while, they argue, professions are important elements of capital accumulation and social control through their relationship with the state and the elites. Neo-Marxist approach also views scientific developments, the pharmaceutical industry, the production and consumption of drugs and medical technologies, the definitions and treatments of illnesses in the context of a capitalist economy, in which the medical profession plays role that is congruent with their interests of the capitalists in their pursuit of profit making (Illich 2010). They claim that the medical profession legitimizes and justifies the implementations of new methods of production and consumption, while having a smaller realm of incentive in determining health policies, which are perceived as being shaped by the bourgeoisie and the state. Neo-Weberian scholars have also emphasized the profession as a group whose interests lies with the elite and the capital, however they have not problematized this relationship, as they were trying to explain how the profession used their relationship to attain market monopoly. What Neo-Marxist approach has in common with other theories that come to the scene after 1960s is the skeptic attitude it holds towards the previously assumed functionality, ethicality and altruism of the profession.

Vincent Navarro (1988) states that the profession never had such dominance claimed by Freidson. Opposing Freidson’s argument that the medical profession has convinced elites of their importance and dominance, Navarro argues that it

was the elites who have selected, established and reproduced the profession (1988, 61). The existent power is declining as well, Navarro accepts, but argues that loss of power cannot be equated to the process of proletarianization, which will be elaborated on in the next section, because this process includes transformation of an intellectual activity into a manual one, as well as losing skills, power of supervision and control over the means of production and organization of production (1988, 70). He argues that although medicine is losing power over material means of production of medical services, organizational forms and even some of their skills, they still retain very much of their influence over these matters (1988, 71).

#### **2.4.6. Deprofessionalization**

The advances in medical technology, information technologies, new managerial practices, employment conditions and physical reorganization led to emergence of the question whether the medical profession can still be considered a “profession”. Mary Haug proposed a hypothesis of “deprofessionalization” in 1973, in which she focused on the erosion of medical profession’s authority over patients. The relationship between doctor and patient has traditionally been an unequal one, in which doctor is powerful and authoritative party, while the patient is passive and dependent due to lack of sufficient information and ability to judge his/her condition (Neuberger 2000). In this traditional relationship, doctor makes his/her clinical decisions based on his/her judgement that s/he has gained through training and experience, without any intrusion from the patient. The patient is convinced that the professional works in the best interest of his/her patients, and that s/he will use his/her knowledge and skills to serve the client’s interest, not his/her own. Authority over patient, achieved through knowledge, skills and claim to service orientation, sustains professional autonomy. The change in this traditional unequal relationship between doctor and patient had initiated a debate on the reasons and consequences of this transformation beginning in 1960s. Haug argued that the medical profession is losing its monopoly over medical knowledge through technology that makes information

more accessible. This accessibility of information, along with increased level of education of the public, and the growing demand of consumer groups have caused professional authority to be challenged by the patients. The claim of altruistic service orientation had also started to lose its credibility in the eyes of the public, according Haug, due to public's skepticism about the increasing health care costs (Haug 1973).

While she mostly focused on decline of professional authority, due to challenges by more informed and more educated patients, professional autonomy was also in a decline. Increasing tendency of medical professionals becoming employees in complex health care organizations, which replace solo practice, bring along new managerial practices that have replaced colleague evaluation, as well as the bureaucratic constraints that limit professional autonomy (Haug 1988, 5). In a similar line, Ritzer and Walczak (1988, 6) have also argued that rationalization of medical procedures, quantification of practices for which efficiency is an emphasized value, and increase in external controls through bureaucratic and administrative personnel results in deprofessionalization. Information technologies such as patient records, e-prescriptions, performance measurement software allow patients, management as well as third party payers like government agencies, insurance and pharmaceutical companies to monitor and keep shared records. These devices enable tracking volume of work, number of patients seen by the doctor, time spent per patient, prescriptions issues, diagnosis and treatments. They transform medical practice into measurable, trackable, therefore, accessible and controllable commodities. On the other hand, information technologies such as Internet narrow the knowledge gap between public and the profession. This leads patients to challenge professional authority. Deprofessionalization thesis emphasizes standardization and routinization as an impact of advancements in medical and information technologies. Arrangements in delivery of health care which prioritize consumerism, emphasis on health as an individual responsibility, promotion of patient-centered care and active patient participation; an increase in patients' awareness of their agency through increased access to information and organized social movements that defend



patient's rights, have all contributed to increase challenges by patients to the medical professionals.

In 1973, Haug wrote that deprofessionalization was a hypothesis. In 1988, she admits that although there is evidence supporting the thesis, it is not possible to argue that it is definitely the case. Although it has also been criticized for omitting the economic context, namely capitalism, that affects the profession and for focusing mostly on its relations with the patients and impact of technology, deprofessionalization argument was significant then in connecting the threats to professional authority and autonomy with the threat to monopoly of access to knowledge and showing how technology and information can affect doctors' authority over patients. The concept of "deprofessionalization" has since then been also used as a consequence of increased use of Internet on patients' access to information (Hardey 1999) managerial demands and managed care practices in medicine (Engelhardt 2002); changes in professional identification as a result of some taking on administrative and managerial roles, leading to diverse professional identifications (Randall and Kindiak 2008); the reorganization of physical spaces that refer to physical isolation in the work space (Siebert et al 2018).

#### **2.4.7. Proletarianization**

Proletarianization argument also examines the impact of organizational and economic developments on professional autonomy. However, different from Deprofessionalization thesis which does not consider the connections of technology or managerial organization to capitalism, it highlights the impact of growing bureaucratization in health care organizations, not simply as an inevitable organizational development or professionalism, but rather as a result of requirements of the logic of capitalist extension (McKinlay and Arches 1988; McKinlay and Stoeckle 1988; Oppenheimer 1973). Traditional solo practice has started to be replaced by employment in bureaucratic organizations around mid-20<sup>th</sup> century, not simply due to professionals' free choice, but rather as a

condition of economic relations of productions in capitalist economy. It requires workers to be controlled, held accountable to enhance efficiency, productivity and profitability, by third parties in form of managerial cadres. While healthcare organizations such as hospitals are not a new phenomenon, however, as Stoeckle points out, the shift in their motivation is new. The novelty of complex and bureaucratized healthcare organizations in the second half of the 20<sup>th</sup> century is that they were no longer organized around civic or religious ideals, as they were in continental Europe in history, but rather around profit and cost control (Stoeckle 1988, 78).

There are several underlying reasons for increase in the tendency of health care to be provided within bureaucratized organizations, and for medical professionals (willingly or steered towards) to become employees. In the literature on most developed and developing countries, the ambition by states to enlarge private health care services, open up the market to private corporations or intervene and regulate the services stand out as important causes. As health care costs have skyrocketed in the Golden Age of medical profession in United States and United Kingdom, skepticism by both the governments and public has also emerged about how these expenditures were spent. The unchecked autonomy of medical professionals, as the dominant power in not only daily medical practice and also on matters of health policy, became an issue of concern. Demanding professionals to obey rules and regulations defined by public authorities, administrators, or managers in medical practice were seen as one way to hold them accountable, to control them, and therefore, control the costs. A vast, expanding private health care sector which includes pharmaceutical and insurance companies besides hospitals, have rendered cost control and profitability an essential goal, which would be accomplished by closely monitoring professional activity.

Another reason is that advancing medical science and technology, and increasing medical specialization have made it difficult for a solo practitioner to have access to medical technologies, both financially and logistically. Therefore, it has

become more convenient for medical professional to work under auspices of an organization. Also, technology and specialization has also brought forth increased complexity of delivery, financing and administration of health care services, which has led the medical professional to cease being seen as solely liable for care. Health care services now embody an elaborate division of labor, carried out by a team which includes occupations which are traditionally seen as auxiliary, such as nurses, technicians, physical therapists, etc. There are now also administrator and managers who are responsible for organizing the financial and administrative aspect of the organizations.

Increased employment of professionals within bureaucratic organizations have led the impact of bureaucratization on professional autonomy to become a major question addressed by many in the area of Sociology of Professions. Earlier work has emphasized that bureaucratization is detrimental to professionalism and professional autonomy (Hall 1975), that bureaucratic and professional values are contradictory (Freidson 1970a), and that professions are “proletarianizing” (McKinlay and Arches 1985; McKinlay and Stoeckle 1988). Bureaucratic organizations were viewed as unsuitable to accommodate professionals and professional values, since their emphasis is on standardization of procedures, regulations and rules. It is the officials within a bureaucratic hierarchy who impose and control the execution of these regulation, while professionalism emphasizes peer control, and decision making based on judgement and discretion. Therefore, the core of the conflict between bureaucracy and professional stems from the emphasis on professional’s autonomy, while in bureaucratized organization the bureaucrat/administrator/manager expects the professional to follow formal rules and regulations that are predefined and impersonal. The inclination within bureaucratized (and, in some cases, corporatized) organizations to standardize procedures that enable accountability and external evaluation of professionals is thus perceived as contrary to how professionals operate and the values of professionalism.

McKinlay and Arches (1988, 161) defines proletarianization as “the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism”. Oppenheimer also emphasizes the shift in autonomy by arguing that extensive division of labor that has led the worker to specialize in narrow tasks, his inability to control the pace and conditions of work, and the nature, the use and the market conditions for the product implies proletarianization (Oppenheimer, 1973). Bureaucratization is presented as the primary process which impairs professional autonomy, and in relation the professional status that emanates from this authority to control fundamental aspects of work.

Bureaucratization, as an implication of capitalist production relations, both requires and enforces professional work to be subordinated to managerial control, rather than peer review, to ensure efficiency and profitability. Professional work, which is previously conceived as nonroutine work that relies on professional discretion and judgement is being codified and standardized to make accountability and evaluation by third parties easier. This evaluation of performance is not based on quality, but rather the “quantity” of care. Standardization and routinization exercised by managerial practices are opposite to the nature of medical knowledge. Its fundamental characteristics are uncertainty and complexity (Southon and Brainwaithe 1988). These characteristics enable legitimacy of profession’s autonomy. The sophisticated, complicated knowledge base and uncertainty of tasks that require professional judgement and discretion has been stated as the basis of professions’ claim to expertise and competence (Pavalko 1988; Larson 1977; Abbott 1988). However, mounting expenses in healthcare and mismanagement of resources were seen as a result of variations in their practice, for which they blamed the immense autonomy of medical professionals. Complaints over under/over/mistreatment have been attributed to this unfettered and unchecked professional autonomy. Evidence Based Medicine emerged as an approach to standardize medical practice and enable accountability on the part of professionals. It implies reliance

on randomized clinical trials to find scientific evidence statistical data and stipulated in most Western countries (and increasingly in others) in form of clinical guidelines, standards and protocols. These are some of “subtle” practices of cost control and accountability, which has made them popular in Western health care services.

According to Harrison and Checkland (2009), Evidence Based Medicine reflects distrust of professions, and in extension, efforts to control their autonomy by management in health services. Although, as mentioned, professionals usually perceive them as recommendations, in some health care organizations they are enforced to apply them through financial imperatives. This strive to fetter professional autonomy through Evidence Based Medicine practices have an impact on the medical labor process, which has transformed into a “Scientific Bureaucratic Medicine”, as they are implemented through bureaucratic rules (Harrison 2002).

McKinlay and Arches also point out the effects of specialization in medicine, which, they argue, may seem as advancement of medical knowledge. However, they argue, it results in a similar process of “deskilling”, since specialization breaks knowledge and skill into narrower pieces, making it easier to be codified, and thus, accessible to third parties and open to their control and evaluation (McKinlay and Arches 1988, 177). Specialization “demystifies” medical knowledge, which will divest the medical professional from its authority and status based on the uniqueness of this knowledge.

It has been pointed out that proletarianization has been a slower process for more privileged groups like medical professions, due to institutionalized authority and strategies they have employed to protect it. However, it is also argued by proponents of this argument that monopoly capitalism’s desire to control workers, accumulate capital and increase efficiency of production, in an industrialized health care, has placed medical professionals in this trajectory as well. While bureaucratization has been emphasized as the primary factor

triggering this shift in professional status, two other aspects of economic context has also been mentioned. The trend in increasing unemployment in professional labor, due to oversupply of professionals, and stabilization or decline of income has been presented as other conditions that lead proletarianization of professionals (McKinlay and Arches 1988; Oppenheimer 1973).

#### **2.4.8. Dynamic System Approaches to Understanding Professions and Change**

The narration of history of institutionalization of British and American professions (medicine in particular) which has to a large extent shaped the area of sociology of professions, somewhat viewed the role of the state and the relationship between the profession and the state as unproblematic. Most of the sociological work on medical profession, similar to that of Larson's or Freidson's, have presented the state merely as a facilitator of the power and authority of the profession. They were also mostly single dimensional analyses focusing either on professional changes in a vacuum of space, as if exempt from interplay between other actors in the domain of medicine and health care; or merely focusing on one aspect of this complex relationship. Health care is an area of ongoing conflicts and negotiations between actors involved, who may be on either demand or supply side of their services, or those who act as a mediator or regulator. These approaches which are based on interplay between profession, state, market and public, relieves the observers from seeing professions in single light, from seeing their autonomy as absolute and static and from seeing their relationships with actors as unproblematic.

In a first step towards understanding professions as forming within a dynamic system, Andrew Abbott put forward his ecological approach to Systems of Professions. He argued that professions make up an interdependent system where each profession has an area of jurisdiction, which, in time may change, shift, narrow or widen through disputes with other existing or newly formed professions. According to Abbott, these jurisdictional disputes are what

determines the history of professions (1988, 2). He offers an explanation where professions are placed in a larger context; an ecology, a system of professions which is not static but dynamic, and that this system will be affected by the external factors.

Abbott writes that the defining characteristic of the profession in this framework is not control, or privileges like licensure or code of ethics, since other occupations can have these as well. A profession is one which relies on abstract knowledge, through which can define and redefine tasks and contains its area of jurisdiction. A profession has to have an abstract knowledge system, so it can give define old problems in new ways throughout time. When a new task is created or an old one is redefined, for example, the change the profession goes through will be determined by its relation to other professions (or new professions), it may be abolished, reshaped, or endure its place in the structure. So, the profession is not identified independently, but through its location in the system, and the relations within the system. The central organizing factor in professional life is the control of tasks. In the struggle and competition among professions, what matters is who controls which tasks, and therefore what amount of jurisdiction one has, and whether external forces will open or close areas of jurisdiction. One example for this is the challenge to the medical profession from nursing. In the last few decades, responsibilities of nursing are increasing and their area of jurisdiction is widening (Liberati 2017). It has sought to increase its educational credentials and broaden are of skills, taking over some of the tasks from medical profession, expanding their autonomy.

The professions are constantly changing as a result of jurisdictional struggles, and the trigger may sometimes be the external events, or sometimes may begin within the professions themselves (1988, 111). Changes in technology, client differentiations, development of new knowledge and skills are some of the factors that may strengthen or weaken jurisdictions. With his systems approach, Abbott was aiming to show that the professions should be defined and identified in relation to other profession and external factors. Professions form an

interdependent and interrelated system. He also showed that the content and control of work are not absolute and inherent, but that they may be affected by many internal and external forces and variables, and that they are subject to change. The changes in profession will be best understood by looking at the forces that affect the content and control of work, and how the changes in content and control of work reflect on the system of professions and their area of jurisdictions (1988, 113). This approach is also critical of the early work on professions, as it is against a static, inherent quality and characteristics of professions, as it points that control and content might change and be redefined over time.

In a similar vein, T.J. Johnson has argued that the inconsistencies between different approaches to the social role of professions will be overcome through “an attempt to understand professional occupations in terms of power relations in society – their sources of power and authority and the ways in which we use them” (Johnson 1982, 17-18). He defines professionalism as institutionalized forms of control, as a way of organizing and controlling an occupation, rather than an inherent characteristic. Most approaches had not focused on social conditions under which professionalization takes place, but rather on assumed characteristics. According to Johnson, we can understand professions through a historical analysis which will present us the source of professional control. “Changing distribution of power in society”, he argues, “has had important consequences for the manner in which the producers and services have related to their consumers and clients” (1982, 37). When scholars have accepted the professions’ own definitions that institutionalized this “ideal” form of control it was at a peculiar moment in 19th century Anglo-American world. There are variations on how professions are controlled, and seeing that will enable us to stop seeing professionalization as an end-state, but rather as a result of distribution of power in society, which may change over time. In time, professions may maintain their symbolic and organizational characteristics, however, institutional control may change hands, depending on social economic and political developments.



State also carries more importance for dynamic system explanations of professions and professional autonomy. In his comparative study of five societies (United States, Britain, France, Italy and Germany), Krause examines the relations between the states, capitalism, and four professions, namely medicine, law, engineering, academic profession. He constructs this triangle of relationships to argue that state, capitalism and profession influence and shape each other, and that “professions act and confront the power of both capitalism and the state” (1996, 2). He focuses on the profession as a collective group, and examines the extent of control the profession has on different dimensions of professional life, which he conceptualizes as “guild power”. He argues that modern professions resemble medieval guilds in that sense, having power and control over associations, the workplace, the market and in relation to state. He states that these dimensions are all interrelated and degree and control of profession over them may vary (Krause 1996, 3). According to Krause, professional groups cannot be understood out of their social context, as well as their guild power and their relationship with the state and capitalism (1996, 27-28). The state and capitalism, as rising powers that intervene in professional life, are obviously most fundamental elements in this social context. He argues that guild power as the system of professional control is diminishing, as state and capitalism appropriate more control over these dimensions.

Finally, Donald Light put forward this new approach against what he called “single accounts of the rise of the profession”, which do not analyze the wider context the profession is located in (Light 2010, 271). He states that this framework “resonated with and expands on” Krause’s approach, where Krause emphasized the state, capitalism and the profession as three stakeholders in health care. Light argues that as health care is increasingly placed in private hands with the aim of profits, the state and the market have bigger roles in determining the stakes in health care and medicine. His objection to previous approaches is that they had taken the relation between the profession and the state as a static one, ignoring the dynamism and capturing only one aspect of the relationship. Since it requires immense amount of economic resources, and its

aim to maintain wellbeing of citizens is to the interest of society as a whole, healthcare system has become an area of political struggle among different actors in society (Blank and Burau 2004, 22). Light adds one more actor to Krause's triangle, the public. He suggests that medical profession should be seen as only one of the "Countervailing powers" in society; the state, the market and the public are also forces that have interest in health care. All these groups compete for power, influence on resources, legitimacy and prestige; and if one countervailing power develops a dominance (for example, as the medical profession did in Anglo-American context until 1980s) others will form counter-mobilization against it. He locates the medical profession within a larger field of institutional and cultural forces and parties" (Hartley 2002, 179). This framework enables us to see profession and the relationships it builds in a historical light, and consider the changing degrees of autonomy, authority, interests, tensions and alliances between powers, as movements and counter movements for balancing dominance.

Using the dynamic systems approach also allows us to bring back the focus on the relationship between the state and profession in understanding how professional autonomy is shaped and transformed. The role of the state has been one significant element used to explain the differences between the history and characteristics of Anglo-American professions and professions in other societies. In the theorization efforts based on medical profession in United States or United Kingdom, the relationship between the state and the profession is presented as one devoid of conflict, where there is minimum state intervention and the state's sole position is to support the legitimization of profession and therefore assuring the public of its trustworthiness. However, studies in different contexts of governing power, from colonialism (El-Mehairy 1984), to imperialism (Johnson 1982) or authoritarianism (Jones 1991) show how profession institutionalizes in cases where the state power may overrule the professional authority or the profession may be integrated within state mechanisms. Seeing autonomy as a dynamic concept that shifts based on a specific configuration of social forces and interactions allows us to put aside the dualism between state intervention and

professional autonomy. Johnson (1982, 189) argues that emergence of professions and state formation are mutual processes and this relationship may result in partial autonomy. The state plays the role of the mediator between professional and clients, pays for or contributes to professional services, especially in countries where there are robust healthcare and social security systems. In some countries the state may play a more central role in organizing social, economic and professional life (Jones 1991). Not all are “free professions” the significant feature of which is the control of the market or conditions of work, as implied by the Anglo-American concept of professions, but are subject to state and its mechanisms. These variations in state-profession relationship also helps us uncover the peculiarities of the interactions between profession and other countervailing powers within certain social, economic and political contexts.

The landscape of theories on Professions demonstrates that most of the discussions among different approaches have taken place on professional autonomy. They debated on its origins, whether it is an inherent characteristic of professions or attained through struggles and negotiations with other social actors, how and whether it is maintained despite changes in social, economic and political context of healthcare services. This study on the transformation of professional autonomy of the Turkish medical profession adopts a dynamic approach to understanding professionalism, as put forward by Johnson, Krause and Light. I view the profession, state, public and the market as actors in an intertwined web of power relationships, who negotiate, balance or move against each other in order to achieve dominance and attain power in the domain of medicine and healthcare. The profession’s tensions, alliances and negotiations with these different actors, in the light of social, cultural, political and economic developments, have determined the amount and extent of autonomy it holds in the domain of healthcare services.

## **2.5. Literature on Sociology of Profession and Medical Profession in Turkey**

Sociology of professions have recently started more attraction in Turkey, along with an expanding literature on various professions in social science. Many studies are specific cases where the consequences of neoliberal transformation on labor processes, social status and stratification professions have been analyzed. In addition, studies that review theoretical approaches in sociology of professions have been also published (Adaş 2012; Koytak 2020). One of the first studies on professions in Turkey was Cirhinlioğlu's (1997) work on the legal profession that aimed to examine profession's relationship with state and politics. The literature on sociology of professions have been developing since, with other studies on lawyers, (Akbaş 2011), on teachers (Durmaz 2014; Buyruk 2015), those that focus on different combinations of profession such as Koytak's doctoral dissertation on changes in law and medicine in Turkey (2022) and Özkurt's doctoral dissertation on the comparison between lawyers, teachers, bankers and engineers that practices their profession in 1980s and 2000s in terms of income, class position, career trajectory (2018). A significant theme among these studies have been the impact of salaried employment, bureaucratization, commodification of professional practice, deskilling and proletarianization. Öncü and Köse's (2000) study on engineers were among the pioneers in emphasizing the increased proletarianization of salaried white-collar workers, along with Akbaş's (2011) focus on deskilling and loss of status in legal profession, through a contrast between working for corporate firms and solo practice.

Medical profession has started attracting more attention in Turkey in 2000s, within the context of HTP as it started to be implemented by Justice and Development Party (AKP) when it came into power in 2003. Under HTP, comprehensive reforms took place in organization, financing and delivery of healthcare system, which had profound impact on medical profession's conditions of work, social status and relations with other actors in society. Various studies have analyzed HTP and its repercussions on social and economic organization and delivery of healthcare services and healthcare workers, many of

which were written by economics or public health scholars (Sönmez 2011; Bulut 2007; Pala 2017; Yenimahalleli Yaşar 2017; Bilaloğlu 2015; Belek 2012; Elbek and Adaş 2009; Hamzaoğlu 2013; Aslanoğlu 2012; Arslanoğlu 2013; Elbek 2015).

In terms of sociological literature on medical profession, one of the first studies is Terzioğlu's (1998) master's thesis that studies the institutionalization of the profession, socialization and identification of professionals are part of the modernization and rationalization project in Turkey. Ertong (2011) has done sociological research on the relationship between patients and doctors and importance of trust. Başkavak's (2016) study specifically focused on surgeons and the surgical craft in the face of changing technology and social organization of healthcare services. Studies have also been conducted in scholars associated with departments of hospital management and business administration, with the motivation to highlight medical profession's importance in quality and efficiency of healthcare service delivery. For the prior, Akkaş (2016) studies the changes in medical professional culture in the light of changes in social, economic and technological developments. Atalay's (2017) doctoral dissertation, although in business administration, has also focused on transformation of the medical profession in the face of expanding logics of market and bureaucracy. There are studies that focus specifically on other healthcare occupations, such as those that examine midwives (Erkaya Balsoy, 2015; Beyinli, 2014), relationship between nurses and physicians (Demir & Kasapoğlu, 2008) and professionalization of nurses (Gönç 2015).

Studies have examined the changes in work conditions of different segments of healthcare workers, since HTP policies have affected not only the medical practice, but also hospitality services and auxiliary staff as well (Ünlütürk Ulutaş 2011; Acar 2010; Güler 2012; Köksal 2012; Üçkuyu 2012; Soyer 2012; Adaş 2013; Elbek 2013). Most of these studies have a political economy perspective, and encompass all occupations and workers that are involved in the organization and delivery of healthcare services. Labor process and proletarianization have

been popular concepts in these studies that have been completed since early 2000s. Ulutaş (2011) and Acar's (2010) work examines the changes in labor process in different groups of healthcare workers under HTP. Medical professionals themselves have also examined impact of HTP on their professional group and individual members mostly from a political economic perspective (Belek 2009; Belek 2012; Soyer 2012; Elbek 2012). Similar to its counterparts in other parts of the world, the changes in financing, organization and delivery of healthcare services under HTP has led the medical profession in Turkey to become subject of discussions on questions about whether it is proletarianizing or deprofessionalizing. A tendency of increase in bureaucratization in healthcare, with the expansion of private sector, managerialism as an extension of efforts to control physician behavior, emphasis on consumerism explicitly expressed by documents of HTP were important developments that fueled these debates. The decline in economic rewards as a result of increase insecurity and informalization of their labor in private sector and performance-based-payment schemes that resembles piecemeal work in the public sector have led observers to argue that medical profession is proletarianizing, going through the process of deskilling by routinization and standardization implemented through managerial control and assessment (Ulutaş 2011). Soyer (2012) argues that the increase in the number of medical professionals, increase in the number and sphere of activity of other healthcare workers, weakening of professional association, bureaucratization and corporatization are signs that the medical profession is proletarianizing. However, he also emphasizes that the medical profession has had administrative and economic autonomy for a while; the bigger threat is the potential loss of clinical autonomy, which will take place by surveillance and direction of their activity by bureaucracy or managers with the goal of eliminating the inefficient (Soyer 2012, 237). Proletarianization in Turkish medical profession has become more of a concern related to loss of status, privileges and autonomy, rather than a transformation related to class position. It has been accompanied by concerns over deprofessionalization through increased specialization, routinization and

demystification of medical knowledge, especially in relation to increased demands by patients and violence.

A gap in the literature in Turkey is that there is no existing systematic study in sociology that particularly focuses on the medical profession in terms of its professional autonomy. There are statements and surveys by Turkish Medical Association and Chambers of Medicine, since it has been an issue of debate as a result of changes in health care services and AKP governments' oppressive and conflictual relationship with the medical profession. Professional autonomy was generally addressed as an issue of concern by medical professionals themselves as an ethical issue (Ankara Tabip Odası Sağlık Politikaları Komisyonu 2011). This study aims to fill an important gap in the sociology of professions literature in Turkey, by taking the social, political and economic changes brought on by HTP as the context and specifically focusing on medical profession's most distinguishing and prized value of professional autonomy from the perspective of individual professionals themselves.

## **CHAPTER 3**

### **THE TURKISH MEDICAL PROFESSION VS COUNTERVAILING POWERS: A HISTORICAL BACKGROUND**

This chapter examines the relationship between the Turkish medical profession, the state, the public and the market in a historical light. Profession's relationship with state is significant to understanding the relationship between the profession and the public, and the relationship between the profession and the market as well, since the profession and the state have been in a mutually dependent relationship since the foundation of Republic of Turkey in 1923. It is also important to emphasize that this relationship represents a continuity with the manner of the relationship established in the late periods of Ottoman Empire, when medicine as an officially organized professional body, and medical training in official capacity has been established. The aim of the chapter is to investigate how collective political autonomy of the medical profession has been established (or whether it has been established) and how it has shifted as a result of political and ideological conflicts with the state. The formation and change in political autonomy of the medical profession in Turkey will present, as I have argued before, a different kind of relationship between the state and the profession than that is prevalently identified in the literature of sociology of professions. Traditionally, based on Anglo-American medical profession, the state is viewed as the external legitimizer and supporter of the collective autonomy of the profession as an organized body, and in extension, of the individual clinical and economic autonomy of the medical professionals. In sociology of professions, profession is traditionally seen as an independent body, sometimes identified as an "interest group" or a "pressure group" that has the autonomy over matters related to its domain of work, autonomy over its training, credentialing and licensing criteria, influence over health policies and financing, provision and governance of health services. These are important elements of political



autonomy, one of the three fundamental dimensions of professional autonomy at large, identified in previous chapters. The political autonomy the profession has also has a great impact on clinical and economic autonomy individual professionals possess.

Scholars have argued that the medical profession has not developed as independent bodies in other societies, due to divergences in the ideological and historical foundations, as well as in the organizations of health systems. The traditional model of liberal profession in UK and US has been contrasted with a professional model that is more integrated with the state in the case of corporatist health system of Continental Europe (Schulz and Harrison 196; Jarusch 1990; Le Bianic 2003), in the case of deep integration of the profession into state mechanisms in Scandinavian countries (Erichsen 1995), or in cases where the state uses the medical professional as a legitimating apparatus of its regime as in the case of post-colonial African and Arab countries (El-Mehairy 1984; Longuenesse et al 2012). Examination of these different cases and new perspectives in the literature called for reexamination of the professional autonomy in US and UK. Deprofessionalization and proletarianization arguments have also led to reevaluation of the traditional liberal profession narrative in the US and UK, resulting in scholars to argue that autonomy has never been absolute, and that the medical profession has actually never been as autonomous in the face of the state as argued in the previous decades, that state has had more than simply a supportive role in the development and maintenance of the authority and autonomy of the medical profession (Evetts 2002; Abbott 1988; Light 2010 ).

In this chapter, a historical look into how the Turkish medical profession has developed and institutionalized and asking whether it has gained its autonomy will demonstrate that it wasn't simply a matter of deep connections between the state and the profession, but that the medical profession was actually founded and shaped by the state in order to cement its ideological structure in the early years of the Republic. Erichsen (1995) argues that there are two positions with

regards to perspective on state and profession. First is to view professions as interest group outside the state and state as an intervening actor, while second is a state centered perspective, concerned with how professions are integrated within the state, how they are incorporated within the public bureaucracy contributing to policy making and ideology. The Turkish case is a case for the second position in which profession and state are strongly interlinked and mutually supportive. This has led to a more or less mutually dependent and congruent relationship until it entered a process of rupture in 1970s, as part of the ideological conflict with the social and political sphere, and then a breaking point with the 1980 military coup. The transformation process Turkish state has entered with 1980s has reflected on the status of medical profession, as well as relationship with the public and the market. The positioning of the medical profession as an opposition group in society have led to conflicts with state, its historical patron. HTP promulgated by the Justice and Development Party (AKP) in 2003 has deeper strained the relationship of the profession and the state, and in relation the public and the market. The regulations organizing the employment and work conditions of the profession has led to shift in profession's position vis-à-vis the market, and the government's use of rhetoric of marginalization and reminder of profession's "arrogance" as an elite group as a tool to enforce their ideology of conservative neoliberalism. This consequently has led to a shift in the relationship between the profession and the public. The repercussions of these shifts on an individual level will be examined in the Chapters 5, 6 and 7, where the data from individual interviews with doctors will be analyzed to understand the changes in collective political autonomy of the profession and individual clinical and economic autonomy of professionals on a daily basis.

However, first, this chapter will focus on examination of formation and development of the Turkish medical profession with a reflection of its political autonomy, namely its decision-making power of the profession with regards to health policies, its own legislation, training, credentialing and licensing. It will also examine how the extent of this power has affected economic and clinical autonomies. I will demonstrate that the models of professional autonomy used in

the literature based on Anglo-American medical professions are not sufficient to explain the collective political autonomy of the medical profession in Turkey, due to its unique relationship with the state, which I identify as shifting from a mutually dependent congruent one to one characterized with conflict and hostility.

### **3.1. Medical Profession in The Late Ottoman Period**

The origins of institutionalization and modernization of Turkish medicine, medical education and the medical profession can be traced back to the late Ottoman Empire. It corresponds to the modernization efforts in the Empire, first led by Selim III (1762-1808) then continued with Mahmut II (1785-1839). During their reign, a series of institutions were established that would become the basis of social and political life in Turkish Republic. First reforms were made in the military, followed by reforms in other areas that would promote an effective bureaucracy, central and provincial administration, taxes, legal action and education. Modern administrative and secular education institutions were also established to ensure the availability of cadres that would execute these reforms. The first modern medical school and modern hospitals were crucial part of Mahmud II's modernizing social reforms. It is important to examine the medical doctors who were trained in this era, as the authority they attributed to themselves in society became the foundation of identity and authority of the medical doctors in the early decades of the Turkish Republic. The modernizing role that they attributed to themselves in the late Ottoman Empire continued to be maintained in the new Turkish Republic, where they became not only modernizing elites in society, but also active participants in state and government as founding leaders.

Prior to late 19<sup>th</sup> century, health services were inadequate and low in quality. Health system was not centrally financed and governed by the state. Health services were supervised by "*hekimbaşı*", who was also responsible for regulating and supervising the professional activities and health of the Sultan.

There were a few formally trained doctors in the Empire. These doctors either served the Palace or were located in wealthy urban areas. Most were ethnically Greek, Armenian or Jewish (Oktay 1982, 54). Berker and Yalçın (2003, 30) state that these “artisan-physicians” were trained in an apprenticeship system. Foreign doctors had also immigrated to İstanbul after Crimean War, and became the first private practitioners in the modern sense (Gürkan 1967, 22). In addition to trained doctors, there were also traditional religious healers called “*üfürükçü*” (breather).

The first modern medical school, Tıphane-i Amire was established by Mahmut II in 1827. A separate school for surgeons, Cerrahane-i Amire was also founded in 1831. The two merged to establish Mekteb-i Tıbbiye-i Adliye-i Şahane in 1839, and was moved to its building in Galatasaray. This was a military medical school, aiming to modernize and provide health services and doctors for the Ottoman military. Dr. Charles Ambroise Bernard was brought from Vienna to set up the school and curriculum. While the German and Austrian medical professors have been influential in the early years of medical education, the language of instruction was in French. After the building in Galatasaray burned down in 1848, the school moved several times until it made the permanent move to Haydarpaşa in 1903.

The school had separate pharmacy and surgery sections. A student who did not wish to continue the “medical” education was able to enroll in one of these two sections to become a pharmacist or a surgeon. This separation and hierarchy among physicians, surgeon and pharmacist<sup>2</sup> in the Ottoman Empire corresponds to the hierarchy between medical professionals in the Western world, that has persisted until the beginning of 20<sup>th</sup> century when advancements in surgical methods have enabled surgeons to gain their more prestigious place within the medical world (Porter 2004, Bynum 2014, Turner 2011). Physician training was

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<sup>2</sup> In this research, concepts of “medical doctor” and “medical professional” is used interchangeably, to imply both physicians and surgeons, any individual that has a medical school degree. “Physician” and “surgeon”, “general practitioner” and “specialist” distinctions will be used when necessary. Unless stated, “medical doctor” or “medical professional” is used to indicate someone that is a credentialed and licensed physician or a surgeon.

seen as the most difficult and popular. In 1859, there were 352 students in school, 225 of which were in first year language training, 79 in physician section, 35 training to be surgeons and 13 training to be pharmacists (Baytop 1953, 65).

With the establishment of Tıbbiye-i Şahane, scientific activities also gained momentum. Two scientific journals, Vakay-i Tıbbiye and Gazette Médicale de Constantinople (in French) started to be published. They contained articles on medical and surgical practices in İstanbul and other parts of the Empire, on cases in medical school clinics, activity reports about school, and translated scientific articles from foreign medical journals (Ülman 2007, 177).

Since the number of doctors training in Mekteb-i Tıbbiye-i Adliye-i Şahane was only sufficient enough to serve the military, a medical school that would train civilian doctors to serve the public became a necessity. In the face of inadequate health services in the Empire, Mekteb-i Tıbbiye Nezareti was assigned the task of sending doctors to the provinces. Since trained doctors served in the military and private practitioners were located in major cities, training new civilian doctors would be the only way to overcome the shortage of doctors to serve in the provinces. As a result, a civilian medical school, Mekteb-i Tıbbiye-i Mülkiye-i Şahane was founded in 1867. The language of education in this school was Turkish. The first class of the civilian school graduated in 1874. The total number of alumni would reach 725 in 1909 (Erdem 2015, 195).

Although the curriculum and the program in the military and civilian medical schools were the same, the professional trajectories of students would usually be different after graduation. While the completion of military medical school would be culminated with an internship in Gülhane Seririyat Hospital, which was founded in 1898, and other military hospitals, the graduates of the civilian medical school had to serve as “*Memleket Tabibi*” (homeland doctors) under municipalities in different cities around the Empire for 5 years. The military medical school was seen as superior, due to the professional careers of its alumni and its language of training being French. However, French was abandoned as

the language of training in the medical school in 1870, as well. The two medical schools united in Haydarpaşa in 1909, under the name “Darülfünun-i Osmanii Tıp Fakültesi”.

Many medical students were also sent abroad to have advanced training, where they came across and adopted Western intellectual political traditions and values. Sending students abroad to study had become a state policy during Mahmut II’s rule. Until the second Constitutional Period in 1908, 906 students were sent abroad, 154 of which were medical students (Kılıç 2013, 14). France was the country to which most students were sent to, followed by Germany. In the following years Germany had taken on the lead, as a result of the strengthening political and martial alliance of Ottoman Empire with Germany.

Most of the medical doctors trained until 1920s were general practitioners (Berker and Yalçın 2003, 102). Those who were sent abroad by the state for medical school or short-term training came back with new skills and knowledge about advancing medical science in France and Germany. They contributed to the development of different specialties in Turkey, by setting up specialty clinics, and translating and adopting new information.

While the institution of Tıbbiye was established, along with Mülkiye and Mühendishane, with the aim to modernize the military, they gradually began to provide intellectual labor power to all cadres of bureaucracy. These recent graduates had been influenced by the European political and philosophical traditions, and values of positivism and rationality which emerged from their secular and scientific medical education. The state, and serving the state held a central place in their political and intellectual imagination. Dr. Tevfik Sağlam, one of the most important medical and military professionals in early modern Turkey who himself was educated in Tıbbiye-i Adliye-i Şahane stated that the students of the school knew what civilization was in the European sense, and “was able to compare it with the backwardness of the rest of the country”.

Therefore, Tıbbiye, he stated, was the home of “progress and liberation” (Başustaoglu 2016, 37).

Tıbbiye students’ ambition for a constitutional and liberal order, inspired by close contact with liberal and national currents in Europe, and rationalist and positivist mindset they received through their education came to its fruition with the establishment in İttihat ve Terakki Cemiyeti in 1889 by four medical students (Ahmad 2008, 47; Zürcher 2003, 70). The political organization aimed to overthrow Sultan Abdülhamit II, who they believed was repressive and autocratic, and modernize the society in line with nationalist ideas became popular not only among medical students, but also educated bureaucrats and officers as well as students from other modern educational institutions. Abdülhamit II suppressed their activities; some activists were arrested, some, including doctors, were exiled to far corners of the Empire and abroad. Those who were exiled in Paris reunited and formed a small community of activists, naming themselves Jeune Turcs. Although it never gained full political power, İttihat ve Terakki was an important political actor between 1908 and 1918. Many of its member joined the Independence movement between 1919 and 1922 alongside Mustafa Kemal, the founding leader of modern Turkey (Boratav 2009, 22).

In parallel to institutionalization and modernization of medical education, changes also started taking place in the organization and delivery of health services in the late 19<sup>th</sup> century Ottoman Empire. The state started to undertake partial responsibility of provision of health care, however this was only limited to sending doctors to provincial cities and rural areas. This post was called “Memleket Tabibi” (“homeland doctor”), which was later renamed as “Hükümet Tabibi” (“government doctor”). The state did not assume any financial responsibilities for the organization and provision of health care services (Aydın 2015, 206). The emphasis was mostly on preventive care. Curative care was mostly left to private practitioners where they were available. The post of “Hükümet Tabibi” is also the origin of the medical profession that took the form

of civil service, as salaried state employees. However, due to the increasing inflation throughout 1870s, as the purchasing power declined, the Ottoman state allowed these doctors to take on private patients in their free time, while holding on to their duty of caring for the public (Eren and Tanrıtanır 1998, 7).

State's control over the medical profession also had its initial steps of institutionalization in this period. In 1871, İdare-i Umumiye-i Tıbbiye was established to control the medical doctors in cities. Regulation titled "Tababeti Belediye İcrasına Dair Nizamname" to track the number of active medical doctors and their work by the central bureaucracy was established in 1861. This was a regulation on licensing and credentialing stating who would be allowed to practice medicine, under which conditions and the criteria they have to fulfill. This regulation stated that only trained and certified doctors would be allowed to practice and use the title of medical doctor. Those that had started to practice before Mekteb-i Tıbbiye-i Adliye-i Şahane was founded had to have their credentials approved by Tıbbiye or governing jurisdiction. It stated that a record of doctors registered within Tıbbiye would be annually sent to pharmacists and published in newspapers. It stated regulations for prescriptions and the credentials for surgeries. It also stated that the amounts of fines and prison sentences for those who would violate the law (Erdem 2015, 190-192; Kasapoğlu 2016, 134).

The initial development of organized medical profession has been led by the Ottoman state, as a result of reforms that established the modern medical school. Since there were a few trained doctors and professors, the foreign professors who established the medical schools and services became important actors, fundamental in raising the following generations of medical professionals in the sense that they shaped their mindset, therefore their political imagination as well as medical. They determined the parameters of "production of producers" (Larson 1977), instilling professional skills and values to the newly trained, in return, as will be presented in the next section, shaping the character of the profession, health services and society in modern Turkey. Instead of organized



efforts of a collective profession (which was at the time non-existent), the few trained and qualified determined the borders of jurisdiction, conditions and terms of work. However, it was the central bureaucracy that provided the legal and regulative structure through the institution of “İdare-i Umumiye-i Tıbbiye” and the regulation “Tababeti Belediye İcrasına Dair Nizamname”. The state also provided the labor market for medical professionals, since most were either employed in the military or as Hükümet Tabibi. The members of the newly emerging institutionalized medical profession were incorporated into the apparatus of the state as part of administrative units of military. Lack of organized profession resulted in lack of political autonomy, since credentialing and licensing rules were also set by the state. For most of the members of the profession, economic autonomy was also restricted as they were salaried employees of the state. Only few private practitioners who were located in major cities attained economic autonomy. While there were some restrictions set by the state on the content and conduct of work in “Tababeti Belediye İcrasına Dair Nizamname”, they were broad limitations. The major constraint to clinical autonomy of the medical profession emerged from inadequacies in organization health care services, medical infrastructure and technologies. On the other hand, these inadequacies can also be interpreted as broadening clinical autonomy of the professionals, since it allowed them to make critical decisions solely based on their own knowledge and skills in the absence of administrative and managerial organization of health services.

The powerful professional authority the medical doctors have in Early Republican period also has its origins in this time period. The spirit of “Tıbbiyelik” which emerged from the scientific rational training they received and their proximity to liberal and nationalist values through their contact with their foreign professors and training abroad, have instilled in them a sense of duty and obligation to liberate and educate the society. While the seeds were planted in the late 19<sup>th</sup> and early 20<sup>th</sup> century Ottoman Empire, the next section will present how these values and ideas have composed into a political mission to the increasingly organized professional group that would become a significant

influential social and political actor in the formation of the new Turkish Republic.

### **3.2. Medical Profession in the Early Decades of the Turkish Republic (1920-1960)**

Turkish Republic was founded in 1923, at the end of Independence War led by nationalist military officers from the dissolving Ottoman Empire. After fighting four years of foreign occupation, these military officers and bureaucrats led by Mustafa Kemal declared the independent Republic, which then embarked on a series of reforms to achieve the goals of the modernization project they had images for the new society. Radical transformations in political, legal and administrative structure took place, as well as in social life as a result of these reforms. Secularism is one of the most fundamental principles inherent in the Turkish Modernization project. Dole explains how medical authority is related to enforcement of development of secularism, diffused through rational paradigm of medicine and medical discourse (Dole 2015). Being “modern” and “civilized” was seen as corresponding to embracing rational thinking, universal knowledge and technological advancement. Medical discourse and practice were seen as emblematic of all of these goals. When these values coalesce with the aim to reproduce a healthy nation, the medical profession had gained the authority to construct a new relationship between the state and society.

The Early Decades of the Republic can be divided in to two periods: 1923-1938 and 1938-1960. The former time period covers the early years, until Atatürk’s death, when the modernizing reforms were first implemented and the national administrative structure was first built. The first 15 founding years are very important in understanding the position of the medical profession vis-à-vis the state and society, since they had attained great authority in society, however under the mandate of the state which centrally controlled policies, including health, distribution of resources and economy. I will first explain the role of the medical profession and healthcare services in modernizing the society, the

relationship between the profession and the state, followed by a brief analysis of professional autonomy of the medical profession between 1923-1938. I will then move on to 1938-1960, the second period in early years of the Republic. The reason I made this periodization is that by 1938 basic infrastructure and services had been established under a centrally controlled economy. 1945 marks the beginning of loosening of protective industrial policies that had enforced import substitution strategy (Boratav 2009, 94), and a shift in health policies from an emphasis on public health and preventive care to hospitals and curative care. Democratic Party (DP) government, which came to power in 1950, continued this trend. This was also a government that encouraged private investments in health care within its economic liberalization policy and increased dependency on foreign investment and aid. The profession also experienced an important change in this time period, with the establishment of Turkish Medical Association (TMA). Professional association that organized to protect professional interest would transform profession's relationship with state, public and the market, beginning in 1960s.

### **3.2.1. The Medical Profession, The State and Healthcare Services in Turkey between 1923 and 1938**

Republic of Turkey was officially founded in October 29 1923, however efforts of institutionalization of health services started early in 1920, right after the Turkish Parliament was opened in April 1920. Setting up health services and organization was one of the first objectives of the young nation. Ministry of Health and Social Assistance was established on May 2, 1920, with Adnan Adıvar as the minister. The number of laws and regulations passed in the first decade of the Republic demonstrate the priority given to building a robust health care system by the founding leaders. Between 1920 and 1930, 49 laws, 12 by-laws and 21 regulations were enacted (Paykoç 1982, 7). The budget of the Ministry was 4.860.205 TL in 1924, which made up 2.64% of the general budget that amounted to 184.000.000 TL (Karabulut 2007, 153). The country had taken over a poor health care organization and infrastructure from the Ottoman Empire,

which had further deteriorated during the war. There were 63 health care organizations, 6437 patients' beds and 554 doctors in 1923 (Karabulut 2007, 154; Eren and Tanrıtanır 1998, 12).

Most significant efforts for health care organization started taking place after 1925, under Dr. Refik Saydam who became the second Minister of Health and Social Assistance. The priorities of the government were enlarging the health care organization of the state, extending it to rural areas, increasing the number of health personnel, and enforcing laws and regulations that would organize and regulate health care. While new hospitals started to open, the first ones being Numune Hospitals in Ankara, Diyarbakır, Erzurum and Sivas in 1924, the first three decades of the development of health care system in Turkey is characterized by a focus on preventive care and public health rather than curative care. Umumi Hıfzısıhha Law (no.1953) was passed on April 17, 1930, became the foundation of preventive care and public health services in Turkey until 2000s. This law expresses state's undertaking of health of its citizens as its responsibility. Combatting diseases, improving health of the population, ensuring prosperity, and ensuring public's access to health care and social services are indicated as the state's responsibility. Ministry of Health and Social Assistance is identified as the main administrative unit that would carry out these services, and monitor the services delegated to municipalities (Eren and Tanrıtanır 1998, 21). As a result of these efforts, the number of doctors has increased to 728 in 1930, and to 1624 in 1935; the number of beds increased from 11.398 in 1930 to 13.038 in 1935 (Eren and Tanrıtanır 1998; Karabulut 2007, 154). By 1939, the population had reached 20 million, the number of doctors to approximately 2300 and number of beds to approximately 14000 (Paykoç 1982, 8).

Medical education also went through institutional changes in the early years of the Republic. University reform law (no.2252) enacted on May 31 1933 ordered transformation of İstanbul Darülfunun to İstanbul University Medical School. German, Austrian, Czech and Hungarian professors that had taken refuge in Turkey, who had escaped Hitler's invasions during World War 2 have been

welcomed into Istanbul University, and the newly established Ankara University (Berker and Yalçın 2003, 145). These professors contributed to modernization efforts, continuing the tradition of foreign professors of Tıbbiye. Students continued to be sent abroad for training and those who came back established specialty clinics for specialties they trained for abroad. An example is Dr. Osman Cevdet Çubukçu, who graduated from Tıbbiye in 1918, and went to Paris for three years on a state scholarship to train in physiotherapy. He established the physiotherapy clinic in Istanbul University upon his return (Berker and Yalçın 2003). Establishment of psychiatry also took place as a result of a similar process. Students were sent to Germany to study psychiatry, which became the tradition that influenced this specialty in Turkey. After 1945, the American tradition of psychiatry gained influence as more students received training in this country (Kılıç 2013).

In the first three decades, the focus of the government was on developing public health and preventive care policies that aimed at improved health and welfare of the whole population, rather than curative care that targets individual citizens. The aim of improving health of society overall was not independent from the modernization project that was being implemented in form of reforms that would rebuild political, legal and social spheres, including everyday life of citizens. The government embarked on diverse reforms that aim at modernization and secularization of life, the bodily embodiment of its citizens being an important aspect. “Health” and condition of “being healthy” was a fundamental principle of modernizing reforms, both literally and metaphorically. The narrative of founding leaders, which was expressed in Atatürk and other leaders’ speeches, was that the young Republic was freed from “unhealthy” bonds of the past – the Ottoman Empire -, and the aim was to construct a “healthy” future that would be ensured by “healthy” and modern members of the Turkish society (Kılınç 2002, 124-125). Constitution of healthy modern bodies was an important part of reform efforts, as the bodily embodiment was considered a reflection of “modern minds” (Sanal 2013, 88). The desired modern citizen-body was to be attained through reforms, the physical appearance of the public was perceived as a factor that had

to transform in order to achieve the goals of the modernization project, which envisioned the young society as a modern, secular entity that would face the West. How people dressed and how they entertained themselves became important issues of regulation, as they were seen as important aspects of modernization. The appearance of the public was regulated both in formal and informal ways, to correspond to this new ideological regime. It was regulated formally through laws like the Hat Law that passed in 1925, which banned traditional headwear fez, usually identified with the Ottoman past. Appearance was also regulated in informal ways, by promoting new ways to encourage public to adopt the “modern”, secular way of living and looking. For example, Akşit writes that while there was no legal regulation that banned traditional rural attire, those who walked in Atatürk Boulevard, the main axis in the new capital of Ankara, with this attire would be frowned upon in the early years of the Republic (Akşit 2006)

In parallel, institutionalization of health care services is not only seen as a benevolent state policy, but also as a way in which the state infiltrates into and governs lives and bodies of citizens through public health practices. Fertility and longevity were expressed as national interest in the founding leaders’ discourse. The studies on health policies and practices in Turkey employ Foucault’s concepts of “biopolitics” and “governmentality” in the past two decades, in an effort to understand and explain the policies and practices employed by the political authority that aimed to rationalize and regulate society’s problem of health, hygiene, birth rate and quality of life, as well as to educate the public about these concerns. Odabaş argues that the new regime endeavored to inscribe its vision of modernization onto citizens’ bodies through health regulations (Odabaş 2009). Akın (2004) examines the importance of physical education and sports in Turkish biopolitics, as a way disciplining and regulating the citizens. Günal (2008, 160-165) and Kılıç (2013, 119-121) describe how pro-natalist policies were promoted by the state, by encouraging mothering as a noble duty of Turkish women. These studies present how the physical condition of “being healthy” was seen as a way of creating a collective consciousness which

obligated the citizens to also take on the responsibility of disciplining themselves for the interest of their own nation, to increase the healthy population for the advancement of the new nation. Public health practices were seen as immediately connected to social solidarity, national security and economic development.

In this sense, the medical profession carried a profound importance for the modernization efforts of the Turkish state in the early years of the Republic. They had already attributed themselves a social and political mission in the late Ottoman Empire, as presented in their political organization that aimed to construct a new liberal order. They perceived themselves as modernizing leaders of the society, through their education, and adoption of liberal Western values and ideas. This perception persisted with the group through the War of Independence which many of them actively participated in accompanying Mustafa Kemal and other military leaders. After the foundation of the Republic, the Kemalist ideology which commanded the driving imagination of Turkish modernization project was carried out by elites, among them the members of the medical profession who vowed to eliminate all weaknesses from the population in order to create a new, healthy, modern population. The weaknesses they were determined to eliminate were not only illnesses that decimate the population, but also “backwardness” and “illiteracy”. They viewed educating the public, not only on matters of health but about all aspects of social life, encouraging the public to adopt to new modern secular way of life, as their own duty. Their professional ideology overlapping with national ideology and policies increased their authority and prestige in society, which allowed them to play an active role in the political sphere (Terzioğlu 1998, 35). The ratio of medical doctors among parliament members between 1921 and 1923 was 12%. This ratio persisted approximately until 1980. Dr. Refik Saydam, the second Minister of Health and Social Assistance, and the 4<sup>th</sup> prime minister of Turkey and Dr. Behçet Uz, parliament member and later Mayor of İzmir between 1931 and 1941 are important examples.

Memoirs and writings of some of the medical doctors who were trained and practiced in this era reveals their perception of their role in society. Behçet Uz's memoirs present a clear picture of the meaning of being a "Tıbbiyeli" and the mission Tıbbiyeliler have ascribed to themselves. He recalls that he and his friends from the medical school decided to travel around Western coast of Anatolia during summer vacation to examine people free of charge and teach "our very backward people" about the dangers of tuberculosis and malaria (Uz 2011, 17). Dr. Mazhar Osman, one of the founders of branch of psychiatry in Turkey also wrote about the sense of mission of doctors as an extension of authority and prestige attributed to them in the public eye, as a result of their education:

*We were raised in the inglorious and spiritless days of the land, but even in those days being a Tıbbiyeli gave us an exceptional status. Everyone showed respect to our great knowledge, (...) everyone believed that those with velvet collars carried the light of civilization and showed a bright path to the country. Everyone still waited for the sun to rise from horizons of Tıbbiye. (...) I am not going to lie, we were not very modest either (...) Because it was us members of Tıbbiye who were most in touch with Western enlightenment, with European civilization for a century. (Uzman 1939, quoted in Kılıç 2013, 110).*

Dr. Mazhar Osman organized public meetings in Gülhane in 1939, arguing that in order to enlighten the public they need to educate them not only matters of health, but also social decorum. Writings of Dr. Fahreddin Kerim Gökay, who also served as a member of the parliament, as a mayor and a governor, presents the role undertaken by the medical professionals to teach about health, manners, and getting the public to embrace the new regime. He wrote that the medical doctor is the closest person to society, and obliged with teaching the society not only about health, but also about how to eat, visit, and live. He also wrote that the doctors are the biggest strength of the government, and that they are the people who will make the public love and government regime and propagate civilization (Kılıç 2013, 138).

The medical profession was still a small, but growing, group, located mostly in the city centers. Seminal developments in medicine and health care were taking



place not only in the country, but also around the world in the first decades of the 20<sup>th</sup> century. While being a small group did not give the profession much political autonomy, since they were not an organized body, low number of members and being concentrated in centers gave them opportunity to collaborate. Their desire to discuss medical innovations, how to apply them in the newly developing health care infrastructure in Turkey and the efforts of modernization which they believed they were the pioneers of, led to frequent gatherings in form of conferences, meetings and the National Medical Congress. This Congress took place 20 times between 1923 and 1968, and it was a significant event for the development of the medical profession both in the technical sense and for creation of a sense of collegueship and institutionalization of the profession. It was a sphere where the profession could discuss issues and problems independent from the state, which they were under the mandate of and had a very close attachment to. Since their number was low and their privileges and status in society were high, the profession did not feel an urgent need to organize within itself. The organized association was also established through the patronage of the state, under the Law No.1219 titled “Tababet ve Şuabatı San’atlarının Tarzı İcrasına Dair Kanun” in 1928. This law became the official code for qualification, licensing and credentialing of the medical profession. The first part of the law is related to qualifications for practicing the profession, opening and closing private practice, operating on and treating the patients, and how to discipline and punish violations of the law. The following four parts were about dentists, midwives, circumcisers and nurses respectively (Karabulut 2007, 155). The law eliminated non-qualified from the medical practice, such as “üfürükçü”, the traditional religious healers, barbers who also acted as surgeons, and unqualified midwives and circumcisers. The state actively allowed monopoly of practice the medical profession through this law, by eliminating competitors.

Chamber of Medicine (Etibba Odaları) were also established through the 14<sup>th</sup> article of the Law. The aims of establishing these organizations were to address the issues related to professional values and interests, and to solve issues arising from behaviors that contradict with professional ethics or conflicts between the

professionals. While the laws regarding professional conduct and association were made and enacted by the government, it is important to remember that members of the parliament and cabinet who drafted these laws were medical professionals as well. Freidson (1984) argues that even if the professionals themselves cannot control their work, when professional elites are involved in decision making their professional values and interests are reflected in the regulations. Therefore, he argues that although it seems like the profession lacks professional autonomy on the basis of individuals, the profession as an organized body still attains this autonomy as professional elites are involved in the process. However, the peculiar relationship between the decision-making professional elites (who are politician/professionals) and the state in Turkey, as well as the role attributed to medical professionals in society complicates this framework, since these elites held the interests of the state and society above that of the profession, and they encouraged state's control of the profession. The meetings of High Court of Honor (Yüksek Haysiyet Divanı) of these Chambers of Medicine took place in Directorate of Health (Sağlık Müdürlüğü) in Ankara, and the decisions of these meetings were to be reported to Ministry of Health and Social Assistance (Elbek 2013, 220). The amount of control the state agencies had on the professional associations reveals the extent to which the profession as an organized body was seen by the state as a part of apparatus between 1920 and 1950. The protection and patronage of the state began with housing and education of the medical students, and continued throughout most of their professional life, since all were expected to serve obligatory duty (established with Umumi Hıfzısıhha Law) and most were later employed by the state as civil servants.

As the profession was becoming a growing group, with its own platform to discuss its own problems and gain a sense of association, tensions began to arise in the relationship between the state (including professional elites) and the individual members of the profession. State's emphasis on public health and preventive health had led to complaints to emerge from medical doctors who desired to practice privately and not simply be limited to preventive care or work

under the direction of state and its policies. Dr. Refik Saydam, who wrote the Umumi Hıfzısıhha Kanunu, replied by saying that the medical professionals view any regulation and dictation by the state on matters of health care as an invasion of their autonomies. He wrote that while medical doctors believe that they are competent in both treating individual patients and choosing the appropriate preventive care practices for their communities, they are “not coming out of hospital wards and patient rooms”, implying that they do not engage with the public but are simply concerned with curative medical practice contained to healthcare organizations. He states that duties required from doctors in the present day is not simply curing individual patients in hospitals, but increasing longevity of society and strengthening labor power (Saydam 1937, 239-241). Dr. Fahreddin Kerim Gökay also drew attention to complaints by some doctors who argued that “private practice is dying” due to state’s priority on public health issues. He said that being a doctor is not about securing a high income or a profession of trade, and that the medical professionals as an altruistic group should be first to celebrate the development of public and preventive care (Gökay 1936, quoted in Odabaş 2009: 200). Terzioğlu also mentions that the students and professors at İstanbul University did not necessarily fully support obligatory duty, changes in course schedules or regulations, which were drafted by the professional elites and enacted by government (Terzioğlu 1998, 52). The professional elites, some of whom were also politicians who drafted and approved the new Laws contradicted with practicing medical professionals, medical school students and professors. The former group attributed priority to public health and medical profession’s public role while the latter also wanted to preserve its quality of a free profession and the option to choose private practice.

### **3.2.2. The Medical Profession, The State and Healthcare Services in Turkey between 1938 and 1960**

While the emphasis in the first 15 years of the Republic was on developing preventive care and public health practices and organizations, this emphasis shifted to curative care and setting up hospitals in the second half of the 1940s.

This has led public health and preventive care to be retreated into the background. This trend continued when DP came to power in 1950 after transition into multiparty system. DP government also focused on opening in hospitals in all cities and major counties with the aim to prevent piling up of patients in major city centers (Kasapoğlu 2016, 137). However, this shift in health policies in the DP era has led to inequalities of access, and further discrepancies between urban and rural areas. While population was increasing, demand for health care services was also increasing, although infrastructure, staff and access in many regions were still inadequate. As services and the number of doctors were not able to meet the demands of increasing number of patients, and with increase in private practice leading to commercialization of medicine, Günel writes that the image of doctors in society had started to become more negative in 1950s (Günel 2008, 175-188).

In 1954, hospitals that belonged to municipalities subsumed under the Ministry of Health and Social Assistance as well. This reinforced the state's role as the major provider of health services in Turkey. A health insurance program for blue collar workers was established in 1946 and enacted in 1952 under the name İşçi Sigortaları Kurumu (Worker Insurance Institution). It would later be renamed Sosyal Sigortalar Kurumu (Social Insurance Institutions) (SSK) in 1964, uniting different insurance schemes that provided blue collar workers with health insurance and retirement benefits. It later also opened its own hospitals, catering to premium payers of SSK. Emekli Sandığı scheme (Retirement Fund for Civil Servants) was also established in 1953, serving civil servants and public officers. A following scheme for self-employed would follow in 1971, abbreviated as Bağ-Kur (Social Insurance Institution for Artisan, Craftsmen and Self Employed). These institutions have allowed workers, civil servants and self-employed to be provided with health care and retirement funds under the auspices of the state. However, they were focused on curative care and hospital services; and they were autonomous institutions with different health care organizations serving different sectors of the population based on employment. These organizations had differences between the quality of their physical

infrastructure, availability of medical devices, hospitality services. These differences created a hierarchy among the population through social security institutions since those that catered to civil servants were superior to others (Üstündağ and Yoltar 2007, 57). This would be considered one of the biggest weaknesses of the Turkish health care system, and used as a legitimation for health care reforms proposed and carried out between 1980s to 2000s.

During this time period, there were also new developments for the medical profession itself. The members of the medical profession believed that existing professional association regulation (“Etibba Odaları Nizamnamesi”) was not functioning and that it should be eliminated. It was argued that a new regulation for a professional association was required for the rights and demands of the profession to be fully recognized. Dr. Sırrı Aruçlu, who would later become member of the TMA Central Council stated that a new law was necessary due to the one-sided relationship between the state and the profession, in which the state demanded that the profession is kept under its mandate. He argued that the ties between the members of the profession was loosening and that the state was trying to constraint the doctors in their activities and their work (Türk Tabipleri Birliği, n.d.). Already existing tensions between the state and the profession intensified, since demands of the state and the public from the medical doctors was increasing. While high authority and prestige in society, combined with their small number did not push the profession to organize among themselves until 1950s, the doctors’ belief that the state had made them faithful to itself rather than the profession and saw them as officers of the state rather than as professionals who had their own values and interest, led them to demand changes in the legal structure of association. Turkish Medical Association (TMA) was founded in 1953 (Law no. 6023). It became the federative structure of Chamber of Medicine in cities. The location of Central Council of the Association was indicated as İstanbul. Medical specialty was also a growing trend that required closer monitoring and more credentialing. “Tababet Uzmanlık Yönetmeliği” was enacted in 1947, defining 22 branches of specialty. The regulation allowed

specialty training in all hospitals. Diplomas would be verified by medical schools and hospitals (Türk Tabipleri Birliđi, n.d.).

### **3.3. The Medical Profession, The State and Healthcare Services between 1960-1980**

During the 10 years DP was in power, opposition in society, and political and economic instability had escalated, resulting in a military coup in 1960. A new constitution was written in 1961, which declared health services and social security as the main responsibility of the state. Law of Socialization of Health Services was the highlight of this era. While unsuccessful in some aspect it was an effort to establish primary health care services in Turkey, which had not been on the agenda until 1961. 1960s and 1970s was also a period in social movements gained traction in the liberal environment the new constitution had provided. The politicization of the society had also found its reflection in the medical profession. TMA voiced its opposition to the state in 1970s and this led to an even bigger drift between the two Countervailing powers.

After the 1960 coup and the enactment of the new constitution which reinforced democratic rights and recognition of pluralism in society, Prof Dr. Nusret Fişek, Hacettepe University Medical School Professor and undersecretary of Ministry of Health and Social Assistance, drafted a new law that would restructure the health care services in Turkey. The Law of Socialization of Health Services, enacted in 1961, aimed to organize primary care and make it equally accessible to all areas, with a priority on impoverished rural areas. While preventive care organization were still active and the Umumi Hıfzısıhha Law was still in force, primary care had never been organized in Turkey. Health services were provided through “Hükümet Tabibi”, a post that did not exist in all provinces, as well as state hospitals and private practice. The eastern city of Muş became the pilot city for application of Law of Socialization. It was planned to gradually expand and cover all cities by 1978.

The main principles of Law of Socialization included equal access to health services, that the health personnel would report to their own directors (the medical professional) instead of the general administration, and a Full Time Act which banned doctors who worked as civil servants within the framework of law from opening private practice. Sağlık Ocakları would become the backbone of the system, as the main unit of primary care. Every Sağlık Ocağı would be responsible for a population of 5,000 to 10,000, and would include a medical doctor, a hygienist, a nurse, 2 to 4 midwives and a medical clerk. The services in Sağlık Ocakları would be complemented and supported by the nearest state hospital. This emphasized that preventive and curative were complementary, and that the primary and secondary health organizations would have to cooperate. The medical doctor would treat patients both in Sağlık Ocağı and their homes. Regular visits by health personnel would be enforced, and regulation training of the personnel would become a priority. The law aimed for health services to be organized on a village level. Governance of health care services would be on a regional basis, instead of relying on central planning (Kasapoğlu 2016; Uğurlu 1992, 385-386).

The Law of Socialization was effective in practice until the enactment of the family practitioner system within HTP in 2005. It was complemented with state hospitals, SSK hospitals, university hospitals and private practice. However, not all principles of Law of Socialization were fully realized, and it was later evaluated as unsuccessful. Kurt and Şaşmaz (2012, 28-29) identify several reasons why the principles and practice of the Law did not function well. The public had perceived the Law of Socialization only as a law that established Sağlık Ocakları, while it encompassed a wider understanding of primary care. The challenges that were faced in its execution in already impoverished areas has led to perception in society and among policy makers as problems originating from the Law itself. The training of health personnel was an integral principle of Law, however a proper training program on practices of Law was never established. The Full Time Act could never be enforced, leading to shortages in

medical doctors where they were needed the most. There were challenges caused by inadequate infrastructure, devices and vehicles.

Although it was planned to expand the Law into all cities by 1978, it was being executed in 47 cities by that year. A regulation was passed in 1983 that precipitately covered all cities under Law of Socialization with no preparation. This also led the public and the state to perceive the Law as a failure. The dysfunctional Sağlık Ocakları would later become a ground of justification for proposed (and then enacted) family practitioner system that was included in all reform plans since 1980s.

Nusret Fişek had stated that the Full Time Act was one of the most significant principles of the Law of Socialization: “Among the many fundamental principles this Law enforces, doctor’s employment in government’s service in return for a fair salary, and preventing him from spending his time and energy in pursuit of private practices, rather than where most needed the country, is the most important” (quoted in Uğurlu 1992, 358). He stated that the doctors have a leading role in practices of the Law, and that “they will be the force that will mobilize the masses for social development” (Uğurlu 1992, 389). While Fişek’s statements (a medical doctor himself) reflect the persistent extent of professional authority the medical doctors were attributed with in society, the doctors objected to the Full Time Act, arguing that it is an intervention to their professional autonomy. The medical doctors objected to being assigned to rural areas as general practitioners in Sağlık Ocakları. They were reluctant to go to these areas, despite all the incentives offered, they wanted to become specialists, as this offered a more advantageous position in the labor market, and they resisted civil service to be presented as their sole option of work. Günel suggest that the Socialization system discouraged doctors from becoming general practitioners, since specialization is viewed as more prestigious, and that this affects the structure of the health system by creating carriers against egalitarian health care (Günel 2008, 356). Another Full Time Act effort from the state came in 1978, which again met with the resistance of the profession. The state’s efforts



to mobilize the medical professionals as a force of social development was now being met with objections from the professionals who desired to practice autonomously, taking control of their economic means.

1960s and 1970s marked a transformation in the relationship between the medical profession and the state, as the profession's objections to laws and regulations that controlled their work have been voiced. The collective objections to Full Time Act were a first instance. The profession was able to organize to organize for their demands and interests through TMA, but the politicized atmosphere in these two decades had also allowed for unionization of other health care personnel, to some of which doctors were also members of. 1961 Constitution has provided the legal framework that allowed the right to unionize, strike and collective bargaining. Türkiye Sağlık İşçileri and Müstahdemleri Sendikası was founded in 1961, followed by Türkiye Sağlık İşçileri ve Personeli Sendikası in 1962. However, since the unions comprised mostly of auxiliary health occupations, they were weakened by the division among workers and civil servants who depended on two different social security institutions, which fragmented their demands and actions (SSK and Emekli Sandığı) (Kasapoğlu 2016, 141).

The leftist oppositional movements gained popularity among youth and medical schools were not exempt from this wave. The relationship that was dependent on the embeddedness of the profession within the patronage and tutelage of the state, was severed in the politicized atmosphere in which the professional association had located itself within the leftist movement. In the TMA Congress in 1965, delegates had complained that “The Ministry of Health stands in front of them like castle”, implying that it's an obstacle, and that although the doctors have a lot of problems, the Ministry have remained indifferent to them (Berber 2009, 897; Türk Tabipleri Birliği, n.d).

Another military coup took place in 1971, after which TMA took a more political position in society, objecting to deterioration of their work conditions. Unions

united under the roof of “Türk Sağlık Hizmetleri Güçbirliği” led by TMA in order to respond to the rights that were lost through amendments to Civil Servants Law no.657 (Yeşiltaş 2015, 138). The organizations and associations that came together under this organization were unions of several different health occupations, pharmacists and dentists. Some of the activities of this confederation included spending more time per patient than they were allocated and only caring for emergency cases and strikes.

Throughout the 1970s, TMA also identified itself to a broader agenda of social issues as a part of social opposition movement. In 1975 and 1979 Congresses, TMA defined its area of activity not only as the interests of the profession or health care, but also as “democratic rights and freedoms, public health, doctors’ rights and monitoring of health services”. This was interpreted by the state as overstepping the boundaries that had been set for the profession, into state’s sphere of activity and influence. In its 1980 Congress that took place before the 1980 coup, TMA declared that democratic powers have to cooperate in action against fascism, imperialism and chauvinism; that the profession should be more active in the fight against state torture and exiles and suspension of civil rights and appropriation of democratic rights (Türk Tabipleri Birliği, n.d.).

While there are no clearly defined constraints on their clinical autonomy, it is possible to see that the medical profession did not have full political and economic autonomy. The state was keeping conduct of professional work under control by enforcing Full Time Act, by determining the fees of civil servants and not allowing the profession to bargain this issue effectively. The profession increasingly rejected the state’s mandate, not only on their own work but also in health care services. The relationship strained as TMA became more influential among doctors, and found itself a place in the sphere of political opposition. Its rhetoric and course of action became more politicized and radicalized throughout 1970s, not constraining itself into its own debates within the profession, but spilling over to other areas of struggle in society. While the relationship was never fully smooth, and the profession never had absolute autonomy, the

collective discontent on their relationship with the state had started to be voiced more often and in a more organized manner throughout 1960s and 1970s.

### **3.4. The Medical Profession, The State and Healthcare Services between 1980-2003**

Another military coup took place in Turkey in September 12, 1980 transforming the state and society. Thousands of people were detained and jailed, 50 people were hanged. Civil society was repressed, political parties, labor unions and organizations were closed. Severe economic restructuring in line with neoliberal principles also took place after the coup, however this restructuring already began before the coup on January 24 1980, with what is now called “January 24 decisions”. Government led by Süleyman Demirel had ordered Undersecretary of Prime Ministry Turgut Özal, who would later become the main enforcer of these decisions first as Prime Minister than as the President in 1980s, to prepare a new economic stability program. “January 24 Decisions” was a declaration that aimed to fully liberalize the economy, introducing market mechanisms and increasing foreign investment and private enterprise. Liberalization of economy would transform health care services, embarking the governments on efforts to reform what they narrated as “inefficient and corrupt”. Through the discourse they used, the present health system would be discredited, the medical doctors included. The burden of the malfunctioning of the system would be laid on the medical profession by state officials, who publicly denigrated the profession with their statements. Professional authority would begin to decline in the eyes of the public, which affected their relationships with the patients. New labor regulations that restricted rights of workers both in public and private sector would also transform the relationship between the doctor and the market for their services, making them increasingly insecure and vulnerable to market mechanisms in the face of inconsistent health policies.

The objectives of liberalization of the economy and strengthening market mechanisms declared on January 24 decisions also had their reflections with

regards to health care services in the 1982 Constitution. According to this constitution, the state's responsibility would no longer be providing health care services, but it would be limited to regulating and planning. The article also opened space for enhancement of private sector, by clearly stating that the provision would be through public and private health care organizations. It was also stated that a general health insurance would be established to cover all of the population.

By the beginning of 1980s, health care services were divided along lines of employment, which created hierarchies in population with regards to the quality of care they had access to. Emekli Sandığı, SSK and Bağ-Kur were the three different types of social security schemes, through which blue collar workers, civil servants and self-employed had access to different kinds of health care organizations. The large size of the informal sector also made a significant amount of the population's access to health care problematic, since they were not covered by any scheme. Green Card scheme was introduced in 1992 for those who were excluded from other schemes, however their access to health care organizations was still limited. While 10 million people were covered by Green Card scheme by 2000, one third of the population still had no coverage (Keyder, 2007, 18).

The malfunctioning of the fragmented system with insufficient resources was accompanied by the problems in Sağlık Ocakları. Although the Law of Socialization had indicated that the administration of the Sağlık Ocakları would be regional, rather than accountable to general administration, the amendments made to Civil Servants Law no.657 in 1983 changed this. The amendments declared that the district governor would be considered the superior of all civil servants in the region, which gave the responsibility of auditing and regulating Sağlık Ocakları to a non-medical professional, namely the district governor. Autonomy of the medical doctors in Sağlık Ocakları would be weakened by becoming accountable to district governors.

The malfunctioning Sağlık Ocakları, and the fragmented system in which the autonomous health organizations were not being efficiently coordinated had allowed the government to accelerate their effort to restructure health services in line with the neoliberal restructuring of state and economy. “The inefficiency of public health organizations” became a major point of justification for making changes in the health care system on the part of the government officials. The first step toward reform efforts came with the enactment of Basic Law on Health Services in 1987. While this law could not be fully implemented, subsequent reform efforts have included principles from this law. It gave duties of planning and coordinating health care services to Ministry of Health and Social Assistance and it stated that public health care organizations would become autonomous legal enterprises working on managerial principles and contractual employment. Other changes in health care organization were made in 1989. The Ministry of Health and Social Assistance was renamed as Ministry of Health. The responsibilities of both primary and secondary care were transferred to Ministry. Primary care was to be provided through Sağlık Ocakları, Sağlık Evleri, centers for maternal and infant health, centers of family planning, tuberculosis dispensaries, malaria centers, and cancer centers; secondary care would be provided by state hospitals, hospitals of foundations and private practices (Kasapoğlu 2016, 142).

A report titled “Turkey Health Sector Master Plan” published by State Planning Organization suggested reforms based on purchaser/provider split, a general health insurance and a family practitioner scheme to replace the existing primary care arrangements. After this report, two National Health Congresses were held in 1992 and 1993 respectively, bringing stakeholders to discuss potential health reforms. As a result of these Congresses, the Ministry of Health proposed reforms in the following areas: financial and managerial autonomy to hospitals, establishment of a general health insurance, and a general health insurance. These reforms suggestions were line with the reform programs set by IMF and World Bank in return for credit agreements. They reflected the aims and objectives proposed by these two organizations which were attached to the

Structural Adjustment Programs they had set in motion in developing countries, including Turkey. These programs foresaw policy changes in areas of finance and market regulation, introduction of market mechanisms, privatization of institutions and services, restriction of public regulation and mechanisms, encouragement of foreign investment and cutting back on public expenditure and labor costs (Hamzaoglu 2017, 29).

Turkey entered 1990s with a boom in private health care organizations and enlarging of private insurance market (Pala 2017, 45). While healthcare sector has tripled between 1980 and 2020, public health services had increasingly been financed from sources outside of general budget, such as revolving funds and the social security spending had the biggest share in public expenditure (Pala 2017, 45). However, the quality of public health services and organizations had deteriorated. The decline in the quality and capacity of health care services has led those who could afford, to turn to private organizations. Inadequacies in public health organizations, especially heavily publicized problems in SSK hospitals contributed to officials' claims of inefficiency and ineffectiveness in public services. Many newspapers covered stories of daily scandals from SSK and state hospitals about patients put in pledge because they were not able to pay the fees, complaints about overcrowding and long waiting lines. Patients also complained about doctors calling them to their private practices for consultation, although they had made appointments in the state or university hospitals where the doctors worked. "*Bıçak parası* [knife money]" was another informal practice that was often publicized, which implied doctors asking for informal additional payments from patients for certain procedures (Hatun 2012). Corruption in SSK hospitals was also broadly covered in media in 1990s. Named "Neşter Operation" was scandal that revealed corruption among firms that sold medical equipment to SSK hospitals and the bureaucrats that were responsible for purchasing the equipment (Hatun 2012, 39-41). Some medical doctors were involved, which was highlighted in the news, adding to the already discrediting news and poor conditions in SSK hospitals. These new coverages did not only damage the profession's reputation, but also helped accelerate privatization

efforts for officials that claimed public organization were inefficient and ponderous, and SSK, which would be eliminated in 2000s with HTP.

In terms of medical profession, its conflictual relation with the state intensified after 1980 coup. While the organized movement of doctors TMA have objected to repressive political and economic policies of the state throughout 1970s and right after the 1980 coup, there were medical doctors who were members of the parliament and took the side of the state. In the aftermath of 1970 and 1980 coups, they were among the members of the parliament that have ratified the death penalties for political prisoners. However, these decisions can be evaluated as individual opinions exercised based on their political and ideological perspective, rather than professional values. Members of TMA were against writing autopsy reports or patient reports that would indicate lack of torture. TMA was shut down right after 1980 with other civil society organizations, professional associations, labor unions and political parties. Its Central Council members stood trial in Diyarbakır, for violating articles 141 and 142 of Penal Law. Şemin writes that between 1980 and 1986, the medical doctors were among the groups that have been most affected by loss of economic and social rights and privileges in the context of strong oppression by the state. He argues that even after TMA opened in 1984, it did not attain a wide base of support until 1988 and it silently pulled itself back from any strong opposition (Şemin 1992, 21). Some changes were also made to the TMA Law before it reopened, which strengthened state's control over the association, and weakened its membership base. Its Central Council was relocated from İstanbul to Ankara. The ban on military doctors' membership to TMA was lifted, however membership would no longer be obligatory for those who work in public sector. Membership would only be obligatory for private practitioners. Duty of financial auditing of the Chambers was given to Ministry of Health and Social Assistance (Berber 2009, 897).

The relationship between the state and the profession was severed one more time at the end of 1980s and the beginning of 1990s. Obligatory duty was

reintroduced in 1981, which was considered as a punishment to the profession by its members. This also corresponds to negatory statements of Kenan Evren, who led the military coup and became the president, about the members of the medical profession<sup>3</sup>. Throughout 1980s and 1990s media persistently covered politicians' and state officials' statements about greediness of doctors (Ersoy 1998, 105). While some problems in health care system were related to some doctors, like the additional fees they asked from the patients, they were also viewed as responsible for the problems and infrastructure and resources. The public perceived doctors as an important problem in the system because of the media coverage, and because medical doctors continued to be the main providers of health services. The health division of labor was still doctor-centered, although their counterparts have started to share responsibilities with nurses and other health occupations in other countries.

A wave of new medical schools has opened in 1970s and 1980s. The quotas for medical schools were also increased. All of these actions were taken without any planning, or any consultation from TMA. It was centrally decided by YÖK, The Council of Higher Education, established after the coup to regulate universities. The unplanned increase in the number of medical school graduates resulted in concerns about social status of the members of the medical profession among medical doctors. The strained relationship with the public because of problems of the health system was already leading to a decline in trust and respect towards the medical professionals, voiced through complaints in public and media. Competition among medical doctors was also to rise with the increase in number. The concerns on status and competition combined with concerns about quality of training these new medical schools would provide, since they were mostly founded in smaller universities in the provinces.

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<sup>3</sup> He publicly said "If your doctor wants to leave when on obligatory duty, tie him to a poll" ("Milletimiz unutkan ama hekimlerimiz de çok akıllı değil herhalde", <https://www.medimagazin.com.tr/authors/figen-doran/tr-milletimiz-unutkan-ama-hekimlerimiz-de-cok-akilli-degil-herhalde-72-75-3247.html>), and "If you ask doctors to hold a corner of a flag, they will ask you how much you'll pay them" (TTB'den Bakan Akdağ'a yanıt <https://www.ntv.com.tr/saglik/tbden-bakan-akdaga-yanit,-4ZJd7uO2E2GgB4nwy8kOA>)



Two-year obligatory duty that was reintroduced in 1981 for both general practitioners and specialists was amended in 1985 to cover only the general practitioners. This combined with the increased share of private hospitals in health care systems and the increased competition among medical school graduates for work, which led to perception of general practitioner as an undesirable post subordinate to specialist, a disadvantaged position in the labor market. Specialization in Medicine (TUS) exam was also introduced in 1984, making being a specialist more difficult and more desirable in the market place.

The profession did not only become stratified in terms of a general practitioner/specialist divide, but also in terms of their position in the market, their incomes and the work conditions, due to expansion of private sector in the health care services. One of the major problems emphasized by TMA after its reopening in 1984 was how the medical profession had ceased to be an organized homogeneous group with a public image of a social mission.

The increased discontent of medical school students throughout the 1980s was also visible in a survey conducted with Çapa Medical School students. Students were asked in their final year whether they would still choose to study medicine if they could go back in time. Their replies throughout the three years indicate their decreasing level of dissatisfaction with their potential conditions of work. While 86% answered “yes”, it was followed by 37% who answered “yes” in 1986 and 29% in 1988 (Sencer 1993, 40). The incomes of the doctors have also started to decline gradually throughout the decade as a result of economic instability and increasing inflation. While average income was 1200-1500 dollars a month in 1960s, it decreased to 600 dollars in 1979 and 300 dollars in 1994 (Soyer 1991, quoted in Ersoy 1998).

Added to all the negative developments that added the medical doctors' concern about their work conditions and status in society throughout the 1980s, an event that took place in August 1988 was the last straw. Minister of Labor and Social Security İmren Aykut said on record that “doctors were voracious for money”,

that they would never be satisfied. This was a breaking point for recuperating organized efforts of the TMA, which started a petition against the Minister and placed an ad in newspapers condemning the Minister (Şemin 1992, 22). The major action came in October 1988, when TMA organized a “White March” in Ankara, in which medical professionals marched to protest and voice their demands. This became the first legal march of civil servants after the 1980 coup. Parallel marches were organized in İzmir in November 1988 and İstanbul in December 1988. This was the beginning of an intense period of protests and demonstrations on the part of TMA that would last throughout the beginning of 1990s. In April 1989, there were various protests in front of Ministry of Health and Health Departments in Ankara, İzmir and İstanbul. Şemin argues that White Marches have been effective in salary increases, increase in payments from revolving funds of hospitals, and salary increases for other workers (Şemin 1992, 22). These protests coincided with a period of action that took place within the context of a rising workers’ movement in 1989 and 1990. Iron and steel workers, SEKA workers and miners in Zonguldak had all gone on strikes, successfully pushing ANAP government for a 142% raise in the wages of public sector workers (Boratav 2009, 177).

Nusret Fişek spoke in one of the protests in 1988: “We have tried to correspond with government officials in order to solve our problems, but we achieved no results. It is time to perform acts that will disturb the government within the framework provided by the laws, in order for doctors and the patients to be able to attain their right” (Türk Tabipleri Birliği, n.d) The deteriorating work conditions have led doctors to become more involved with the respective Chambers of Medicine in their cities, and the TMA. Young doctors who had returned to cities from their obligatory duties in rural areas, assistant doctors, young specialists and young general practitioners were especially active since they were a group within the profession that had harshly experienced decreasing salaries and deteriorating work conditions (Şemin 1992, 21) The issues that were raised in the mass protests between 1988 and 1992 were, government’s neglect of public sector and public health care organizations, government’s intervention

in medical schools and hospitals, increased share of private sector, concerns about heterogeneity and divisions within the profession, concerns about quality and equality of health care in different types of organizations and lack of resources, overcrowding, concerns about politicians' attitudes towards the profession and the decline in public's respect and trust as a result.

1980s and 1990s were a period of strain not only in the relationship between the state and the profession, but also between patients and profession, and market and the profession. The changes in health care services, expansion of private sector, increased number of medical schools have led to loosening of the ties between members of the profession. Number of medical doctors were increasing, which resulted in increasing competition among them. This was a major concern for the profession, along with growing heterogeneity within the profession. The discrediting discourse of the state officials about medical doctors and putting the blame of dysfunctional aspects of the system on doctors further strained the relationship between the profession and the state. As they had difficulties meeting increasing demands from patients within an enlarged health care services market, doctors, the main providers of health care, were seen as responsible for all misdoings arising from the system, and behaviors of their colleagues who took advantage of patients. Although divisions within the profession were surging, the negative developments in work conditions had also allowed TMA to open upon a new space for activism within the profession. While it would be mistaken to argue that all members of the profession had attended the demonstrations or were actively involved within TMA, it became the voice of professional values and interest.

### **3.5. The Medical Profession, The State and Healthcare Services under Health Transformation Program (2003-....)**

The fragmented health system in Turkey based on different social security and health care organizations, inadequate infrastructure of medical services and the inequalities between urban and rural areas led health services to be a constant

issue for reform throughout the 1990s. It was argued that it is difficult to ensure equal quality, delivery and effective coordination of services in the public sector. Calls for reform have echoed the neoliberal agenda which was implemented in health systems around the world, arguing for restricting the role of the government, increasing the role of the market and instilling market logic into the public sector through privatization and deregulation to obtain efficiency, effectivity and cost control.

Therefore, it was not surprising that Justice and Development Party (AKP) promised a major health reform with the same principles to its constituents in the first election campaign they ran in 2002. HTP was put into effect in 2003, right after AKP won the general elections by 34,4% and formed a single party government. Various elements of the program were introduced throughout the following 10 years. It brought changes in organization, provision, financing and governance of health care system in Turkey. This Program resembled the reform plans that were made by State Planning Department and Ministry of Health in 1990s, in line with the proposals of World Bank, International Monetary Fund and World Health Organizations. The main elements of the program were as follows: Administrative and financial autonomization of public health care organization; Promotion of private investments in health care; promotion of public-private partnership; a general social health insurance; family medicine scheme; a Full Time Act; a new payment scheme based on performance. The main goals of HTP were identified by Ministry of Health as effectiveness, productivity and equity (TC Sağlık Bakanlığı 2003, 4). Effectives was defined as improving health of population through policies, productivity as using resources in a way that reduces costs and increases services, and equity is defined as ensuring that citizens access to healthcare and contribution to services in proportion to their income (Işık 2017, 96). The implications of this program have important consequences for political, clinical and economic autonomy of the medical profession as it affected every aspect of their professional lives from their volume of work to their payments.

Under HTP, Social Security Institution (SGK) was established in 2006, uniting different social security schemes that had existed under its roof. While all public hospitals were united under Ministry of Health, the ministry did not undertake the provider role, instead it became the regulator of all agencies, institutions and services under its roof. A general health insurance system (GSS) was also introduced in 2008, with the aim of covering majority of the population. It is funded by the premiums collected, however as public healthcare organizations would no longer have contributions from the general national budget, out of pocket payments are also required to purchase services (Pala 2018). Therefore, citizens have to make extra payments in addition to taxes and social insurance premiums in order to receive healthcare (Sönmez 2011; Pala 2018; Belek 2012). Those who are not covered by social security are not eligible for any SGK contributions to any kind of healthcare organizations.

SGK, as the single purchaser of health services, covers the services in public hospitals, as well as partially in private hospitals to which it pays contribution fees to. In fact, SGK pays more contribution to examinations in private organization, rather than public (Pala 2017, 50). In 2002, SGK had spent %64 of all fees to public hospitals, followed by 22% to university hospitals and 14% to private hospitals. However, the share of private hospitals has increased to 30% as of 2012, leading to a 78% increase in fees it allocates to private hospitals (Hamzaoğlu 2014, 46). A Complementary Health Insurance Circular was also accepted in 2012, defining private insurance schemes that would complement the partial coverage of GSS. This allowed an expansion of private insurance sector in Turkey.

While SGK had allowed service provision from health care organizations, and made contributions to services in these organizations, these organizations are allowed to bill up to an additional surcharge of 200% which will be provided from out-of-pocket payments or third-party payers. While SGK's coverage of private public organizations services made them accessible to everyone at first

glance, this was not the case in practice, due to their reliance on these extra payments.

Ministry of Health took on the role of coordinator and supervisor of services, rather than the provider. It became an institution that only determines the general policies, audits and regulates the healthcare market. Therefore, while minimizing its role for provision of healthcare, the state also achieved centralization and monopolization in privatization and marketization process. Through Full Time Act, which prevents medical professionals in public sector from working in private practice and other restrictions, it allowed private sector to enlarge in form of sprawling of chain hospitals, shutting down of smaller hospitals and restriction of private practice (Belek 2012, 13). It extended direct support to private sector through allocation of land, tax advantages and investment incentives (Belek 2012, 113). The number of private hospitals has increased from 271 in 2002 to 556 in 2014 (TC Sağlık Bakanlığı 93). One third of all hospitals were private in 2015, while it was only one fourth in 2002. Visits to private hospitals have increased from 5,7 million in 1992 to 72,3 million in 2014 (TC Sağlık Bakanlığı, 139). The financing of healthcare services relied increasingly on out-of-pocket payments and their parties like private insurance companies. The share of private sector persistently increased, through private hospitals and clinics, public-private cooperation or outsourcing of imaging technologies, laboratory and hospitality services.

Another new role of Ministry of Health is facilitating the cooperation between new institutions established to provide care. Turkish Public Health Institution (Türk Halk Sağlığı Kurumu), a newly established public agency became responsible for primary healthcare services, while secondary and tertiary healthcare services fell under the scope of another newly established agency, Public Hospitals Administration (Kamu Hastaneleri Birliği). Under this umbrella agency, public healthcare organizations resembled private enterprises in financial and administrative terms, with appointment of a General Secretary to each as the chief administrator (Atay 2007). *Başhekim*s, medical professionals who were

previously the chief in charge of the medical, administrative and training processes, now became subject to these managers. Köksal (2012) argues that this practice has led to politization of administrative cadre of healthcare organizations; together with differences in budget, has led to varying implementations among hospitals.

The purchaser/provider split and managerialization of public health organizations has introduced market mechanisms into their administration and finances, which prioritized efficiency and control. The obligation to manage their own budgets had led to outsourcing of certain services, and setting quotas on the number of examinations, procedures or tests, in a similar way to way it was managed in private hospitals. The patients were now viewed as consumers that would pay to purchase the services from a market that is increasingly becoming privatized. The obligation to attract “consumers” in order to survive, fueled consumerism in health care services, which, combined with increased patient demands also fueled the usage of medical technologies and pharmaceuticals. Also, since a referral chain was not imposed, citizens could visit any healthcare organization they wanted, including tertiary healthcare organizations (Köksal 2012). This has led to outstanding demand, exceeding number of examinations and procedures. While doctor’s visit per person was 3 in 2002, it increased to 8,3 in 2014; total number of visits have increased from 209 million to 644 million (TC Sağlık Bakanlığı 2015, 101). The health care costs had not been cut back, as a result; they instead increased. The health care costs and their share in GDP increased, as access to services, demand and use increased, and private sector has enlarged (Sönmez 2011, 24). It is important to point out that the increase in health care costs does not necessarily point to higher public spending on health care services. Sönmez calls attention to a decline in public health expenditure within total health expenditure during AKP’s rule, while total expenditure was constantly increasing. Healthcare spending per person has annually increased more than 25% between 2002 and 2012 (Belek 2014, 33). Instead, out-of-pocket payments have soared during this period. They comprised over 15% of all spending in 2012 (Belek 2014, 32). The out-of-pocket payments which were

around 3,4 billion dollars in 1999 have reached 8,5 billion dollars in 2007 and 10 billion dollars in 2008 respectively. It has shown a 147% increase between 1999 and 2008 (Sönmez 2011, 46). This has created an outstanding burden on citizens who want to use health care services.

A family practitioner scheme was established, which was interpreted as observers as a first step in the privatization of primary care. This system practically eliminated the Law of Socialization as it replaces Sağlık Ocakları with family practitioners. Family practitioners were usually general practitioners that would take part in the scheme after a short certificate training. These family practitioners would be provided with an office, medical technologies and devices, a nurse and medical clerk. They would be responsible for their own budget and administration; however, they would have a quota of patients and procedures that they would have to fulfill. It represents a shift in approach to primary care; while Sağlık Ocakları were about preventive care and ensuring the welfare of the community, family practitioner scheme focuses on curative care that places the individual at its center.

In case of public hospitals, their self-generated funds, which are called “revolving funds” have become an important aspect of autonomizing financial and managerial administration of hospitals. It has become a major financial source for hospitals, whose share from the general budget had declined. The main source of revolving funds were fees paid by SGK. This fund is also the source of additional payments known as “Performance-Based Payments” made to the personnel in public and university hospitals. The regulation for performance-based payments enacted in 2013 identifies the amount of additional payments to be made to the personnel based on their rank, conditions and duration of work, contribution to provision, performance, examinations, educational and research activities, procedures and operations conducted and invasive procedures (Resmi Gazete No.28599, 14.02.2013). It is viewed as a tool to increase productivity and quality through competition between public healthcare organizations and medical professionals. Recep Akdağ, who was the



Minister of Health between 2002 and 2013 stated that “with the revolving funds system, we have almost turned our doctors into hospitals’ partners for profit, without the risks and required capital” (Akdağ 2004, quoted in Elbek 2012). However, medical professionals have complained that performance-based system inflates the system by resulting in unnecessary procedures, operations and tests, and less time to be spent per patient. The medical professionals are in fact promoted to increase quantity, rather than quality of care through additional payments.

A development in HTP that had an impact on not only the present but also the future of the medical profession which was not in the profession’s control was the outburst of medical schools in Turkey throughout 2000s. While there were 48 medical schools in Turkey before 2004, 39 new schools opened between 2004 and 2014. There were 24 private and 63 public medical schools as of 2015. The quotas for medical students were also increased substantially. This was an unplanned development, for which the medical profession had not been consulted with. AKP has seen opening new medical schools even in the smallest cities that lack infrastructure and academic staff, as a pledge to rural voters. Some of the schools belong to public universities in smaller cities, as medical school boom was part of the general trend of expanding higher education institutions under AKP rule, and others to private universities which have also increased in number under AKP. This increase in the scale of medical training has led to questioning of its quality, especially in the medical circles. Concerns about the raise in the number of medical students, the inadequate infrastructure and insufficiency of both quality and quantity of academic staff in these medical schools, and the discrepancies among these new medical schools and the older, most established schools were voiced widely by TMA (Sayek et al 2008; Türk Tabipleri Birliği 2013; Türk Tabipleri Birliği 2009).

The medical profession has reacted strongly against elements of HTP, since it had negative consequences for their practice. However, the reaction also had a political component. The already strained relationship between the state and

profession slowly came to a breaking point with implementation of HTP, drastically intensifying in 2010s when AKP government systematically started repressing all opposition. The practices of HTP which directly impacted the work lives of medical professionals, such as performance-based-payment scheme and Full Time Act were introduced without any consultation with the profession. This period presents a continuation in governments' rhetoric about the medical professionals. While 1980s onwards the government officials as high up as presidents characterized medical professionals as greedy and self-interested, AKP officials have intensified this rhetoric, and even implying that "Era of Mr. Doctor is over"<sup>4</sup> The responsibility of failures of the health care services continued to be burdened on the medical profession, which created a paradox with AKP's promotion of HTP as the great transformation of the system achieved by their government. The social authority and status of the medical profession was implied in statements of AKP officials as a tool that enables them to exploit the poor, while claiming that doctors are no longer inaccessible elites since HTP has enabled health care services to be within reach to everyone despite their income. Performance-based payment scheme has also allowed this image of medical professionals to be maintained as it was presented as allowing them to earn more than they already did. The consumerist orientation of HTP which came together with the emphasis on this unrealistic presentation of medical professionals' income, paved the way for a skeptical view on the part of the public.

This skeptical view and promotion of healthcare services which do not match the realities of medical professionals' conditions of work have led to the patients to express their frustrations to the medical professionals who they viewed as responsible for all malfunctioning of the system. Thereby, violence against healthcare workers become a major issue that has affected their lives (Çorbacıoğlu 2017; Keser Özcan and Bilgin 2011; Al et al 2014; Adaş and Elbek 2008; Ayrancı 2005; Açık et al 2008; Boz et al 2006; Sağlık Çalışanlarının

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<sup>4</sup> " 'Doktor Efendi' Zamanları bitti" <https://www.milliyet.com.tr/siyaset/doktor-efendi-zamanlari-bitti-1385335>

Sağlığı Çalışma Grubu 2015; Annagür 2010, Adaş 2011). Physical, psychological and verbal violence against healthcare workers have become a daily occurrence for many, even resulting in murders. Five medical professionals were killed by patients or relatives of patients between 2005 and 2015. The violence especially soared in emergency rooms, visits to which have increased as appointments could not meet the overwhelming demands and due to the fact that emergency visits are free of charge. Pala (2017, 61) writes that 30% of all examinations took place in emergency rooms in 2013. While medical professionals and TMA have asked for regulation to prevent increasing violence that threatens the lives of healthcare workers, their demands have not been met. An application called Beyaz Kod (White Code) was put in place to report the violent attacks, however, since it mainly aimed to enable the administrative process after the attacks, it did not help prevent violence. The psychological and verbal abuse also started to visible take its toll on medical professionals. A public complaint system called SABİM was established for patients to anonymously file their complaints about medical professionals and healthcare organizations. This has turned to into a tool of abuse, as medical professionals were asked to write statements against each complaint. On November 30, 2012, a physician in İstanbul committed suicide after writing a statement for a complaint made to SABİM.

TMA had voiced its opposition to HTP since the first year of its implementation. However, the biggest protest against it did not take place until 2011. The medical profession organized a major protest against HTP on March 13, 2011 in Sıhhiye Square in Ankara. First months of 2011 had also witnessed smaller protests and demonstrations in many university hospitals around the country. These have culminated in a two-day strike by medical professionals in public, university and private healthcare organizations on April 19-20, 2011 (Köksal 2012).

The tensions between AKP governments and the medical profession increased with governments' efforts to exclude the medical profession even more from decision making on matters related to health and medicine by issuing new

responsibilities to Ministry of Health or new agencies and councils that has been established. One example was Sağlık Meslekleri Kurulu (Health Professions Board), which has been established with Executive Order No.663 (KHK) in 2011. The duties of the Board included delivering opinion on curriculum of medical professional training, on health professions' ethical principles and inspect their compliance with these principles, inspect and discipline members of all health professions (including the medical profession) and ban members of all health professions (including medical profession) from practicing temporarily or permanently (Bilaloğlu 2012). By establishing this board and attributing the duty to regulate the medical profession, AKP has taken away self-regulation, one of the major privileges and important criterion of political autonomy from the hands of the medical profession. The board also does not include any members from the medical profession, TMA is not invited to join to deliver an opinion. This implies that the state aims to take control of disciplining and regulating the medical professionals, as well as members of all other health occupations and profession. The board also takes control of the curriculum of health professions, an authority which, in cases where there is full political autonomy, lies with the medical profession. Amidst objections from the medical profession, Board's duty to regulate and discipline health professions have been found in contradiction with the Constitution and has been revoked. However, the Board has not been abolished.

Another attack on political autonomy of the medical profession, which has tremendous impact on individual professionals' clinical autonomy is a Bill that has been passed in 2014, which has come to known as the "Gezi Act". Gezi Protests that took place in 2013 was an important event after which AKP's repression in the social sphere severed against those it saw as its enemies and challengers (İlhan 2014). TMA also received its share, facing a government that did not only constrain its political autonomy, but also criminalized it (Can 2016). In fact, in many cases medical professionals and TMA were directly called "terrorist lovers" by AKP officials and Recep Tayyip Erdoğan himself (<https://bianet.org/bianet/siyaset/193716-erdogan-ttb-ye-terrorist-seviciler-dedi>).

TMA was very active during the protests, as part of a coalition of opposition. Medical professionals have organized in the protests in different cities around the country, aiding those who were injured in the make shift infirmaries they established with their individual efforts and under the organization and coordination of Chambers of Medicine in İstanbul, Ankara and İzmir. During the protests some medical professionals were detained and some were later put on trial. Ministry of Health opened an investigation into actions of healthcare workers who have volunteered in Gezi Park protests in İstanbul. It also demanded information of all injured citizens who visited public, private and university hospitals during Gezi Park protests (İlhan 2014, 123). TMA has published statements on the effects of tear and pepper gas used by the police in protests and objected to arrests (Türk Tabipleri Birliği 2013). World Medical Association and other international associations around the world have published declarations in defense of TMA and Turkish Chambers of Medicine, calling for charges against medical professionals to be dropped (World Medical Association 2015).

In the aftermath of Gezi Protests, on November 23, 2013, a new piece of legislation on health services was approved in the parliamentary commission. It has, very controversially, included a clause which barred the medical professionals from treating people in places outside of hospitals or clinics. It states that those who perform health services without a license and authority will be prisoned to 1-3 years and 20.000 days of judicial fine. The clause intended to intimidate medical professionals from providing care in incidents like protests in public areas. After much opposition, two limitations have been added to the Bill, which state “until emergency health services arrive” and “until the consistency of health service is achieved”. This legislation is seen by the medical profession as a direct attack on the profession, Hippocratic oath, professional ethics and duties by AKP, since it punishes them for exercising what they swore to do. World Medical Association has also reacted to the Bill, stating that it will have profound negative impact on “the availability and accessibility of emergency

medical care in a country prone to natural disasters and a democracy that is not immune from demonstrations” (World Medical Journal 2013).

In Ankara, Police Department’s summary of proceedings on Gezi Protests singled out TMA and Ankara Chamber of Medicine as “civil society organizations opposed to government” “that supported the protesting groups” and that they “constituted psychological pressure on the Police department and the judiciary” (İlhan 2014, 125). These statements have also emphasized government’s view of healthcare services being provided during Gezi Protests not as an ethical and professional obligation of medical profession, but rather as an expression of political stance.

Since 2003, HTP has changed all aspects of healthcare, annihilating its “public” service characteristic. Implementation of HTP has affected every dimension of medical practice and therefore, medical profession’s autonomy. The organizational, financial and administrative reforms have impacted economic and clinical dimensions; with performance-based-payment scheme, Full Time Act, increased privatization, promotion of competition among organizations -and professionals- economic and clinical aspects of their daily working lives are being affected by HTP policies. On the other hand, the political autonomy of the profession has been deeply challenged under AKP rule, who has aimed to take the medical profession under its control in more than one instance through new public agencies and legislation. As a reaction, the medical profession has strongly organized against the attacks by AKP governments which tried to criminalize and discredit it, campaigning strongly to protect its most prized value, professional autonomy.

Similar to its counterparts in other parts of the world, the changes in financing, organization and delivery of healthcare services under HTP has led the medical profession in Turkey to become subject of discussions on questions about whether it is proletarianizing or deprofessionalizing (Ulutaş 2011). A tendency of increase in bureaucratization in healthcare, with the expansion of private

sector, managerialism as an extension of efforts to control physician behavior, emphasis on consumerism explicitly expressed by documents of HTP were important developments that fueled these debates. The decline in economic rewards as a result of increase insecurity and informalization of their labor in private sector and performance-based-payment schemes that resembles piecemeal work in the public sector have led observers to argue that medical profession is proletarianizing, going through the process of deskilling by routinization and standardization implemented through managerial control and assessment. Soyer (2012) argues that the increase in the number of medical professionals, increase in the number and sphere of activity of other healthcare workers, weakening of professional association, bureaucratization and corporatization are signs that the medical profession is proletarianizing. However, he also emphasizes that the medical profession has been administrative and economic autonomy for a while; the bigger threat is the potential loss of clinical autonomy, which will take place by surveillance and direction of their activity by bureaucracy or managers with the goal of eliminating the inefficient (Soyer 2012, 237). Proletarianization in Turkish medical profession has become more of a concern related to loss of status, privileges and autonomy, rather than a transformation related to class position. It has been accompanied by concerns over deprofessionalization through increased specialization, routinization and demystification of medical knowledge, especially in relation to increased demands by patients and violence.

## CHAPTER 4

### METHODOLOGY

#### 4.1. The Research

This research aims to understand changes in professional autonomy of the Turkish medical doctors in the specific case of Ankara, under the changes in health care financing, administration and provision brought by Health Transformation Program, that came into effect in 2003. While understanding objective work conditions is important for the framework of this research, its specific significance emerges from my effort to understand and analyze the subjective perceptions of these professionals on professional autonomy with regards to their relationship to state, market and public.

The main questions that are asked in this study are as follows: What was the extent of professional autonomy of medical professionals prior to implementation of HTP? How and in what way did it change after HTP? How do their relationship with the state, the health care services and professional labor markets and the public have impact professional autonomy? What are consequences of the changing extent of their professional autonomy? Do medical professionals experience political, economic, clinical dimensions of professional autonomy as independent or interrelated values? If they make a distinction between these dimensions, what are factors that affect their experience? Is the case of professional autonomy of Turkish medical professionals distinct from other explanations in literature which tend to view it as inherent characteristic or an absolute value that is attained independently from the state, the public and the market?



While professions have been studied in different contexts in different regions, there is no existing systematic study in sociology in Turkey that particularly focuses on the medical profession in terms of its professional autonomy. The existing studies on medical profession either have a political economy perspective or do not focus on professional autonomy. There are statements and surveys by TMA and Chambers of Medicine, since it has been an issue of debate as a result of changes in health care services and AKP governments' oppressive and conflictual relationship with the medical profession. This study aims to provide an alternative framework to Anglo-American and European conceptualizations of professional autonomy, in which the relationship with state plays a significant role in shaping profession's relationship with public and the market, three actors in turn affect the extent of economic, clinical and political autonomy the profession has. It aims to demonstrate autonomy is not an inherent quality of profession, as presented by early theories of professions, but rather a fluctuating and dynamic value that may be experienced differently as a result of changes in healthcare policies and conditions of work. Unlike the Anglo-American models, I argue that the case of Turkish medical professions shows us that while autonomy is not absolute and never fully free of outside regulation, it may still be still present, even under state's mandate and patronage. However, it also presents that political, clinical and economic dimensions are not independent from each other; when one deteriorates, others are also negatively affected.

My interest in the subject comes from a personal place. As the daughter and granddaughter of doctors, I have witnessed the impact of changes in health care services on two generations of the profession. While I was thinking about my dissertation topic, I had one significant conversation with my father about impact of HTP on his work. This was the significant turning point for my research process, as his testimony awoke my academic curiosity on this specific topic, for which I could not find any sociological studies in Turkey. There is a plethora of studies and narratives by the medical doctors and medical academics themselves since the enactment of HTP, on its impact on the profession as a collectivity and

practitioners as individuals. There are also a few studies on changes in the labor process of health occupations under HTP by other social scientists (Ulutaş 2011, Acar 2010), or medical professionals themselves and mostly from a political economic perspective (Belek 2009; Belek 2012; Soyer 2012; Elbek 2012). Another lacking aspect of research on this issue has been systematic examination of subjective perceptions of the doctors on the issue. I aim to shed a new light on different aspects of professional autonomy as perceived by medical professionals, through a qualitative and sociological approach.

#### **4.2. The Qualitative Approach**

I found a qualitative approach to social research, practiced in the form of semi-structured interviews the most appropriate method for this research. The qualitative researcher tries to get as close as possible to participants, accessing information that cannot be available to quantitative approaches (Creswell 2013). This information is gathered by interpretations or meaning-making by people who are studied by researcher in their natural settings (Denzin and Lincoln 2011, 3). My aim to access the subjective meanings people developed out of their experiences allows me to access the complexity of views of this specific group of people, which are actually not independent from social and historical context. While participant observation, oral history, life history, focus groups are some commonly used for qualitative research methods, I found longer semi-structured in-depth interviews conducted face to face by individuals would be the method that would allow me to gather most information and make an analysis of their interpretations and perceptions of their experiences. McCracken identifies these type of interviews as “The Long Interview”, the aim of which is “to access”, and “not to generalize” (1988, 17). Instead of previously identified patterns and relationships, interviews help us enter the life-world of the respondents, and make sense of the meanings they draw out of their experiences.

Semi-structured interview was the most useful form for this research, as it allowed me to refine and reorganize the questions on the spot. In some

interviews, the respondents had already given the information before they were asked for it, or withheld information until I asked for further clarifications. While I had a set of fixed questions, they were flexible enough to attune to the flow of the conversation; new questions could be added, questions could be reformed or eliminated completely, depending on the information respondents had given.

Interviews were also the appropriate method for research with my respondents' specific qualities. It introduced similar challenges and advantages with "elite interviews", which is the category of interviews conducted with high level experts, politicians or bureaucrats (Davies 2001; Lilleker 2003; Morris 2009; Richards 1996). While my respondents do not fit into the category of elites to be interviewed for a specific information on policy making or decision-making processes, the social and cultural authority and high status of the respondents had brought similarities which had led me to make the decision to conduct in depth interviews. Aberbach and Rockman (2002) draw attention to differences regarding receptivity of respondents in case of interviewing highly educated people, which in fact, was a defining quality of my respondents. They argue that elites and highly educated respondents "do not like being put in the straightjacket of close-ended questions", since "[t]her prefer to articulate their views, explaining why they think what they think" (Aberbach and Rockman 2002, 674). In order to create me research design, I first conducted a detailed literature review on professions, with a focus on medical profession. This review included theoretical framework in sociology of professions as well historical studies on professions and medical profession. This initial step of research led to the decision to focus on professional autonomy as the central concept of this study; the basis on which the design of field work and questionnaire was constructed. The literature review was complemented by a study of how the health care system works, the changes brought by HTP, as well as the history of the medical profession and health care services in Turkey. This has also allowed me to refine the question sheet, enabling me to ask about specific objective aspects of work to my respondents, such as the decision-making processes in the organization, the management of work, the actors that take on specific tasks and the work load.

However, interviews have proved most useful in understanding the processes or negotiation, bargaining and corner cutting in daily work life practices, which would not be accessible without conducting these longer interviews. This study did not only aim to examine the changes in objective work conditions of medical professionals which impact their professional autonomy, but also how they interpreted the transformation of this autonomy. While research design had started by focusing on a central conceptual framework that was achieved by a review of theoretical work on professions, focusing on subjective perceptions of the respondents led the analysis process to be data driven, allowing me to distinguish particularities of the professional autonomy of Turkish medical professionals.

As my aim was to understand how medical doctors perceived the extent of their professional autonomy in the light of changing health care regulations and work organization, “subjectivity” of workers emerged as an important methodological debate to address. The importance of subjectivity in studies on work have been important part of the debate on the framework of “Labor Process Theory”. While these studies are originally on changes in work conditions and organization of manual and blue-collar workers, debates on importance of studying subjectivity of workers also provide an insight on why studying subjectivity of professionals are also important to the same extent. To a large extent, the debates on subjectivity emerged after Braverman’s (1974) study which explored changing objective work conditions in capitalist production process, specifically process of deskilling, under management control. He had been criticized for focusing too much on objective conditions of work, and ignoring the role of agency, subjectivity or any possible worker resistance (O’Doherty and Willmott 2001). While we need to understand the objective conditions of work and the political and economic dimensions that form the structural context, looking at subjective interpretations allow us to see how these dimensions are inscribed on, or internalized by, the practices of labor (Burawoy 1979), how ideological processes function, and how workers may be diversified and stratified within the changing conditions of work. For professionals, professional ideology and

values, and profession's role and status in society also come into play as factors that may impact their subjective interpretations of changing work relations and organizations, in the face of other countervailing powers. Considering the role professionalism and professional ideology play for the attitude and behavior of my respondents, interpretations of their experiences allow us to understand how they position themselves against organizational control and management, against patients, or the extent to which they identify as members of their profession against actions of the state. These are factors affect their relationship with these actors, and the negotiation processes that may open or constraint space for their professional autonomy.

Work is a mental and symbolic effort that has economic as well as symbolic value. It does not only help produce economic value, but also constructs an identity for one's self (Budd 2016). Therefore, a question that emerges, what happens to professional identity for occupations such as medical doctors, who are identified with great professional autonomy and attained authority in society though its high status and privileges, as the conditions start to change and their privileges decline? Collinson (2003) and Sennett (1998) both argue that while paid employment is seen as a significant and values source of identity, individualized contracts, flexible or casual work in bureaucratic (or 'post-bureaucratic') organizations may increase the economic, social and psychological insecurities people may experience. These "material" and "symbolic" insecurities have a big impact on subjectivities that shape the work place practices (Collinson 2003, 532). This is especially important for medical professionals who had been for decades very "secure" economically and socially. So, a question that should be addressed is whether the existing professional identity or ideology and social status appear as a way to negotiate, comply with, or adapt to changes in work conditions and organization. To answer this question will only be possible through listening to the subjective interpretations of professionals' experiences.

It is also important to consider that the medical profession had never been a homogenous unity, although its public image was on the contrary. It is becoming more heterogeneous as different types of health care organizations emerge, which offer different types of employment contracts, work conditions and constraints. Lin (2014) points out that differences among organizational settings may lead to different levels of perceived professional autonomy, regarding different kinds of decisions medical professionals have to make. She also argues that, contrary to the common statement, employment in a bureaucratic organization does not necessarily bring decline in autonomy. Understanding the variations among perceptions of (different categories) of professional autonomy and professional autonomy requires interviewing professionals employed in diverse types of organizations to make comparisons (public vs private sector, or employment vs solo practice being main comparisons). It is also important to address whether the shared professional culture, values and ideology is maintained in this changing environment as the professional is becoming more heterogeneous.

In this sense, it is important to ask the members of the professional group, who have been attributed highest professional autonomy in division of labor and highest status in society, how they perceive the changing environment, how they “manage” or negotiate the “objective” conditions of work, and whether they think they still maintain their ability to control these conditions of work autonomously.

### **4.3. The Field**

The field study for this research was conducted in Ankara between July 2013 and February 2014. I chose to focus on Ankara because it is not only the country’s capital but also a capital for health services with major hospitals and medical school facilities which are visited by locals as well as people coming from other cities. Many people around Ankara seek medical assistance, especially for more severe and long-term illness in hospitals in Ankara, which gives the medical professionals working in this city a wider perspective of the public. Ankara is

also among the first cities that are chosen as pilot cities for practices of HTP. Therefore, the medical professionals working here had a longer experience with most of the implications of HTP.

Initially, a pilot study was conducted on May 2013 with three respondents, using a draft semi-structured question sheet. This was useful in seeing how interviewees respond to the questions, whether I would receive the information I was seeking for in my study, and to have a better understanding of the area and scope of the study. Through these pilot interviews, for which the questions were broader, I reviewed and refined the question sheet, eliminating or adding in questions. As a result of these pilot interviews, I also made decisions with regards to focus points that would accommodate the comparison of similarities and differences among medical doctors, such as the number of interviews that would be arranged in public and private health care organizations and the number and kind of medical doctors with specific specialties.

After refining and rearranging the questions, I started searching for respondents who would be willing to accept my interview requests. Since medical professionals have very busy workloads, I assumed that it would be difficult to convince them to spare time to answer questions by someone they do not know. Therefore, I thought it would be practical to reach out to one medical doctor I personally know to make initial contacts. She connected me with the first three respondents. From there on, I asked each respondent at the end of the interviews whether they know another medical specialist that would respond my questions. Drawing out a specific sample was difficult due to their time constraints; therefore, a snowball sampling was most convenient in allowing me to reach as many respondents as possible.

I aimed my sample to be composed half of medical doctors that practice in the public sector and half in the private sector, in order to be able to compare the differences between work conditions, incentives and limitations in the two sectors. However, I did not limit the kind of health care organization within the

sectors, in order to increase my chances of reaching more respondents. I also did not specify the medical specialties my respondents would be practicing; however, I determined an experience of minimum 10 years as a medical specialist would be instrumental for the respondents to have a broader understanding and experience of changes that were brought on by HTP.

I interviewed 25 respondents in total; however, two interviews were eliminated, on the basis of the respondents having less than 10 years of experience as specialists. Eleven of the remaining 23 respondents worked in private health care organizations, while 12 worked in public health care organizations. The type of organizations they were employed in differed. Among those who were employed in private sector, 5 were employed in Private Medical Centers (Özel Tıp Merkezi), which are organizations that do not include inpatient facilities. One single respondent was a private practitioner, however had opened her practice very recently at the time of the interview. Since the last organization she worked in until very recently was a Private Medical Center, she was also placed in this category of employment. The remaining 6 respondents in the private sector worked in Private Hospitals, large scale establishments with inpatient care infrastructure.

Twelve of the respondents worked in the public sector, however the type of organizations they were employed in varied more than those of the respondents in the private sector. While one respondent was employed in a state hospital that was affiliated with Ministry of Health (which, until 2005, was a SSK hospital), six respondents were employed in Training and Research Hospitals. These hospitals are also affiliated with Ministry of Health. What distinguishes them from other state hospitals is that they train assistant doctors and conduct research, while at the same time providing inpatient and outpatient services. Five remaining respondents were employed as faculty in University Hospitals. They also carried the responsibility of training and research as well as treatment to patients.



While my respondents in university hospitals were assistant, associate or full professors, it is important to point out that some respondents who were employed in private sector at the time of the interviews used to be faculty at university hospitals. One was a retired professor, while the other three were associate and assistant professors who had quit universities to work in the private sector. All other respondents who were employed in the private sector had had experience in the public sector as well. Most were retired from the public sector and were working in the private sector in their retirement. The respondents having experience in different sectors had sometimes made interviews more challenging, as I had to ask for clarification on whether the answer they had given were based on their experience in their current or former organizations. There were no unclarified answers, and this dual experience in the case of most respondents has, on the contrary, enriched the responses I received from respondents, as it provided a better opportunity to compare the work conditions and extent of autonomy in the two sectors throughout time.

While the issue of gender was not a focal concern in this study, I paid attention to arrange interviews to represent male and female respondents proportionately. Ten of the respondents were women, while the remaining 13 were men. The average age of the respondents was 50 at the time of the interviews, the oldest being 64 and youngest being 38. Although the literature emphasizes the prospect of social mobility profession provides to its members as a result of market closure (Larson 1977) and authority and prestige (Sullivan 2000), this study did not focus whether they have achieved mobility as a result of their profession. Questions about their background were asked to gather general demographic information and information on why they have chosen this profession, but not used for the purpose of evaluating the trajectory of social mobility of each individual respondent.

**Table 1.** Information of Respondents

Number	Specialty	Age (at the time of interview)	Gender	Type of Healthcare Organization
1	Neurologist	56	F	Private M Center
2	Physical Therapist	53	F	Private M Center
3	Radiologist	38	F	Private M Center
4	Internist	56	M	Private M Center
5	Pediatrician	57	M	Training and Research Hospital (public)
6	Urologist	51	M	Public Hospital
7	Anesthesiologist	48	F	Training and Research Hospital (public)
8	Pediatrician	55	F	Training and Research Hospital (public)
10	General Surgeon	52	M	Private Hospital
11	Radiologist	58	M	University Hospital (public)
12	Public health	64	M	University (public)
13	Public Health	55	F	University (public)
14	Anesthesiologist	59	M	Training and Research Hospital (public)
15	Emergency/Family	47	M	Private Hospital
16	Urologist	45	M	Private Hospital
18	Psychiatrist	46	F	Private Practice (Private M Center)
19	Pathologist	38	M	University Hospital (public)
20	Internist	55	F	Private Hospital
21	Internist	39	F	Private Hospital
22	Pediatrician	54	F	Training and Research Hospital (public)
23	ENT	56	M	Private Hospital
24	Nuclear Medicine	46	M	Training and Research Hospital (public)
25	Nuclear Medicine	41	M	University Hospital (public)

I arranged interviews on the phone, after introducing myself and giving a brief introduction about my research. Since I applied snowballing sampling in my research, all respondents were aware of me and expecting my call. Two doctors have rejected my request for interviews upfront on the phone. One had stated that she did not have the time although she liked my research topic, and the other one stated that she did not find it appropriate to be interviewed about such “controversial issues.” Twenty-one interviews took place in the doctors’ offices in the health care organization they were working in, one took place in the doctor’s home and one took place at a café. The longest interview took approximately 2.5 hours, while the shortest one took approximately 30 minutes. The duration of interviews on the average was 59 minutes. All interviews, with one exception, was taped on location and later transcribed verbatim. One doctor did not want to be taped, however he allowed me to take detailed notes, at times pausing and waiting for me to write down his answers.

Almost none of the respondents were accustomed to being interviewed, except for two of them who were very active in TMA, which had allowed them to have contact with other stakeholders and journalists in the past. While some respondents were hesitant about answering questions in the beginning (the reasons for which are indicated in the next section), all of them got comfortable once the interview has started. I did not feel any hesitation or concern during the interviews, except for a few who were concerned about the issue of anonymity.

Although respondents were clearly told in the beginning of each interview that they would stay anonymous, five of them said that I could openly use their names if needed. However, after I explained that this was not an interview for journalist purposes but rather for a sociological study to understand patterns and perceptions of members of a profession which requires all respondents to stay anonymous, they accepted not being named. Several respondents wanted confirmation throughout the interview that they would stay anonymous, even though they were clearly informed about this issue before starting the interviews.

This reflected their concerns about answering questions on what they considered a controversial topic, since it involved criticizing the governments.

In the beginning of each interview, I reintroduced myself, orally presented a summary of my research question, assured them of anonymity and confidentiality. While the question list sometimes changed based on the flow of interview, I had several groups of questions pertaining to specific issues which I asked all respondents. In the first part, I asked for their demographic information, such as age, education history, past work history, the reason they chose to be doctor in the first place and whether they feel any differently about being a doctor compared to when they first graduated from medical school. In the second part, I asked questions about their daily work practices, such time they spend per patient, daily number of patients, their workload, whether they have seen a change with regards to these technical issues since HTP was enacted, changes in managerial organization in hospitals, their opinions about how performance-based payment, Full Time Act and technological changes affected the profession and them as individual practitioners. The third part was about their relationship with patients. Here I asked about whether there have been any changes with regards to their attitudes toward patients, patients' attitudes towards them, and the issue of violence. I asked whether they experience any changes in their social status, respectability and authority in society. Fourth, I asked them about profession's relation with the state, the current government, and the past governments. Fifth section was composed of question on their individual relationship with TMA, and the problems of the profession. Sixth group of question was about the new medical schools that had opened under HTP and what they think of future of the profession and health care services in Turkey. Last, I asked them whether they believe they still maintain their professional autonomy, and what it means to be a "good doctor" in the current health care environment.

Most of the respondents made appointments with me for time slots in which they did not have any patients. However, some did not have such opportunity,

therefore I either had to wait in the halls until they found a free period, or interviews sometimes had to be interrupted when patients or other staff came in the room. There were no major interruptions or inconveniences; the patients who walked in had come in for brief questions. Only in one case a patient came into be examined. The patient was a baby, and the doctor asked for her mother's permission for me to stay in the room. I stayed in for the examination after the mother approved, then we continued with the interview after the mother and the baby left the room. Interviews were briefly interrupted by nurses, other health care staff or incoming phone calls.

I aimed to go in two or three hours earlier for each interview, and stay in the facility for one more hour after the interview. This gave me the opportunity to observe the daily routine in these organizations, the interaction between staff and patients, eavesdrop to conversations to have a glimpse of understanding of patients' expectations from organizations and doctors and watch the patient flow in and out of examination rooms. However, it was not possible for every interview. In more than one instance security guards have approached me asking questions, suspicious of what my intentions were walking down or waiting in the halls. In one case I was forcefully taken out of the hospital by a security guard, although I had first clearly stated who I came to see, and then politely that I would comply. In two instances I was mistaken for Ministry of Health inspector, although I had explained that I had to come to see a certain doctor.

It is important to underline that the interviews often presented a two-layered narrative; one where the respondents' answers to questions taken as references to their individual daily working lives, and the other referring to the developments that affect them as a member of a specific professional group. Therefore, most answers pointed at how the respondent's views and perceptions have changed through HTP as "me, the individual practitioner", and "us, the professional group". For most respondents the sentiments and views aligned for both categories. They argued that what they as individuals were going through in the daily work life were typical of how the other members of the group were in fact

experiencing the changes in their relationship within the profession. However, a small number of respondents argued that their specific positions and conditions of work diverged from the common experiences of the professional group. This small group consisted of doctors who practice very rare specialties, whose experiences do not reflect a general image of the working lives of the individual doctors.

#### **4.4. Importance of Reflexivity for this Study**

Reflexivity is a fundamental aspect of social research, which requires researcher to recognize his or her own “situatedness within research and the effect it may have on the setting, the people being studied, questions being asked, data being collected and the interpretation” (Berger 2015, 220). It is important that the researcher does not only detail his or her own experiences with the subject of research, but also be self-aware that these experiences may shape the interpretation in the study (Cresswell 2013).

As I have mentioned earlier, my being witness to family members’ experience of changing practices of the profession was the reason why I wanted to conduct this study. Therefore, reflexivity, as well as questioning my position within the Insider/Outsider dichotomy in this research, particularly within field work, was especially important. This necessity does not simply emerge from striving to present objective findings, but also in order to stay relevant as well as in distance from the respondents in the field work. In her research on grief resulting from losing a loved one by contextualizing the factors that influence the grief, Breen (2007) draws attention the disadvantages and advantages she experienced by neither being an outsider, nor an insider. She was involved in the grieving process of her friend’s family member; however, she was not personally was a member of the family. This allowed her to understand the process, made it easier to access and understand the respondents who went through grieving for a loved one in her field study. She argues that her blurred position as neither an insider nor an outsider maximized the advantages and minimized the disadvantages.

I agree with Breen's argument in that my proximity to a person (my closest family member) going through similar social, economic and emotional processes as my respondents, have helped me achieve a better understanding of the situation. However, I also had to be cautious about the disadvantages this blurred position may bring in the research process. As Kacen and Chaitlin (2006) argue, the background and worldview of the researcher may influence the style in which she asks the questions, or the information gathered from participants. At times I had to rethink how the conversation with the respondents would proceed in order to prevent from my biases on the issue to hinder my objectivity, my question style, or even the tone of voice.

Within the process of reflexivity, I also evaluated the advantages my proximity to the issue and subjects contributed to the research. Some of my respondents have asked why I chose this particular topic to research, to which I replied honestly. I am aware that the cooperation of the respondents and their willingness to share information may have been a result of this piece of information. In three cases, although the appointments for interviews were already made, the respondents were hesitant and reluctant to talk to me in the beginning. One respondent in particular was uncooperative, questioning my motives and asking me "which institution I actually was affiliated with". The interview was taking place right after the Gezi Protests which took place in spring and summer of 2013, after which social polarization and skepticism had started to intensify in Turkish society. I was aware that in such a politically sensitive context I might come across suspicion from respondents almost none of whom did not know me personally and were never interviewed by a researcher before. In these three specific cases, after repeating my affiliation and my purpose of research, I told the story of how I came to choose this topic, although stating that the interviews were voluntary and they did not have to participate if they did not wish to. After hearing the profession of my father and my grandfather and how the challenges my own father came across have influenced my choice of research topic, all three respondents seemed much more relaxed, and even happy that I contacted them, saying they would be happy talk to me. In

the instance of this specific respondent who was suspicious of me, he suddenly shouted “E baştan söylesene kızım!” (“Why didn’t you tell this in the beginning my girl!”) In this case my positioning has influenced the field work, since it might have made it easier and more effective for respondents to talk to researcher who they believe is more sympathetic (De Tone 2006). My personal affiliation with a member of their own profession might have scattered their reluctance and suspicion and enabled a more cooperative conversation.

Another aspect of my reflexivity practice allowed me to see that the one situation may have proved both an advantage and a disadvantage. Since I was immersed in the topic more than a researcher as a result of my personal relationship with it, this situation has also helped me understand some of the implied content in the conversations. However, from the side of my respondents, this sometimes led them to withhold information (without realizing), assuming that I would understand what seemed as obvious to them. In these cases, I had to repeat them I was asking about something I had not experienced myself, that I was only a witness to it, and was researching the issue. Questioning myself on whether I required more clarification for responses was one way to balance this double-edged situation.

Overall, while turning around to look at myself as a researcher and question how my personal positioning may affect the research process and findings have been very influential in this study. It also helped keep a “close distance” with my respondents, from whom I have received cooperation, to which I approached cautiously, as a result of practice of reflexivity.

#### **4.5. Sources**

In addition to interviews, I benefited from immense number of additional sources. I read historical accounts, memoirs and biographies of Turkish medical professionals, especially those who practiced in the first few decades of the Republic. This was important to understanding the relationship between the



profession and the state and profession and the public, how the profession was perceived in society and how doctors identified with the profession. In a similar vein, I tried to watch movies and TV shows and read fictions books which provided me with a sociological imagination of how medical profession practices and is perceived in the past. I also attended meetings and conferences organized by TMA and Ankara Chamber of Medicine where I took extensive notes. I benefited from weekly bulletin of TMA and its monthly publication as well as reports and press release it has published. I also followed publications of Ankara, İstanbul and İzmir Chambers of Medicine.

#### **4.6. Limitation of the Field Work**

This study has several limitations emerging from the difficulties of the field work. One limitation is that this study is conducted entirely in Ankara, the second largest city and the capital. Therefore, it was not possible to observe how changes in financing, administration and provision of health care services and in work organization reflected on medical doctors working in rural areas and smaller provinces. Another limitation is that this study only focused on medical specialists, while the general practitioners and assistant doctors are groups that experience changing conditions and regulations in very detrimental way. Different research on these two groups would complement this study in presenting HTP's impact on professional autonomy.

While most respondents were open, enthusiastic and very detailed in their answers to my questions, in one case the respondent was reluctant to answer the questions. That was the shortest interview, where the respondent gave very vague answers and did not have almost any negative approach towards changes brought on by HTP. However, after the interview was finished and I turned off the recorder, she started complaining about every aspect of health care service and her work conditions, and asked me to keep these statements confidential. There were three more instances where respondents asked me to turn off the recorder and keep the next few sentences confidential. I complied not only

because it was the ethical action to take, but also to sustain their sincerity, believing that they were not obliged to say those few sentences if they did not want me to hear them. Accessing respondents that will accept to participate and not hold back information is a challenge for any qualitative study, but in times of social and political tension or sensitivity such as when this field work was conducted, this may become an even bigger challenge. This study was not exempt from these tensions, however the rapport I built with the respondents as a researcher allowed my study to avoid these difficulties to a great extent.

Another limitation of this research is that there are a few years between the field work and writing up stage of this study. While I was conducting the interviews, there were few studies outside of medicine on the situation of the medical profession under HTP. It was the TMA and members of the medical profession that were vocal about their problems. Since then, it is mostly public health experts who continue to write on the medical profession, with not much focus on professional autonomy in specific. Despite the few number of studies, coverage of medical profession and its challenging work conditions, which are covered in this study, increased in the media, especially due to intensifying violence against health care workers and then since 2020, due to COVID-19 pandemic. A new issue of debate has also emerged, intensifying especially with the COVID-19 pandemic, which has steered public's attention to the medical profession: brain drain, especially among younger medical professionals. In 2012, only 59 doctors had applied to TMA to receive documents that allow them to practice abroad. However, in comparison, in the first 8 months of 2022, 1402 doctors had left Turkey (Genç 2022). Many, mostly younger, medical professionals are in the process of moving or planning to move abroad. This situation, result of challenging work conditions, low pay and increasing violence is not covered in this study, since migration of medical professionals was not an issue when this field work was conducted. Therefore, the lack of a debate on how medical professionals perceive this problem and its potential repercussions to the profession and the future of healthcare environment in Turkey is a limitation of this study.

## **CHAPTER 5**

### **PROFESSION-STATE RELATIONSHIP AND PROFESSIONAL AUTONOMY**

It is essential to examine profession's relationship with the state in order to understand professional autonomy in the countervailing powers network, especially in countries such as Turkey, where the state has the authority and control over most financing, administration and delivery of health services. The power of state in these dimensions of health system and how it organizes them carries significant importance in determining work conditions and the extent of autonomy of medical professionals. How much the state allows the medical profession to contribute to policies related to health services, regulations, medical credentialing and medical training is necessary to understand the extent of political autonomy the professional group has, namely the collective power to determine and control its own affairs. I argue that the extent of political autonomy is not separate from the economic and clinical autonomy the individual professionals have, therefore it has implications for their control over clinical decisions and financial rewards. The regulations and policies also determine their relationship with employers, labor market, and patients. The state's rhetoric on and attitude towards the medical profession and its competency will also have an effect on how the profession is perceived in public, and therefore how the individual professionals interact with patients on a daily basis.

Countries and their health systems vary based on the level of contribution by the state and profession in establishing and operating the health system. The relationship between state and profession is dynamic in the sense it may change depending on the social, economic and political context. This chapter, through statements of respondents interviewed in the field, will analyze how this

relationship is perceived by the medical professionals, both as individual doctors working in the Turkish healthcare system and as members of a professional group that has had an intense relationship with the state and the governments, most recently with AKP governments.

A glimpse into history of professions demonstrate that they need state support in order to have legitimacy, autonomy and be recognized as an organized body that has the authority of a certain realm in society. Theoretical approaches put forward since the beginning of 20<sup>th</sup> century have one way or another mentioned the state as an actor that plays a role in profession's social existence. What has been missing in these analyses is that they see this relation as smooth and stable, lacking any conflict and resistant to social and political changes. The traditional Anglo-American theories on the matter view the profession as a more autonomous, independent body, which receives a one-sided support from the state for its legitimation. However, as scholarly interest in professions increased in other parts of the world, such as Continental Europe, Scandinavia or the then Soviet Union, so did efforts of theorization on alternative models of professions and state-profession relationship (Saks 2013; El-Mehairy 1984; Filc 2006; Riska and Wegar 1995; Heitlinger 1995; Erichsen 1995). The relationship between the state and profession in other regions and political systems around the world present a much more mutually dependent relationship, some where the professions are under the mandate of the state and some that include clashes or a perpetual cycle of cooperation and conflict. The studies covering the medical profession outside the Anglo-American theoretical realm have demonstrated the importance of focusing on state-profession relationship in order to understand professional autonomy. They presented a much more intimate relationship, and that the role of the state as supporter or enabler is not universal (Evetts 2012; Nigenda and Solorzano 1997; Tousjin 2002; Hoffman 1997). For example, in Norway medical profession is integrated into the state structure in a way that strongly influences health policies that it is called "profession state" (Erichsen 1995). In France the profession has developed with strong links to the state which has legitimized it as the main trainer and employer (Le Bianic 2003). In

Czech Republic under socialism, the political power of the state had an impact on constraining most basic clinical decisions (Hoffman 1997). In Mexico the state has always dominated the profession, continuously oppressing the professional association and fragmenting the medical professionals (Nigenda and Solorzano 1997). States' increased involvement in regulation of health services, whether in terms of increased public financing, governance of public sector or involvement in private sector, implies that the economic, political and clinical conditions of work for medical profession is increasingly coming under the scope of states. Possession of more authority in the realm of health services by the countervailing power of state may result first and foremost in the decline of extent of political autonomy of the medical profession, which may have an impact on economic and clinical autonomy of professionals as their level of authority over realm of health changes.

Also, most of the theoretical models based on Anglo-American conception of profession viewed the state as external, providing support to professions. While this included socio-economic control in some cases, what defined a profession was seen as its technical autonomy (Freidson 1970a, 1970b). However, later on different accounts of professions lead to different theoretical explanations, such as that of Johnson's (1995), which is inspired by Foucault, arguing that state embodies expertise and professions, eliminating duality between state and professions. According to him, autonomy of the profession depends on the interventions of the state and the state is also dependent on autonomy of the profession "in securing its capacity to govern as well as legitimating its governance" (Johnson 1995, 16). He describes a relationship which also defined the relationship between state and profession in Turkey in the first several decades of the Republic, arguing that "the professions are emergent as a condition of state formation and state formation is a major condition of professional autonomy" (Johnson 1982, 189). This statement can be observed in Germany and in Scandinavian countries in which the professions are created in a close relationship with bureaucracy, public universities and public services (Evetts 2012). In this sense, the question that should be asked is how do we

address the context in which the professional practices in order to understand autonomy? What happens when a state uses the profession to legitimize itself but this strategy shifts from one that can be identified as mutual support to hostility, in a way that encroaches upon professional autonomy?

In Turkey, the medical profession has also institutionalized in a very different manner than its Anglo-American counterparts. It has developed in a very close mutual relationship with the state, one which includes close interaction and support. While the Anglo-American theorization of profession views profession and state relationship is unproblematic and independent (Carr Saunders and Wilson 1933; Freidson 1970a; Freidson 1970b; Haug 1973; Larson 1977), in Turkey this relationship has been tense and conflictual especially in the past 50 years. The relations have turned hostile since 2003, with the implementation of HTP as AKP came into power to rule for the next two decades. HTP has an impact on all dimensions of autonomy of medical profession. For example, it is not medical profession who is responsible for establishing health policies including employment and salaries but rather Ministry of Health as a state agency; Social Security Institution as a state agency is the third-party payer which determines how much procedures and remedies will cost and how much out of pocket cost can be received (Belek 2012; Pala 2017; Pala 2018; Bilaloğlu 2015). Medical profession has no power over payment schemes; involvement in such decision is also an indicator of political power and autonomy (Elston 1991). The many actors involved in the health realm and complex relationship with state requires a dynamic approach to looking at the relationship between state and profession, which is why Countervailing Powers is most useful in showing how profession's tensions, negotiations and changing alliances with other actors involved, including the state, changes over time in a manner that will determine the extent of professional autonomy that it will possess (Light 2010).

In this chapter the first emphasis will be on the extent of political autonomy of the medical profession according to respondents since the implementation of HTP, as the most useful way to assess state-profession relationship is to

understand how the profession as an organized corporate body reacts to and interacts with the state. Political autonomy includes ability to control decisions on financial and organizational aspects of health policies and on licensing, credentialing, training, and disciplining medical professionals. It should not simply be seen as the ability to control its own affairs, but it is also the ability to have power over political decisions regarding resources and policies. This also has implications for clinical and economic dimensions of autonomy, namely the market position of the profession, fees, and incomes of the professionals, as well as decisions regarding distribution of resources, diagnosis, treatment and relations with patients. Respondents are asked their views on extent of their profession's political autonomy, especially under AKP governments and how HTP has affected profession's political autonomy. They are asked about the repercussions to their individual work lives, including how their economic and clinical autonomy is affected. Understanding respondents' perception of relations with the state and extent of political autonomy of the medical profession will also enable us to see how the position of the profession against the state in political and ideological terms will have an impact on the clinical and economic autonomy under HTP. A final issue regarding the state-profession relationship that has come up intensively in the interviews was the relationship between the state and the professional association, TMA. In this scope, how respondents perceive their professional association and the level of identification they have with it has also been examined as a representation of their relationship to the state.

### **5.1. Legislative Restrictions**

Respondents' statements and developments that have taken place since 2003 demonstrate that AKP does not only present the medical profession in a bad light, targeting it to provoke the public against the profession, it also tries to take over the mechanisms of control, regulation and supervision which the profession has the autonomy to exercise on itself. There is an effort to dissolve political autonomy of the profession. Respondents argue that their profession does not

have collective political autonomy that is necessary to operate in a professional manner, since their professional association, TMA is not consulted about health policies, not only because the Ministry is the central policy making organ (unlike many other countries where the professional association is), but also because it is excluded from the process on purpose by the government due to their opposing views on policies and politics. TMA does not formally have a voice in or collaborated with on issues of organization of labor of medical professionals, salaries and payment schemes or number of medical professionals employed, medical students that will be accepted to medical schools and the number and operation of medical schools. Respondents have also mentioned Board on Health Professions established to regulate health professions. TMA or any other representative of the medical profession is not included in this board, therefore excluding the opinion of the profession on its own matters. Ministry of Health's legal restrictions on private practices as part of HTP steer medical professionals towards working as employees in private healthcare organization, which, according to a respondent, further reinforces the loss of economic autonomy and loss of characteristic of a free profession. Medical profession is no longer a profession one can practice freely and on his/her own terms.

*They don't want a doctor who can determine his own fee. You can't be butcher who owns his own shop, they want you to be a butcher who works 8 to 5 at a Migros supermarket. They want to say that 'I will tell you how much you'll earn'. (R10, general surgeon, private hospital)*

The restrictive state regulations mentioned by the respondents pertained both the private and public sector. While the Ministry of Health oversees the health services provided by the public hospitals, it has the more general authority to determine the number of specialists and general practitioners that will be employed in private health care organizations as well. According to the respondents, Ministry of Health's central control over private organization limits their economic authority, by restricting their choice employment, as well as the decisions of the management for hiring staff.



*The Ministry of Health even determines .... the number of staff, which departments will open (in private organizations). Which devices you can buy, how many doctors from certain specialties you can employ, Ministry of Health has readjusted all of these issues. (R3, radiologist, private medical center)*

*Again, the state certain implementations, you can't go to any hospital you like. For example, you are the owner or medical director of a certain hospital and you want to employ me. However, there is a fascist practice here, it says, there can only be two urologists in this hospital, you can't have a third one. Therefore, these men can't hire you even if they want to. (R16, urologist, private hospital)*

Another restriction Ministry of Health imposed in the private health care services were restrictions brought on to private practice. These are two kinds of restrictions in private practice. One had been the regulations on the physical infrastructure of the private practice, which made most private practices offices to suddenly become dysfunctional in the face of these new regulations. The second was Full Time Act, which was a very controversial regulation change which brought the profession and the state against each other.

Implementation of the Full Time Act is another major issue based on which the respondents argue that decreases their political autonomy under AKP rule. While they argue that working exclusively and full time in public sector (in case of this specific Act, medical schools) is essentially the right principle. However, they are against having restrictions on solely their own profession, which they view as a political decision, when other occupations and professions or other realms of economy is not imposed to such restrictions as to limit a person's freedom to work.

*In a place where everything can be bought and sold in the market, in a place where governments that takes pride in liberalism argue to have built liberal systems, in a geography where you claim that labor and capital move freely, it is not acceptable if you dominate labor (of one sector alone). It is one thing, like in Turkey of 1930's, if you say, come on brothers, let's work together to build railways for our homeland, let's establish tuberculosis dispensary, if you all put an effort, from engineers to doctors, from workers to politicians; it's another thing when you're doing everything in line with the spirit of capitalism but you say 'you doctors are not allowed to do it'. (R11, radiologist, public university hospital).*

*I think that working full time is right and ethical. I don't think that using your academic title or your position at a training hospital to earn money outside, as a tool to gain profits, is ethical. However, I also understand the necessity to work two jobs. On the other hand, I also defend this, I defend medical professionals' right to practice their profession freely. Not in terms of working two jobs. (R13, public health, public university hospital)*

Full Time Act is not only seen as an interference in collective political autonomy of the profession, but also into economic autonomy of the individual medical profession, as it prevents them to make their own decisions about where to work and interfere in their earnings. While they argue that it is not ethical to have commitments to work at two different locations at the time frame, they should be able to make their own decision about whether to work more after their workday is over. Respondents have argued that the reason the state enforced Full Time Act was not necessarily to improve the quality of medical and health care services, but rather to “imprison” the medical doctors within conditions of not their own choosing. “Devaluing professional labor so that it becomes cheap” emerges as another significant explanation by respondents, since they argue that the private sector takes advantage of the employment restrictions placed on professionals by further devaluing their labor under precarious conditions.

*You are an academic faculty at the university you may not go and earn money at your private practice at 1 or 2 PM. That is not ethical, yes. But you should not have to explain where you work, where you turn your labor into money if you leave after 5 PM. He can care for patients wherever he wants once he gets an operating license. (R21, internist, private hospital)*

*For example, I send a case to an academic at a university, to my friend, the guy says 'I can't operate at the hospital', he says 'we don't have the authority'. How come. Did you get it, it's because of these last developments. I tell him 'I'm sending it to you, why?', the guy says 'I can only do it at a private hospital'. He says he cannot operate at a hospital. We are about master-apprentice relationship, as well as about theory. The guy is teaching this many hours a week, so if he's there he can actually do more for it. It is really about transfer of knowledge. Maybe it's like this in every job, every profession, but it is more so in ours. Our profession is like a mechanic, it is master-apprentice relationship, especially in surgical specialties. How can I explain? There is a big difference between seeing and performing an operation and reading about it and performing it. ... After a while there won't be any qualified people at the thing. I don't know how they will be trained. (R23, ENT, private hospital)*

Full Time Act did not only ban medical school faculty from practicing outside of medical school before 5 PM, but also banned them from teaching clinical practice classes and conducting operations at university hospitals. This is an attempt to dissolve clinical autonomy, as it is restriction on doctors' decisions on which medical care they will provide. Respondents have also stated this as a major limitation that has a negative impact on medical education, as the medical profession, especially specialties in surgery, is still seen as embodying "apprenticeship" in its approach to training. Therefore, Full Time Act is not only a restriction of the political, economic and clinical autonomy of the medical professionals whose ability to determine their own conditions of work are hindered, but also results deteriorating quality of medical education and service provided at medical school hospitals.

Another legal restriction that aims to prevent professional autonomy is the bill that is known as the Gezi Act. It has come up regularly in the interviews as a significant expression of AKP's hostility and ambition to control the medical profession. The medical professionals have played an important role in the Gezi Protests that have taken place in different cities in 2013, organizing quickly to provide care to injured. Medical professionals were arrested, some were injured themselves and there were lawsuits against some others. The controversial bill that was passed 2014 did not only also hinder political autonomy of the profession by controlling its conduct of work, but also wipes out the clinical autonomy of individual professionals as interferes with their responsibility to treat those who need it.

*TMA committee has even met with the President but... It passed anyway. This is acceptable at all. I travel a lot, I come across a lot on airplanes, with the "is there a doctor on board?" announcement. Am I going to say I do not have a license, what is it that am I supposed to do? (R13, public health, public university hospital)*

The bill states that those who perform health services without a license and authority will be prisoned to 1-3 years and 20.000 days of judicial fine. After much opposition, two limitations have been added to the Bill, which state "until

emergency health services arrive” and “until the consistency of health service is achieved”. However, respondents have still found it unacceptable as they argue that constraining a medical professional’s obligation to act is against professional ethics as well as public interest and fundamental value of service orientation.

## **5.2. Medical Education and the Future of Medical Profession**

Turkish medical profession does not have the autonomy to collectively determine the curriculum of medical education and the number of students that will be admitted and graduated each year. Instead, this authority lies with Higher Council of Education (YÖK), which determines the quotas for students and Students Selection and Placement Center (ÖSYM) which conducts the central exams that students take to be placed in medical schools. Health Professions Board established in 2011 and in which there are no representatives from the medical profession, was assigned with delivering opinion on medical training curriculum. Concerns about the soaring number of medical students, inadequate infrastructure, questions about the competency of some of the academic staff and the discrepancies among medical schools have been vocalized often by TMA. However, AKP governments and state agencies have consistently rejected its input on the issue. These themes have also been expressed by the respondents in this study, in relation to their concerns over profession’s lack of autonomy to determine its own training and its potential consequences for the future of the medical profession in Turkey.

Respondents present a lack of trust and confidence on the younger generation of medical professionals stemming from their lack of confidence in the medical education, which is under the control of the agencies of the state whose health care and education policies they do not approve. These agencies do not invite professional input this most vital process that makes a profession, the “production of producers” (Larson 1977). Respondents do not have confidence in the medical schools, especially those that have been established under the AKP rule, to train competent colleagues.

Respondents express concerns over number of medical students, which they interpret as potentially a negative impact on the quality, as well as status of the medical profession. Sustaining limited supply of professionals is one dimension of maintaining the privileged status of the profession in the society. Traditionally, the political autonomy to determine the professional supply enables the high status to be sustained, by possession of the right to determine the number of incoming and graduating students each year as well as the curriculum. In countries where the profession has been independently established, the professional associations maintain this autonomy. However, neither the medical profession nor its representative professional association in Turkey does not have this autonomy. Respondents believe that this increase is unsustainable and will negatively affect the quality and status of the medical profession.

*Now, normally if you admit 600 people...normally when there were 300 people studying at that school, 50 of them would turn out to be rotten. Fifty may be a very optimistic number. When you increase it to 600, you won't have equal number of rotten ones. More will turn out to be rotten. They can't even test that many people. Therefore, professors will go "don't bother me" in the exams. [Students] won't be able to see operation in operation rooms. They won't be able to see patients in class. They won't be able to listen to patients in the hospital, in the services, they won't be able to talk to them, examine them. (R19, pathologist, public university hospital)*

Another important concern that respondents express is the discrepancies between newly established and long-established medical schools. Standardization of professional training, traditionally institutionalized by the professional itself, is one of the significant aspects of political autonomy of the medical profession, as it creates a standard competency among the members of the profession, resulting in the public's trust and respect. However, the increase in the number of medical schools, majority of which the respondents argue are under a certain level of quality, hinders standardization of training and thus, quality of future health care services and potentially the status of the profession.

*I can't get my head around the new medical schools. They are unnecessary and insufficient. They are in every city. I, for example, as an older medical*

*Professional, cannot imagine a medical training without an anatomy lab. They begin training without basic medical sciences, with some clinics; it is easier to give (academic) titles to people now, they rapidly give out titles. (R8, pediatrician, training and research hospital)*

This leads the respondents to have a skeptic view of their future colleagues. None of the respondents agree with AKP's medical education and training policies, however since the profession does not have the autonomy to determine the number of medical students or the medical training curriculum, they express that they feel hopeless with regards to the future of their profession.

*In the not-too-distant future, 10 years later, if I, you or that person happens to have a problem, we may not be able to find a doctor to treat us." (R16, urologist, private hospital)*

Not having political autonomy as a professional group has a negative impact on professionals' view of the future of their profession. HTP and other AKP policies constrict the medical profession into a corner where they do not have the privileges of the past generation of doctors but have also lost hope for improvements for the future generation. Instead, they are pushed into a point where they themselves will become skeptical of the medical profession, similar to the attitude they argue the public has towards the profession in the present day.

### **5.3. AKP Governments' Rhetoric and Polarization**

A historical look at the relationship between Turkish state and Turkish medical profession demonstrates that it resembles the European or Scandinavian models in which the state plays a major role in institutionalizing and legitimizing the profession, making its existence possible through public education, employment and by mutual ideological and political support. The medical profession has helped legitimization of Turkish state especially in the Early Republican era, when medical professionals played important roles in health services but also in social and political life. However, the transformation of this relationship since

1970s also shows that it is affected by the political context and therefore it is not possible to refer to a given and stable relationship between state and profession.

The conflict between the state and the medical profession is not simply caused by a disagreement on health policies, but also rather a clash based on political and ideological conflicts. The social and political authority the Turkish profession had in other realms of society along with health care, and the constant political tensions in the country since 1970s have led the governments and the medical profession to confront each other on many occasions and issues. The mutually supporting relationship between the state and the medical profession in Turkey had started to strain in 1970s, in the context of a politicized society where the profession had located itself with the leftist political movements. The hostility in relationship had intensified after the 1980 coup, when TMA was shut down and its directors were detained.

The conflict has intensified with governments' persistent aim to privatize healthcare services since the economic liberalization efforts of 1980s. There were continuous reform efforts in line with Structural Adjustment Programs enforced by World Bank and IMF and liberalization of economy by governments in power throughout the 1980s and 1990s. The main was that problems of the fragmented health system laden with discrepancies of service provision to different sectors of society and rural-urban inequalities would be resolved by privatization, rationalization and managerialization of health services. While these reform efforts were not fully realized, one of the major promises of AKP to its constituents in the election campaigns in 2002 was to reform the health system. The most disadvantaged group with regards to access to health care was the rural and urban poor, a demographic that coincided with the group AKP targeted as its potential voters. As HTP was launched in 2003, the group that was presented as responsible for the malfunctioning of the health care system was the medical doctors. The doctors were the main providers of the health care services; therefore, they became the main target of AKP's rhetoric legitimizing reform efforts. Doctors had also been targeted by AKP as "educated elites who misused

their authority in society” especially against the poor that already had difficulties in accessing and paying for health care costs. The objective of privatization is a constant during the AKP governments since 2003, materialized with the introduction of HTP but political conflict reaches new levels with the Gezi Park protests in 2013. There the medical profession played an important role in treating the injured in the field and TMA had a voice as part of a coalition of opposition.

As an expression of this political conflict, respondents believe the AKP antagonizes the society against the medical profession with its actions and statements that discredit it. They argue that this attitude is to support AKP’s ambition to subject the medical profession to its control by dissolving its autonomy. The two reasons that lie behind the ambition to control the profession are, according to respondents, to turn the medical professionals into cheap wage laborers and to earn votes.

*Vulgarizing the doctor in his view; the doctor is going to wait in the corner, he’s going to accept all the patients that arrive... This kind of discourse reduces the doctor to the status of a worker, he is to do whatever he is told to do. Practices such as this that exist in the public sector also have a profound impact on the private sector. Because they implement something similar. As the state presses, reduces the opportunities, implements obligatory service, reduces monetary resources, says ‘shut down your private practice, you cannot work in private, you cannot do additional work’, as it restricts all this, then private hospitals do not pay over X lira, makes the doctor work on Saturday and Sunday as much as it likes, uses him with no consideration for work hours. (R21, internist, private hospital)*

This conflict between the state and the profession is not only limited to the collective level but also has repercussions on the individual level, as the hostile statements and arguments the government and its officials use against the profession cause the patients to become skeptical of the medical profession and lead them to challenge them in daily interactions. The doctors I interviewed in the field were in agreement that the AKP government had targeted them and exposed them to public’s hostility, declining their authority in public.



*What is the difference between me and a judge or a prosecutor? His salary is at least 3 or 4 times more than mine. People are scared to walk by his door, never mind scared, they respect him, why don't they respect me? Because (medical profession) is deprived of being a respected profession. Do you know the reason for this? It is to be able employ cheap doctors. Because some people have investments in this area. Since these investments will earn less if they pay the doctor more, they want to make it cheap. (R5, pediatrician, training and research hospital)*

*People's attitude is different; it is as if they are provoked against the doctors. They are more disrespectful, it's like doctors are targeted. At least it's how I feel. It's as if doctors are responsible for everything, for things that are not working as they should. In the past there was respect towards us, people were more attentive, now we are shown as people who should be complained about all the time, people who should be beaten up. (R7, anesthesiologist, training and research hospital)*

The loss of respect and trust of the patients which is partly provoked by the AKP governments' attitude result in a sentiment of devaluation and degradation. Although respondents mention not earning the level of income they deserve, they complain more about their feelings of loss of value and becoming obsolete in the eyes of the public. Respect and status in society is important for the legitimation of medical profession as a trusted group that has attained its autonomy, therefore for them losing these privileges imply a bigger loss compared to the financial.

According to respondents, there are four implied political messages underlying governments' discrediting statements that target the medical profession. The first one is that the profession and public do not only have a distance between them due to training and authority, but that there is also a class difference and social distance. Respondents argue that AKP governments' emphasis on these differences actually aim to imply that the medical profession misuses its hierarchical place in society as a tool of oppression and exploitation. While the power and information asymmetry make doctor-patient relationship open to abuse, the professional ethics, values and service orientation prevent this kind of misconduct. Nevertheless, medical professionals are portrayed by AKP as greedy elites, whose self-interests result in them financially exploiting the poor, an action that has been only prevented by efforts of AKP governments. It tries to legitimize this argument by claiming that HTP has brought on improvements in

their salaries, through performance-based-payment system, which allows them to earn a lot more than they actually can.

*Lies have been told on TV, 'We've increased their salaries', 'they can earn up to 15000 lira'. It was later understood that this was impossible. When lies were told about doctors being able to earn up to 15000 lira, minimum 3500 lira through points-based system, people have said "they earn so much and they are not never satisfied". So they have equalized doctors with money. This bothers us. Because in the eyes of the patients we are either trying to earn money or do not pay attention. (R21, internist, private hospital)*

Therefore, the changes in the financing, administration and delivery of the healthcare system under HTP is also strategically used by the AKP to discredit the medical profession in a way that will increase the skeptic perception of the public.

A second message by AKP, which is also related to its presentation of the medical profession, is the hostility it demonstrates to all educated professional classes. Respondents believe that AKP's virulent attitude is not limited to the medical profession, but, as many respondents worded it, to all "literate" (educated) fractions of the society. Since AKP's largest voter base has traditionally been less educated urban and rural poor, this polarization between what AKP conceptualizes as the elite and privileged educated urban population and the disenfranchised and less educated rural or marginalized urban population is strategically used to define its ideological foundation to its voters. It aims to intimidate and take under control all more educated groups in society in order to silence and prevent any opposition against it. The reason medical doctors are highlighted most often is that it is the professional group that the general population interacts most often with. Since these interactions usually take place in very stressful and intimate contexts, they are also easiest to provoke.

*There is indeed a hostility towards the medical professional in this government. However, in my opinion, there's hostility towards all well read people. When I think, I cannot separate the doctor from that. I think there something against all people who have received an upper-class education, who are above a certain level of education." (R16, urologist, private hospital)*

*There is an attack against not only the doctors, but all educated segments of society at the moment. ... it's not only against the doctors but since doctors generally represent the educated group, we get our share of that. (R25, nuclear medicine, public university hospital)*

These claims, according to the respondents, coincided with AKP's assertion to represent the conservative urban and rural poor who, it claimed, were denied an equal social position in society. It also highlights the social distance and privileged position of medical profession in modernization and secularization of life, against which some constituents of AKP situate themselves from. As claiming to be the party of populations that have been subordinated to the secular urban elite since the foundation of the Republic, presenting medical professionals as culprits is an attempt to equalize these different fractions of society. It is also used strategically to confirm the outcome of HTP and its claimed improvement in access to healthcare.

A third message implied in AKP's attitude towards the medical profession, according to the respondents, is that the doctors are presented as solely responsible for the failings of the healthcare system both prior to and after 2003. This is contrary to many models of profession in sociology, since in these models the profession and the state have a mutually endorsing relationship where the medical profession help legitimize public services and the state supports legitimizing the autonomy of the profession. In Turkey, the character of the relations between the medical profession and AKP governments have become almost the contrary. Instead of endorsing and supporting the medical profession, AKP government is discrediting and targeting it in order to claim that it has improved the healthcare services, posing medical profession as a historical impediment to functioning of public services.

*In the last 10 years, the difficulty of being a doctor is everything. Because in the last 10 years, the doctor has been singled out as the reason for all kinds of problems that stem from the health system. In every problem. In high fees, work conditions, in patient's contact with the doctor, in patient's arrival to the hospital. The doctor has been held responsible for everything. This is horrible. (R4, internist, private medical center)*

A final message delivered by AKP governments in their attitude towards the medical profession is a discourse that promoted a consumerist approach in healthcare services. This includes not only promoting and organizational structure that supports patient rights but also rhetorically implying the medical professionals are obliged to do whatever the patients (customers) want. By constructing the new healthcare system as one in which health is presented as commodity that can be traded and by emphasizing patient/customer satisfaction as a criterion by which performance of medical professionals are assessed, the government damages the trust fundamental to doctor-patient and public-profession relationship. According to respondents, AKP governments have willingly participated in dissolving the trust in these relationships by injecting financial concerns, and benefiting from it, as a strategy to increase skepticism of the public.

*There is no respect left, no love, no trust left. He [Erdoğan] constantly did that, 'attack them, bang on his door, barge in' or 'if there is something, it is definitely ill intentioned'. You hit someone you receive healthcare service from. And when asked, you say 'it is much better'. Do you think you can receive healthcare service like that? 'Yes, it's much better'. (R10, general surgeon, private hospital)*

They believe they are told that the doctor is nothing, healthcare is nothing, you can attack them right on. The perceived message is that they [doctors and healthcare workers] don't have any rights, the customer is the only one that has rights, only you have rights, you can do whatever you want. This is the message that is perceived, it is this administration that conveys this message.” (R19, pathologist, public university hospital)

While all respondents state that hostility towards the medical profession from the AKP governments is immense, they also state that the previous governments did not view the profession in positive light either. They point at 1980 Coup and Kenan Evren's presidency as a milestone in this sense. 1980s and 1990s hostility towards the profession correlated with the efforts of healthcare reform which aimed at privatization. State's hostile attitude in 1980s and 1990s was also

expressed as the denigration of public health service, especially the SSK hospitals, where the malfunctioning of the services was blamed on medical doctors. The respondents who worked in SSK and state hospitals in 1990s recalled the events where the past Ministers of Health made unannounced visits with members of the press to make a spectacle to show that the doctors were under the control of the Ministry.

The medical profession has been presented as responsible for setbacks of the system since then. However, one respondent highlights a mutually beneficial relationship between the state and a fraction of the medical profession, stating that there was a quiet consensus between the two parties behind spreading of private solo practice which has, especially by AKP governments, come to be identified with exploitation of patients and greediness. While the system had many failures and medical professionals were paid low salaries in the public sector, the state agencies did not create any inconveniences for establishing private practice, in a way encouraging doctors to open their own practice or operate it on the side while they work as civil servants.

The difference between the previous governments and AKP governments is the hostility instilled in the relationship. Respondents argue that while the relationship was also conflictual in the past as well but it was not based on hatred and hostility and the state did not create obstacles to the profession. Scarcity of resources was the major impediment that challenged their autonomy. What distinguishes AKP is the hostility and its provocation of the public. The government situates the medical profession as the opposition, using its political and ideological difference to pose it both as a target and scapegoat. All respondents in this field work approve AKP's generalization, locating both their professional group and themselves as individuals against AKP politically and ideologically. According to them, AKP is aware that the medical profession as a group in Turkey does not consist of its voter base and since their number is small, it is easy to view as disposable.

*The group that he is targeting is a very small group in terms of community, also in terms of resistance and in terms of pressure group, and in terms of votes. When you lay your hand on education, you're talking about a population of 1 million, 2 million. When you lay your hand on what not you're talking about a population of 400.000. However, the doctors who constitute the main dynamic of the healthcare sector is 120.000 people whichever way you look at it. What does it matter if all of the 120.000 people are a pressure group or all of them do not vote? (R12, public health, university public hospital)*

Respondents are aware of the social distance they have between the AKP voter base and themselves, but they are also aware that despite their higher status and authority in society, their small number has little power in conventional politics and therefore an easier target that is used as a tool to earn votes for AKP.

#### **5.4. Professional Association, State and Identification**

The professional association is the organization representing the interests of a profession as an organized body, mediating its relations with the countervailing powers of market, public and state. It negotiates profession's demands and voices its opinions, protects its privileges and most importantly presents a unified image of the profession, its members and accommodates self-regulation and self-discipline of the profession. Therefore, it is indispensable to protecting political autonomy.

The level of control over medical profession and the professional association also depends on the relationship between the state and profession (Immergut 1992). Considering the turbulent relationship between the state and the professional association in Turkey, which has become increasingly intense under AKP rule, respondents were asked about their views of the TMA. They were asked about their level of participation in activities of TMA or the local chamber, Ankara Tabip Odası (ATO), the extent to which they identify with their professional association, their views on whether TMA is able to defend professional autonomy, other rights and privileges against attacks from the AKP governments.

The respondents who were, or had at one point been, actively involved in local or national TMA activities or administration exhibited full trust in TMA by supporting the view that TMA is the ardent defender of the interests of the profession to the best of its ability and capacity. This group emphasized that while TMA's activities are restricted by the state and it's not as powerful as it should ideally be, it still fulfills its function of defending the profession, informing them about their rights and supporting them in legal matters. One respondent has described it as "they cannot be the remedy to our problems but they embrace them"; while another respondent stated "at least they can be a guide". The respondents in this group have emphasized that they are aware of the restrictions TMA comes across in the face of the government's efforts to hinder its legal power and political conflicts. The respondents in this group identified strongly as members of TMA, with one respondent who has been very active in its administration highlighting that the right approach to a professional association by its members should not view the professional association as an external separate body that works for individuals but rather an organization that professionals should participate in and identify with in order to receive their desired outcome.

*I never thought about how I can take advantage of it, because I do not see it that way. It's an institution and it is there to do anything for me. We have to do it together. I will go there and we will do something together. It is place that makes it easier for me to do something, a place that organizes. Otherwise it is not something that has power independent of me or has a magic wand in his hand; at the end of the day TMA is not a place that makes the health policies. For me TMA is a place that can build what we can do together by taking into consideration the ethics of healthcare workers, health policies, respecting patients' rights and professional autonomy. It includes man power and a tremendous accumulation of knowledge. Therefore, I do not get this point of view: 'What has it done for me?' It is not going to do anything for you, we will do it together. (R2, physical therapist, private medical center)*

On the other hand, the respondents who had a negative view of TMA present a detachment from identifying with it; with statements that reflect a view of it not as a professional association that they are members of but rather an organization that is external or above them. The respondents in this group had mostly never been active participants of its activities or administration. With this group,

TMA's embracement of wider political, ethical and human rights questions as professional issues have emerged as a controversial issue. The respondents who had a negative view of TMA have all complained that TMA was not prioritizing the problems of the medical profession but instead was too focused on, as one respondent put it, "more universal issues". TMA's preoccupation with political problems other than medical profession's needs and demands has been expressed as "doing politics" by these respondents.

*I don't believe that it is doing right in terms of doctors' rights, employee rights. I don't think they are doing anything right. ... TMA always had the obligation to give priority to its own members but TMA has always dealt with more humanitarian universal issues and put the problems of its own doctors on the backburner. (R14, anesthesiologist, training and research hospital)*

*It would be more favorable from my point of view if they approach some event less politically. (R3, radiologist, private medical center)*

TMA being involved in "politics" or having a "political identity" emerged as a common theme among those who expressed that they do not believe or trust in TMA to represent their own interests. Here, the Kurdish issue in Turkey were among the most frequently given explanations as to why they believed was too preoccupied with non-professional issues. These respondents implied that they were especially displeased that TMA, in their opinion, was too much involved in Kurdish politics. This also reflects a political fragmentation among the members of the profession, who are mostly seen as unified against the AKP government but divided internally as individuals who are pro-Kurdish politics as part of universal values that should be defended by the profession and those who have a subtle resentment towards TMA being too involved in wider political issues, which includes ethnicity politics encapsulated in the defense of the Kurdish question.

*I don't believe [them]. They have been doing politics for years. They have done "Kürtçülük", that was one way they have put off everyone. They are not honest. Ultimately everyone is thinking about their own interest. There is no association whatsoever. (R6, urologist, public hospital)*

*Honestly, for many years what has been said is that TMA is more after politics rather than professional issues, that they are more interested in all that, the*



*Kurdish issue, that issue, this issue. Are this our primary problems? To be honest, if we are doctors of a developing country, all issues are our issues but really, when the problems of medical profession is out there, not being concerned with them but with others has pushed people away. Besides being wrong, it was a fractionated period, and that still continues. Nationalism, so and so forth. Kurdish politics and all that. We could not get rid of this, no one could. Everyone had their share of it. (R10, general surgeon, private hospital)*

TMA's political identity as an opposition actor was also problematized some of the respondents who held a negative view of it. They stated that "being stuck in opposition" led to TMA not being seen by the state as a credible authority to negotiate or consult with. This causes it to be ineffective, according to this group of respondents, who state that by "being less political" and restraining its area of activities to problems regarding the profession and health policies, it will attract less reaction from the government with whom the association will eventually have to make some contact to solve the problems of the profession.

*Maybe today they are showing more effort, but since the old days they have had an eagerness to politics. This is the reason why they have always lost. Instead, they had to build better relations with the government, with the Ministry. If they had stayed out of politics and worked as a professional association, maybe they would have gotten better results. No what they do, the perception is "TMA? Oh okay, they are an opposition party"; so unfortunately, it did not happen. Now they are working a lot but it is not sufficient. Because they cannot even access the people who have the authority on the issue. They cannot go meet a Minister of Health. Unfortunately, it is not possible. ... It is due to being political. (R22, pediatrician, training and research hospital)*

A third group, who had an ambivalent view of TMA, represented a mixture of respondents whose participation to TMA was limited with paying their membership fees and those who, at one point in the professional career, served in the administration of ATO or TMA. The respondents in this group had neither a negative nor a positive approach towards TMA. "Paying their fees regularly" was a commonly used phrase among this group; paying their membership fees on time and regularly implied some sense of belonging, albeit weaker than the members who ardently identified with TMA.

*Our relationship is at membership level, at the level of paying our membership fees. Maybe it's our incompetence, we cannot attend. However, the conditions*

*and time are really restricted. We only have a Sunday and when they call meeting on that day no one attends. (R4, internist, private medical center)*

*Let me say this, my late father, what was is the membership fee then, 2,5 lira or something, he would go and pay his fee. My father has openly said to my face, 'Chamber of Medicine is cannot do shit, but still look after your Chamber.' So, I'm looking after it, that's it. He was right. (R5, pediatrician, training and research hospital)*

*We don't have a very committed relationship but from time to time we have something. I'm a member of the Chamber of Medicine, but I don't actively attend their meeting or anything. We pay our membership fees. That is how it is. (R21, internist, private hospital)*

TMA's "political identity" has also been raised as a concern for respondents in this group, as a factor that leads to their ambivalent view as well as an explanation for why some of their colleagues view TMA in a negative light. This group is similar in this sense to the group that view the association in a negative light, arguing that while existence of the association and supporting it is vital, TMA actually constitutes a danger to itself by embracing political values that do not directly concern the medical profession, according to the respondents.

*First of all, I think TMA should be free of any political view. Of course, it can have a stance. However, this stance should be in line with our general, our society, our constitutional principles, meaning a secular and modern stance. But that is it. I think people should be members of TMA no matter what their political views are. I think it should not be used for other objectives. Honestly, people have reservations about TMA. There are a lot of people who think they will be stigmatized if they are seen as TMA member or if they join one of its activities. They are not that wrong. There is a lot of stigmatization in our society. Therefore, they do not want to take active part in it, they even shy away from going to its meetings. They do not even want to be seen paying membership fees. This is ridiculous. As its name implies, it's TMA, of course you should be a member, what could be more natural than that? (R25, nuclear medicine, public university hospital)*

This respondent's statements present that it is not only the content political views of TMA that drive some colleagues away, but also the tense political atmosphere in Turkey which is encapsulated in the contentious relationship between the state and TMA that makes medical professionals hesitant about participating in the activities of TMA.

The findings in this chapter emphasize state's important role and precedence of profession's relationship with it. The profession cannot achieve public recognition and legitimacy solely through technical competence or claims of altruistic contributions to society. State's support is required to solidify its legal supremacy to practice and self-regulate and maintain its social status, social and economic privileges. Through respondents' statements, the relationship with the state is implied to be the determinant factor shaping profession's relationship with the public and the market. State's attitude and rhetoric towards the profession has an impact on the public, according to respondents. Since the beginning of HTP, AKP governments aimed to curtail medical profession's autonomy by legislative restrictions and by using denigrating rhetoric that provokes the citizens against the profession. how the state authority views the profession and expresses this view, bears an impact on how it is perceived by the public, not only as a collectivity but also in terms of the relationship between the individual professionals and patients on a daily basis.

In states, such as Turkey, where the state is the major provider of healthcare and employer of medical professionals, this relationship also has implications for their conditions of work. Respondents' statements also present that the regulations and organization of public healthcare services under the authority of state and state agencies have an impact on profession's position in the market and even on their most fundamental ability to practice. AKP governments made efforts to even further erode medical profession's political autonomy by taking control of all fundamental decisions related to its matters, restricting even the most basic clinical obligations, forcing medical professionals to act contrary to their professional ethics. It aimed to take control of economic autonomy by introducing legislation that limits their freedom of work, an action which it has taken exclusively against the medical profession. The partial political autonomy the Turkish medical profession historically had, exceedingly declined during AKP rule, affecting economic and clinical autonomy negatively. The tension between the state and the profession also reflects on the medical professionals' level of support and identification with their professional association. In a

context where it does not possess much political autonomy, TMA's position as an opposition force in society is not favored by some medical professionals, as they find reconciliation over their own issues and demands impossible as the tension between state and TMA persist. The ideological conflict with AKP, which perceives TMA as a threat to its existence, and the expression of this conflict in efforts to discredit the profession, causes a division among the profession based on skepticism towards their own colleagues and its formal representative.

## **CHAPTER 6**

### **PROFESSION-MARKET RELATIONSHIP AND PROFESSIONAL AUTONOMY**

Since 1970s, with increased bureaucratization, privatization and corporatization of healthcare services, the market has emerged as an important countervailing power challenging the medical profession's dominance in the area of health (Light 1995). There are two intertwined markets involved in understanding the transformation of the medical profession: The market for healthcare services and the labor market for medical professionals. These two markets which were viewed as dominated by the medical profession in the Sociology of Professions literature prior to 1980s are now shaped by other actors, the most significant of which are healthcare organizations (public and private, large or small), state agencies like social security institutions and third-party payers like insurance companies. The financial and organizational aspect of healthcare services are controlled by these actors, causing the medical profession to lose power and autonomy not only in determining their fees and volume of work, but also in how their services will be provided and the distribution of resources necessary to perform these services.

This chapter examines how medical professionals' autonomy is affected by the changes taking place in these two intertwined markets. In this sense, the chapter focuses the relationship between the organizational structure and operation of healthcare organizations which have become the main mediator between service providers -the medical professionals- and receivers -patients- and main employer of medical professionals. As a result, the medical professional labor market has also changed, as external rules and regulations determine the employment of the medical profession in corporate and highly bureaucratic organizations. By analyzing the in-depth interviews conducted with respondents in the field work,

this chapter explores the implications of the changes in the structure of the healthcare services market and labor market on the working conditions of medical professionals. In relation, it examines how these changes affect their perception of professional autonomy.

Accounts that analyze the historical development and institutionalization of professions generally focus on three or four actors that contributed to this process in Anglo-American and European countries: members of the profession, the public (clients), state and universities (Burrage et al 1990; Freidson 1970b; Larson 1977; Krause 1996; Berlant 1975). These accounts do not take into consideration the role of the market or service providing organizations since while hospitals have existed prior to 20<sup>th</sup> century, healthcare market was mostly comprised of solo practicing medical professionals as the prevalent form of service delivery. These theories also focused on agency, power and status of professions in society and viewed professions as unified groups pursuing collective interests. In these analyses medical profession is attributed almost absolute autonomy, which enabled monopoly of services, of labor market, self-regulation and control over content of work. The physical space or the organization structure they worked in was not usually elaborated on.

Until the second half of the 20<sup>th</sup> century, medical professionals were traditionally solo practitioners who receive payments for their services directly from their patients, rather than employees who work for and get paid by a bureaucratic organization. This had allowed them to immense autonomy over their work, in economic and clinical sense, and also reinforced their authority in the public's view. The image of the fee-for-service solo practitioner who treats patients in his own practice or through house visits started to change as the market for healthcare services became more dominated by healthcare organizations. This has been accompanied by public service delivery and social security institutions, private insurance companies and other third-party payers and providers. Second half of the 20<sup>th</sup> century witnessed an expansion of healthcare sector, as well as the formation of centralized public health services in some parts of the world,

which resulted in prevalence of larger institutions and organizations as provider of medical services (Elliott 1972).

This is an important shift from the emphasis of traditional Anglo-American focused theories of professions, which view market closure as a privilege that distinguishes professions from other occupations and that reiterates its authority and power in society (Larson 1977). Profession's autonomy over determining supply of its members, criteria for entrance into the profession and required credentials to practice allows it to have a market monopoly over services, which becomes an important source of power in the face of other countervailing powers. However, changes in the shape of the market for healthcare services in the second half of the 20<sup>th</sup> century, had a transformational impact on the shape of the market for medical professional labor as well. Healthcare organizations becoming prevalent providers of services resulted in an increased tendency of medical professionals to become employees, rather than solo practicing self-employed. Turkish healthcare sector has also witnessed a movement in this direction, with restrictions brought on private practice, expansion of private healthcare sector and changes in the structure of public healthcare service financing and delivery. This development has affected autonomy of the Turkish medical professionals over their fees as well as their conditions of work.

Advancement of medical science and technology was another development that led to increased tendency of medical professionals to become employees in healthcare organizations. As medical technologies become more complex, diverse and costly, they require more staff, space and capital. The increasing complexity in the delivery, financing and organization of healthcare services causes these services to be housed in larger and more complex organizations, embodying an elaborate division of labor, carried out by a larger teams of healthcare professionals and occupations (Liberati, 2017). While medical professional remained being the direct providers of medical services, employing organizations act as mediators between professionals and patients, who no longer have a direct financial relationship between them.

Both in the public and private healthcare sectors, concerns emerged about prioritization of cost efficiency, productivity and principles of managerialism replacing clinical judgement. New ways of organizing and delivering healthcare were manifested in standardization practices that allowed assessment and control by external actors, based on quantity rather than quality of services. Performance assessment tools started to be executed by management instead of implementation of professional self-regulation. In this context, healthcare organizations have a central role in determining employment arrangements, work conditions including volume of work and fees and remuneration. This leads them to have a significant power in facilitating or constraining professional work (Leicht and Fennell 1997).

By analyzing in-depth interviews conducted in the field work, this chapter examines how the changing structure of healthcare services and medical professional labor markets, which have come to be dominated by actors other than medical profession, affect professionals' perception of autonomy. The economic and clinical dimensions are critical in understanding the impact of organizational structure of healthcare services on professional autonomy. It will also aim to answer the questions whether the medical professionals view professional autonomy as one single value or make distinctions between economic and clinical dimensions. The economic decisions respondents were asked about in the interviews included volume of work, distribution of resources, payment methods and employment conditions. The chapter will present whether professionals view their autonomy over economic issues as having an impact over their clinical decisions and their coping and negotiation mechanisms in the face of changes to their autonomy. It also examines to what extent organizational structure and management impacts these dimensions and whether medical professionals view them as two independent, distinct dimensions of autonomy. The differences in perceptions of professional autonomy among those who work in public and private healthcare organizations will also be examined. Considering the diversity of type of organizations, employment arrangements and work conditions, it is important to point out that corresponding experiences



of respondents are also diverse. This diversity is reflected in their perspective of extent of professional autonomy, as not only their views and perceptions as members of a group but also their individual narratives on how they negotiate and navigate their work environment is taken into consideration. I argue that while all medical professionals experience changes in their professional autonomy in the face of restrictions that monitor and control their professional activity, these experiences are also diverse. They are reflected in their perspective of extent of autonomy, which becomes evident when they are examined not solely as a unified collective group but also as individuals who negotiate and navigate their work environment. It is important to study the medical professionals not only as a unified group but also their individual behaviors, reactions and perceptions, since they work in a variety of types of organizations and under differing contexts (Hoff and McCaffrey 1996). The chapter concludes with an analysis of how medical professionals define their professional autonomy and whether their conceptualization of it has changed as a result of their conditions of work in a changing healthcare and labor market.

### **6.1. Professionals' Conflictual Relationship with Management**

Management, its demands and direction comprise a large part of medical professionals' daily working lives. Management cadre determine the conditions under which doctors work and control economic aspects of the operation of the healthcare organization. Their imposition of practices of control cost effectivity clash with professional values by constraining professional autonomy.

Management imposes managerial criteria to evaluate medical practice, prioritizing economic efficiency of the organization. Respondents argue that they are not evaluated based on medical criteria, which is against professional values and the nature of quality healthcare. Alignment with predetermined budgets, performance indicators, managerial reviews replace evaluation of wellbeing of patients (Harrison and Ahmad 2002). With the institutionalization of bureaucratized administration of healthcare, executed by a managerial class,

there is a shift from peer assessment to managerial assessment, allowing external control over medical practice. This results in doctors viewing management in a conflictual light, since they feel their autonomy is restricted by managers. They no longer feel exempt from external evaluation; they feel their authority of medical decisions are captured by management.

Professions and management are traditionally seen in conflict in Sociology of Professions literature; the underlying reason of which is management's impact on professional autonomy. While some scholars argued that technical (i.e., clinical) autonomy is sufficient to describe medical profession as autonomous, an analysis of respondents' statement on their relationship with managements present that the technical and economic dimension of autonomy cannot be uncoupled in a clear-cut manner. While most of management's control lies in the economic and logistic aspects of medical practice, clinical decisions are impacted by their direction. Both in public and private healthcare organizations, management has authority over almost every condition of work. They assess performance based on quantitative indicators, such as volume of work, number of patients, revenues; they determine the volume of work for medical staff; they make the decision on distribution of resources, which technology and to acquire and, in some cases, how much they are to be used; they draw up contracts, determining salaries and method of payment; organizing staff and work flow.

When respondents talk about their relationship and experience with this new stratum involved in medical practice, they use a narrative that can be encapsulated as "us versus them", implying that they are two distinct groups, not colleagues, mostly in conflict. Respondents who work or have experience working in public hospitals reminisce of the past when the medical professionals were also responsible for administration of the organization, in control of logistic and economic decisions. In the administrative hierarchy, *Başhekim* was a medical professional who was the chief in charge of the medical, administrative and training processes. All personnel and doctors working in the hospital reported to *Başhekim*. With HTP, hospital administrators and directors whose

responsibility were administrative, economic and logistic issues, were appointed to public hospitals (with private hospitals already having professional administrators). This way *Başhekim*'s responsibility were mostly relegated solely to medical issues.

*In the past başhekimlik was a more influential and authoritative post in the hospital organization. Now a CEO has been appointed as hospital manager. He is in a way above başhekim. He is more influential. (R7, anesthesiologist, training and research hospital)*

Management by colleagues is no longer the case, as the managers have replaced *Başhekim* as authority for administrative authority in public healthcare organizations, similar to that of private sector organizations. Health management has become a distinct area of work, with its own curriculum. Respondents underline that hospital managers are almost always people with Business Administration or Economics degrees, with no grasp of medical practice. Respondents draw attention to managerial staff's qualifications in order to highlight the differences among them. Managers' degrees in Business Administration and Economics have been often mentioned, as well as one respondent using pant suit (*tayyör*) as an example to make underline its distinction with the white coat:

*The term CEO has arrived. Business administrator. They have no idea about the field so think about everything on paper but honestly, that's not how it works. ... For example, the organization of the appointment system, purchase and sale of devices, I don't know, the organization of nurses who will work in departments. ... It is usually people outside of medicine who do this stuff. They usually have a tendency of not listening to the doctors. They have usually graduated from business administration departments. At least they have an MBA. (R16, urologist, private hospital)*

*Two terms have emerged, hospital administrator and hospital başhekimliği. Head nurse [başhemşire] no longer exists. Those navy blue dressed head nurses tuned into people that wear tayyörs. They have become hospital services managers and started wearing tayyörs. The person we call administrator have become completely inaccessible. (R8, pediatrician, training and research hospital)*

The distinctions in qualifications and attire are made to emphasize that the managers are not from the medical world and they do not make decisions based on medical criteria but rather financial ones. Their attention to financial indicators or imposition of managerial principles are not suitable to nature of medical practice. New managers that come from non-medical disciplines also have a different, a more business-like manner of interaction with doctors, according to respondents. When administration was in the responsibility of colleagues, doctors were able to voice their concerns about the day-to-day operation of the organization or resource allocation to the *Başhekim* since he was also a colleague. A respondent stated that they would eat lunch together and voice their demands to the *Başhekim* during lunch, collegially. In a way management of the hospital was part of collegial relations. With the new management departments, this is no longer the case; they are two different groups operating in different circles in the same organization. They do not have collegial relations, as implied by respondents' statement in which they indicate that when the management is not happy with their performance, they are "summoned" to the managers' office:

*A very senior professor who has been working for years has told me, 'We have reported to başhekim for many years, they were our friends or our professors, when we saw each other at lunch we would tell them our problems and they would tell us what they were not happy about. Now I receive a phone call, we are being summoned to his office, I have to go'. An economics graduate, for example. 'Hocam' he would say, 'Last month you have done 15 iodine therapies, you have to do 50, it doesn't save the day.' This is a patient. 'Will I go to the hallway to find a patient? How can this be? That guy is an economist, not a doctor, that's how he tells it', he says. (R25, nuclear medicine, public university hospital)*

The managers' directions based on financial indicators interfere in clinical autonomy. Medical professionals view some of these demands as unsuitable with realities of medical practice, although they have no control over these demands. How respondents perceive their professional autonomy with regards to managerial pressures is one dimension that shows differences within both the public and private sector. While all respondents believe that their absolute autonomy is not regarded by the management of respective organizations, it can

be observed in statements of private sector employees that there is no uniformity in private sector's attitude towards professional autonomy. The amount of managerial pressure that aims to constrain their autonomy presents a range from complete control to allowing reasonable discretion. However, even the respondents who state that their management do not impose a lot of pressure to control their actions also argue that, in words of one respondent, "You're a good child as long as you earn them money" (R20). Therefore, even when they are allowed their professional autonomy to wider extent, it is based on the condition that they bring in revenues. Considering the range of perceptions of autonomy in the private sector, for most respondents' autonomy now has a conditional and organizational character, rather than professional.

The differences within the private sector are varied, including the work conditions, payment methods, volume of work and restrictions on autonomy. However, doctors working in public sector also experience differences, most notable in their perception of professional autonomy. In this sense, respondents who work at university medical school hospitals distinguish themselves from their colleagues working in training hospitals and public hospitals. While academic medical professionals also experience difficulties in their practice stemming from budgets and time restrictions, they state that they believe they have more autonomy over their work. They accept that their autonomy is also to an extent restricted, however, they argue that these restrictions are not a result of pressures put on them by managers in the name of earning more revenues, but rather by inevitable financial and infrastructural difficulties and shortages. A respondent who works as an associate professor at a medical school hospital argues that while they have to struggle with similar financial obstacles as their colleagues in private and public hospitals, they have more autonomy since they are not subject to as much surveillance, although in reality they are also required to record their every action in order to receive performance-based-payments.

*For our university, at the university in general, if leave aside the pressures of the system I have previously talked about, like you have to care for many patients, you have to accept all patients, et cetera et cetera... But our profession*

*is autonomous, this still persists at universities. But I cannot say this for private hospitals and hospitals affiliated with Ministry of Health. Because it is very direct there, being directly under common registration system, being subject to surveillance, observation, they inevitably feel the pressure of the management on their back. (R12, public health, public university hospital)*

*I think we are still autonomous here. But in individual practice, I don't have a dependency, but I have obligatory dependencies. For example, our specialty depends a lot on technology. For example, our cameras get old. We need to buy a new camera. But we come across obstacles of budgets. (R25, nuclear medicine, public university hospital)*

This argument is striking since it presents an example of how academic medical professional distinguish themselves as having higher autonomy compared to their colleagues, although they work under similar pressures and obstacles. This can be explained by medical school hospitals being tertiary healthcare organizations, which receive cases more complicated in their nature and less in their number, also allowing research and training. Academic medical professionals situate themselves in a different terrain than their other colleagues, arguing that the specific type of their organization allow them more professional autonomy, although in reality their autonomy is still restricted by similar economic factors, if not directly by managerial staff.

These factors which are a result of changes in the structure of the health care services market and medical professional labor market, organization of the workplace and their conditions of work, all of which they no longer have dominance over, do not only have an impact over doctors' economic and clinical autonomy. They also lead medical professionals to have different perceptions of their professional identity, compared to prior to HTP. Decline in their professional autonomy impacts their self-identification of professionals and values and qualities identified with professionalism.

Prioritization of cost-effectivity through increased control of their actions by managerial practices contradicts with respondents' professional values and aspirations. These practices disregard doctors' indispensable need for professional autonomy and imponderable nature of clinical knowledge and

judgement. Respondents feel that this disregard trivializes and depreciates the profession in the current health care services market. As an extension of this feeling, they often use examples of other occupations in order to explain what they feel their profession resembles under HTP. These examples are occupations and practices that are generally seen as contrary to values and status of the medical profession, such as tradesman or manual worker. These are occupations paid per piece they sell or produce. They do not embody values of altruism or service orientation, implied as not indispensable to human life and are viewed as solely providing livelihood to the people who practice them. Some occupations that were mentioned by respondents were “*ayranıcı*”, “*yoğurtçu*”, “*patatesçi*”, “*pantoloncu*”, “*tüccar*”. Performance-based payment is a significant aspect of changing work conditions when making these comparisons, since it resembles payment for piece-meal work, a payment scheme viewed by respondents as unsuitable to characteristics and qualities of medical practice. One respondent has emphasized that people who provide services critical to human life, which include medical professionals and teachers, should not constantly have to think about how they will make a living. Another respondent highlighted that health care is not a product that has elasticity of demand, which implies a possible change in customer demand in the face of change in the price of the products. However, health care organizations and their managerial practices that aim to control medical professionals’ actions and constrain their autonomy function in ways that assume that medical practice can be adjusted to changes in the market conditions and financial fluctuations.

There are two important questions this study aims to answer. First, do the respondents perceive their professional autonomy as declining? Second, do they make a distinction between economic and clinical aspects of their professional autonomy?

In answering these questions, it is important to acknowledge that there is variety of organizational settings and conditions medical professions work at. Public and private health care organizations have similarities and differences between, as

well as among them. This makes it difficult to observe one single, uniform trajectory of change in professional autonomy. Instead, medical professionals under different conditions experience varying levels of perceived autonomy, which may correspond to economic or clinical or both kinds of decisions.

Half of respondents in this research, equally composed of those working in public and private sectors, perceive their professional autonomy as declining, with some even stating that it is no longer existent. They imply that strict decoupling of clinical and economic autonomy is not possible and plausible, that interference in their economic autonomy affects their clinical autonomy negatively. They place significance on their autonomy over distribution of resources and volume of work, which, for most, is the most fundamental indicator of loss of professional autonomy over all.

This contradicts with some work in literature on professional autonomy that argued that organizations and professional values are not necessarily contradictory. Against arguments of proletarianization and deprofessionalization, these studies have claimed that employment brings secure income and therefore freedom from burden of making economic and managerial decisions, while solo practitioners work under a lot of pressure to make economically sustainable and sound decisions (Hoff and McCaffrey 1996; Lin 2014). However, the majority of respondents in this research argue the contrary. Since a major portion of their income relies on performance, i.e., volume of work, both in the public and private sector, concerns over financial situation or distribution of resources in organizations may result in external direction of their action. The medical professionals in the Turkish health system are inevitable concerned about economic and logistic arrangements even when they are employees in an organization. The respondents who had experiences of solo practice eulogize and are nostalgic for it, not because they were financially more secure. They rather emphasize the autonomy it provided them over their volume of work, to spend as much time as needed on patients and being able to decide all aspects of their clinical actions.



On the other hand, the other half of the respondents argued that they still maintained their professional autonomy, despite restrictions and interventions by external actors. This group embodies two distinct sub-groups: One is those who argue that their professional autonomy is intact since it is the driving value that keeps them working despite circumstances. They state that if they felt it decline, they would quit medicine. This group presents how strong professional culture and values internalized through socialization process is in shaping their perception of autonomy. The second group is composed of respondents who argue that the profession as a whole and their colleagues working in other organizations are losing autonomy, while they, as individuals, maintain it due to their specific conditions of work. These respondents in this group who work in the private sector implied that the managers in their organization do not “interfere as much” in their work. This presents the existence of sharp distinctions among private organizations, since half of respondents who stated very strongly that their autonomy has declined also work in the private sector. The respondents in this group who work in public sector are mostly academic medical professionals who argue that their professional autonomy is largely intact in medical schools, with little or no interventions from outside forces. However, they emphasize that due to restrictions on budgets and resources, their autonomy is limited to “clinical decisions”. Therefore, one factor that determines the professionals’ perception of extent of their autonomy is how restrictive and overbearing managerial demands and interference is.

The two groups of respondents who argue they maintain their professional autonomy imply a clear distinction between economic and clinical dimensions of autonomy. They do not repudiate that rules and regulations of SGK and efforts to reduce costs and increase revenues by management interfere with economic aspects of medical care. However, since this interference is isolated to financial and logistic issues and do not directly interfere with their clinical decisions in form of pressures about how to diagnose or treat patients, they believe that they retain their autonomy.

## 6.2. Volume of work and Time Pressure

Discretion over managing volume of work is a significant dimension of economic autonomy. Medical professionals' autonomy over how and on whom they spend time affects the content and quality of their work. Respondents both in public and private healthcare organizations have stated that the time they spend per patient is determined by management and automatically assigned to each patient, regardless of the particularities of the case. Restrictions imposed on the time doctors can spend on patients emerge as a work condition that constraints their professional autonomy. Respondents have stated that having a restricted amount to examine a patient affects the relationship doctors build with their patients, the diagnosis and choice of the appropriate treatment.

*An outpatient clinic system has been designed in which every doctor is forced to care for 150 patients. What does this mean? If you put 150 patients in front of a doctor who will approximately work for 480 minutes, you will have 4 minutes per patient. You can do nothing with 4. Then the doctor will exercise in a way that intends to brush off the patient. He will either ask for tests, or blood tests, or radiological tests, or will write a prescription and send the patient. This has nothing to do with providing service in healthcare. (R11, radiologist, public university hospital)*

In both public and private healthcare organizations, standardized automated time intervals are appointed for each patient. Doctors are allowed fixed time per patients, regardless of the severeness or complexity of patient's condition. This practice contradicts with the uncertain and complex nature of medical practice, which requires doctors to decide how much time they spend with the patient independently, based on the specific case, to be able to decide on the appropriate diagnosis and treatment.

*There are many doctors who do not talk to the patients, do not look at the patients at all, do not hear the voice of the patient. ... They stick the names of 120 patient, these will all be cared for, it's your problem, eat your lunch if you want, or don't, that's up to you. If you want, curl up patient's face and month and stick in a medicine in 10 seconds. They do the same thing to anyone that comes along and send them away. (R19, pathologist, public university hospital)*

*Sometimes even 10-15 minutes is not enough to evaluate a patient. There can be very complicated patients. I think it should be stretched out based on patient. A patient comes and you are able to understand his problem in two minutes. You can write his tests or prescription. But another one may require half an hour, to be evaluated, to explain to the patient. (R21, internist, private hospital)*

Respondents stated as a result of restrictions placed on the time they spend with the patient they are not able to receive sufficient information from the patient on their medical history and health complaints. This leads to frustration on both sides, as the doctors end up with inadequate information on patients and patients feel that they are being brushed off.

*There can be patient, you can solve his problem in five minutes. It's a classic, cliché, compatible with your experience... You diagnose in the fifth minute, you're done. But you may deal 45 minutes with another patient. He comes to you with a file, with all details. If you know what I mean. Then they act up, 'He spent 5 minutes for me, the other one gets 45 minutes'. He waits outside. He has been examined by me before, it had been done in 10 minutes, 'he spends more time with the other guy, does he chat with him'. These kinds of things happen, you know what I mean? (R16, urologist, private hospital)*

Although respondents find the standardized fixed time intervals for appointments, which range from 5 to 15 minutes depending on the organization inadequate for providing quality healthcare, both public and private healthcare organizations are managed through managerial principles that are imposed administrators and managers who are not medical professionals. The main aim of these principles are accountability, productivity and efficiency, which require measurable standards to assess work conducted in the organization. Restrictions placed on time per patient is an example of a managerial practice that enables medical practice to be standardized, and therefore making it accessible to outside, which implies non-professional, assessment. It is also imposed to make sure that doctors see the number of patients that will allow the organization to bring in the maximum possible revenue to the organization. Management imposes fixed time intervals to keep track of each doctors' volume of work, not based on the quality of care they provide, but rather the quantity, which implies how many patients they see per day and therefore how much revenue they bring into the organization.

*We struggle for the wellbeing of the patient, he [management] says, you are not allowed. You will increase the number. You will not decline. How many patients have you seen? 50 patients. How many of them have gotten better? How many of them have you given the right treatment to? Nobody asks that. It's just numbers. (R22, pediatrician, training and research hospital)*

*It's all about, the more you do the better. There is no such thing. I give this most basic example; the duration of examination has been reduced to 5 minutes. If you put a gun to someone's head, if a soup or a dish cooks in an hour, the ideal, it cooks in an hour with its taste, flavor intact. If you offer it after half an hour, what does it taste like? Our job is exactly like that. (R3, radiologist, private medical center).*

Accountability to managerial control is demanded in bureaucratized healthcare organizations; standardized time intervals are one way to achieve this accountability. Standardized time intervals allow easier surveillance of physician activity, not only in financial terms but also to measure how much work is achieved on a daily basis. One respondent has stated that the volume of work being observed through surveillance enabled by time intervals and electronic patient record systems results in “feeling the pressure from management on their necks at all times” (R12)

Fluctuations in the doctors' volume of work, even when it is out of his or her control, becomes a source of conflict with the management who have a standard expectation of number of patients parallel to an expected amount of revenue that will be brought in by the doctor. However, the expectation of standardized volume of work does not always correspond with the patient flow; as one respondent argued it may even be affected by the seasons in her specialty.

*So, a characteristic of my specialty is that I don't have many patients in the summer. I have patients in winter. Since I have started here 4 years ago, almost 5, for 5 years my revenue declines in the months of July and August. But for the past 5 years they call me in every July and August and ask 'what's the deal with your revenue?'. Although I have explained many times that I do not have patients in Ramadan, you don't get chest patients, you don't get chest patients in the summer. Still, they have not gotten tired to asking what the deal is with my revenue in July and August. This year I did not care for it at all, I said 'Don't worry, it'll get better, it'll get better'. That's how I managed. (R20, internist, private hospital)*

Public and private healthcare organizations are similar in the way that they only allow a standardized fixed time interval for examinations, which according to a respondent who works at a private hospital, defeats the purpose of providing a more exclusive service at private sector. She stated that while patients believed that they are receiving “special care”, since they are at a private hospital and pay more out of pocket, time allocated per patient is actually the same as at the public healthcare organization she used to work at. The respondent argued that the amount of time she can spend with the patient and having no autonomy over it does not make any difference to the quality of service she provides in the public or private sector.

*For example, the hospital I'm working for is actually a hospital that serves the public, it's only private in name. The group of patients we get is similar to public hospitals'. It is just that the state pays a certain fee to the hospital, for serving in its behalf. Poor people think these hospitals really provide exclusive, different service. However, an eye doctor sees 30-40-50 patients a day in the public hospital, in the private hospital he also sees 30-40-50 patients. What is it about going to private practice, it means the doctor spends more time with you, informs you more, being able to talk to your doctor in a more comfortable environment. That's not how it is here. There is no difference. Imagine, he sees 100 patients. It is also like that in the public hospital. There is no difference. (R1, neurologist, private medical center)*

When the appointments are organized to occur back-to-back, leaving no possibility to take a break, time restrictions do now only affect the quality of the service provided by the doctor negatively. It also leads to his/her mental and physical capacity to be deteriorated.

*In terms daily routine, there was no such thing as break between patients. I first started with 40-minute consultations; I had made the bargain saying I would only accept the position with these terms. Then I had to... with the duration of consultation. First consultations were 30 minutes, the next ones were reduced to 20 minutes and these were back-to-back. I was starting at 9 and seeing patients back-to-back until 12. I was only able to go to the bathroom running if someone was late or something had happened in between. (R18, psychiatrist, private practice – private medical center)*

According to respondents, taking no or very short breaks between patients becomes dangerous not only for them, but also for the patients, since it affects

their clinical judgement and even forces them to take short cuts in their assessment of patients. This may result in unnecessary tests and diagnostic procedures, which may be risky for patients in some cases.

However, respondents also argue that they rely on their clinical judgement to cut corners and depart from the managerially designated standards and routinization. Some have come up with a survival technique, as a resistance to managerial practices, which includes negotiating time per patient based on their clinical judgement. They balance time between patients based on which case they think requires more time and attention. However, two respondents stated while they believed this practice of professional autonomy in a covert way is necessary for providing better service, it creates tension in the waiting line. Since patients are aware that they are allocated a standard time interval, they may question why the patient before them was in the examination room longer.

While medical practice with its nature that requires accommodating uncertainty and complexity, cannot be standardized, spending the same amount of time per patient does not necessarily mean equal quality of service. Management's interference in time spent per patient may seem as a logistical matter, as simply an interference in the economic dimension of their professional autonomy. However, pointing out to how time restrictions affect their decisions on diagnosis, treatment and quality of their service, respondents highlight that standardized automated time intervals cause one of the most overt restrictions in their clinical autonomy.

When talking about different dimensions of health care service provision, respondents almost unanimously mention that public and private healthcare sector increasingly resemble each other. They emphasize that this is especially valid for work conditions and degree of autonomy of medical professionals. In both private and public sector professionals, the most important similarity was the overwhelming emphasis on increasing tendency of financialization of medical decisions. This is highlighted as having the most profound impact on

their clinical autonomy. Managerial pressures for cost efficiency are reflected to doctors as demands to increase patients, restrict time per patient, increase or decrease amount of tests and procedures conducted (usually based on how the organization is reimbursed by SGK) and fluctuations in their salaries. While the content of demands by management may differ, the perpetual emphasis on cost efficiency puts pressure on the doctor to perform in a way that is not necessarily in line with his/her clinical judgement in both sectors.

*What is indeed broken there is the doctor's own knowledge and free will... The fact that what he will ask for a patient will tend to turn towards algorithms and more cost-effective ways. I might ask for a certain test which will allow me to direct the treatment in the right path, but it may not be cost-effective. May I will do something cost-effective, won't ask for all the test, I will only do one, it will hit the mark and I won't need the rest. This is what autonomy is about. I think this autonomy, the autonomy in patient management has deteriorated. (R8, pediatrician, training and research hospital)*

This pressure results in similarity in medical professionals' volume of work. Respondents working in both private and public hospitals have complained about the overwhelming number of patients they have to see each day, which also corresponds to the limited time they have to spend per patient. A respondent who works at a private healthcare organization and is retired from public sector argues that private healthcare organizations do not offer "special" or "exclusive" care, since the number of patients she sees daily is almost the same as the very busy public hospital she previously worked at. While SGK coverage of partial fees at private healthcare organizations made them more affordable, therefore increasing demand for them, the volume of work resembles that of public healthcare organizations, affecting the quality of care.

Increase in affordability and accessibility of private healthcare organizations have led to an expansion of the private sector, attracting more medical professionals to work in these organizations. However, two respondents who have switched from working in public sector to private have pointed at a unique situation that makes a remarkable difference in their work conditions and quality of care between public and private sectors. In the private healthcare

organizations, medical professionals are either the sole specialist in their area of medical practice or one of the few. This creates problems when they leave work at the end of the work day after they conduct a procedure, a condition in which patients may need further care, when they go on annual leave or when they have to take a sick day. Since they are the only specialist and do not have training structure that includes interns and assistants to support them, they are constantly required to be on the job and on call. One respondent who is an otorhinolaryngologist (eye doctor) stated that when he started working at a private hospital after more than 20 years at a public training hospital, he realized that assistant and resident doctors had lifted a lot of his load, especially in later hours. He stated that additionally, since there are not many staff at night, he had to reduce the number of cancer surgeries he performs. These statements demonstrate the importance of team work and other health care workers in health care; even when a specialist is responsible for conducting the treatment, more staff is required for patient care.

### **6.3. Consumerism: Increased Emphasis on “Customer Satisfaction”**

Changing healthcare environment in Turkey led to new priorities in assessment of medical practice. Consumerism and in extension, customer satisfaction, is one of the managerial principles that enable external (however, non-medical) assessment of medical professionals. Privatization of healthcare services led to prioritization of customer satisfaction, since patients are needed for private organizations to operate. This approach has also been utilized for public healthcare HTP. Official Ministry of Health documents, as well as statements by Ministers and government officials have also contributed to this approach. Patients are encouraged to consider the improvements in the health system not in terms of quality of services, but rather non-medical, and even physical aspects of services and facilities.

This approach leads to customer satisfaction, which is not necessarily a reflection of quality of care, to become a criterion in assessing medical professionals by



organizations who want to keep volume of business. Financially concerned healthcare environment dictates that assessing medical practice, which is not possible to achieve through lay knowledge, is to be conducted by non-medical criteria. Therefore, while management in organizations considers costs and revenues, patients are encouraged to consider physical appearance of facilities or hospitality services, rather than quality of care.

*The guy says 'never mind, let's go private and will be comfortable'. You go in, sit down, there are flowers, plant pots, people with smiles. I'm not saying that this is wrong or in vain. Of course, it is not good when there are fights and people pushing each other when you walk in. But this is not the main thing I'm looking for. Let's see what will ultimately happen? How many billions will they take from you? Will you be treated? Will you have confidence in that treatment? How will you know that that guy has done it right? Maybe you did not even need that operation or that procedure in the first place. (R19, pathologist, public university hospital)*

While being imposed to ensure customer satisfaction emerges as a significant theme among doctors working in both public and private healthcare organizations, it affects those in the private sector more predominantly. This results from private healthcare organizations often promoting themselves with emphasis on elements that emphasize ensuring the making patients satisfied not only in terms of medical attention, but also the physical and infrastructural aspects of the organization. Respondents stress that patients pay more attention to the appearance of the healthcare organization and the behavior of the doctor, rather than the effectiveness of the treatment.

*The patients are very happy about it. They think this is good. 'We don't wait anymore, we can go to any hospital we want', they say. There are better hospitality services, more hygienic environments, so on. I also think it is better in that sense. However, the quality of the service, its inspection, I don't know how much they can do about these issues. (R7, anesthesiologist, training and research hospital)*

*Some has improved in terms of management quality, really luxury hospitals, this and that have emerged. However, within that luxury management quality, the product quality, can he say 'I've had the right operation, I was prescribed the right medicine, it loves me'? I can't say. (R12, public health, public university hospital)*

Patients evaluate the service they receive at the organization based on the waiting time, hospitality services or aesthetics. While respondents state that lay knowledge is not sufficient to evaluate the quality of their work, they also complain that whether they are being treated or not becomes secondary to how the doctor approaches them. They argue that patients judge them based on their “friendliness” or “liveliness”, which are qualities irrelevant to the quality of medical services they provide.

Doctors have to face scrutiny by the management in case their number of patient decline or a patient makes a complaint about them. When asked about the happens as a result of these inquiries, all respondents stated they did not face any sanctions, financial or otherwise, except for warning from the management.

However, respondents’ statements demonstrate that principles that manage the healthcare organization, including consumerism and customer satisfaction, create contradictions with the factors that are actually required to make the patients happy. First, as a result of the effort to maintain customer satisfaction through keeping patients content, respondents argue that they are forced to part with their professional autonomy. With increasingly demanding patients and a salary system that awards volume of work, some doctors feel like they have to follow patients demands as they practice in order to avoid any complaints and have more visits. This interferes in their clinical autonomy, since it may lead them to choose the diagnostic or therapeutical processes that the patient demands rather than what they find appropriate using their clinical judgement.

*So much as you seem cute to the patient, and that means doing whatever patient wants, the patient is going to come to you as much, and that means points. This job has no principle, no spine left. (R6, urologist, public hospital)*

The principle that referred to in this statement is making decisions based on clinical judgement and not on patient demands. Professional autonomy as the most prized professional value is being violated when medical professionals are obligated to keep patients satisfied.

Second, while management insists on doctors to keep patients “happy” and satisfied, the managerial principles that guide the operation of the organization prevents doctors from building a sound relationship with patients built on trust. Trust is the most important pillar of doctor-patient relationship, however practices like restricting the amount doctors spends on patient does not allow it. In some cases, it even prevents doctors from receiving the basic medical information needed to make a diagnosis, or even patients’ name.

*They have created an appointment fetish. It is not possible to get a good quality service in every appointment. For example, at C...Hospital in the cardiology service, the automatic appointment machine is set to every 7 minutes. Imagine, in winter an Aunt Ayşe dressed almost like a cabbage will arrive, when will her blood pressure be measured, when will her medical history be asked, will she have an ECG, because there’s Uncle Veli waiting at the door. And he’s waiting with fury saying you’re stealing from my time. Like a customer. When he enters, he wants to stay for a long time, when he’s outside he does not want to wait. People were motivated to have a mentality of ‘she should come out so I go in, I should stay, I should take advantage of this’. But not every appointment concludes with high quality service delivery. I don’t think that quality of healthcare services can be measured by patient satisfaction. (R13, public health, public university hospital)*

Third, imposing doctors to increase their volume of work and see more patients contradicts with customer satisfaction, since, according to respondents, the less time doctor spends with the patient, the lower the quality of care will be. Therefore, respondents argue that when management is seeking customer satisfaction, they are not interested in assessing the quality of care but rather the amount of revenues that will be brought on by larger number of patients that visit the organization.

*As humans, we are left in a tight situation in patient evaluation. It requires a very strong will, assessing patient independent of that. Looking at the patient without thinking ‘how much do I earn from this’ or ‘how much can I get the hospital to earn or lose’, assessing the patient solely based on his illness and complaints leaves the person in a dilemma, but of course we try to assess on the basis of patient. (R21, internist, private hospital)*

Fourth, while managerial principles aim to standardize medical practice in order to be able assess physician activity, principle of consumerism results in patients

expecting individualized and exclusive care from doctors. The automated standardized examination time contradicts not only with the essence of medical practice which requires different solutions for each individual patient, but also provides insufficient time to extend to the patient the kind of close attention they demand. The kind of attention they demand requires non-medical skills, which respondents claim are not part of their professional values or pillars. Respondents use lower status occupations in the service sector and entertainment as resembling what characteristics are expected of them by management and patients. The examples used are occupations that prioritize customer satisfaction, entertainment and sales, rather than wellbeing.

*What you do is mechanical, doesn't have much meaning or value. ... I think I'm doing a kind of waitressing, not much more. ... It takes energy to deal with every patient. In the meantime, you're doing public relations. The expectations of the patients who come here have risen excessively, so they expect special treatment from you, a constant state of pianist chanteur and therefore an outrageous amount of energy is spent on each patient. I'm definitely sure of this, for the patient your behavior is more important than your diagnosis. (R2, physical therapy, private medical center)*

*Doctors have conditioned themselves with doing everything the patients says. With keeping the patient content. Take care of you like they do when you enter a store. Selling. But this is not what being a doctor is. (R6, urologist, public hospital)*

Respondents argue that patients' priority is not whether they receive good quality medical service, but rather individualized attention, that it can almost be argued that they expect "to be entertained". According to this respondent, patients no longer prioritize their wellbeing in their evaluation of performance of medical professional, but rather how much personalized attention they receive. This leads patients to complain to the management about the most irrelevant aspects of the service they receive, such as doctor's mood on that specific day. One respondent even stated that a complaint about her was filed to the management by a patient for "not being lively enough":

*I don't get tough with any of my patients, but I know one, she has gone to the başhekim secretary and said, 'Today M. Hanım is not sufficiently...', wait what has she said, that I am stagnant? 'Not animated enough'. I can't exactly*

*remember how she expressed it. I was shocked. She doesn't say 'She was sulking at me' or 'was angry with me', or 'did not take care of me'. She found my performance, my stage act insufficient, can you imagine? (R2, neurologist, private medical center)*

Patients' expectations of medical professionals are no longer only medical, but also related to how the doctor behaves. In a healthcare environment that is prioritizes customer satisfaction, medical professionals think more non-medical skills are required from them in order to be able to keep their employment and continue practicing medicine, which is not in line with their professional values.

#### **6.4. Use of Medical Technologies**

Medical technologies include all devices used in medical practice, from the simplest syringe to the most complex medical imaging tool. During the interviews, medical technology is used to imply radiological instruments, most commonly used medical imaging tools, such as Ultrasound, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT). Respondents' use of medical technologies and the extent to which they have autonomy over decisions regarding these practices came up regularly during the interviews, since these tools have become indispensable part of medical practice. Since the beginning of 20<sup>th</sup> century, with advances in medical sciences and technological advancement, technology has become an important tool that maintains professional autonomy. By facilitating, accelerating and making more precise the diagnosis and treatment processes, medical technology reinforced the trust in medical profession and its expertise among the society (King 1987; Green and Thorogood 1998; Stevens 2009). However, among all the advantages it brings to diagnosis and treatment, technology also became emblematic of increasing healthcare costs (Bynum 2014, 175; Bloom 2002, 205). Widespread use of medical technologies is also one of the reasons of increase in the number of medical professionals working as employees in healthcare organizations, alongside other financial and administrative changes taking place in healthcare services. As medical technologies become more complex, they become more expensive, require more space and more assisting staff. Therefore, hospitals and

clinics tend to have an upper hand in technological equipment compared to solo practice.

Since the beginning of HTP, there has been a major increase in the number and use of medical imaging tools both in public and private healthcare organizations in Turkey. There were 836 MRI devices in public and private healthcare organizations in Turkey in 2016, compared to a total of 58 in 2002. While there was a total of 323 CT devices and 1005 Ultrasound devices in 2002, the numbers have reached 1.152 and 5.470 in 2016 respectively (TC. Sağlık Bakanlığı İstatistikleri 2016, 117). Along with increase in number of devices, there have also been an astounding increase in the imaging exams per devices. While Turkey ranked 30<sup>th</sup> with regards to number of CT devices and 23<sup>rd</sup> with regards to MRI devices among 34 OECD countries, it was the highest ranking country for MRI exams per device and among the top ranking for CT exams per device (OECD Health at a Glance 2017, 171). Respondents argue that the increase in usage of these devices is mostly a result of increase in patient demand and management demand. Their own clinical judgement was least mentioned as the reason for increased use of medical technologies. The demands by patients and management being most frequently mentioned factors to explain why doctors use these devices more, reveals that use of medical technologies is one of the dimensions of medical practice into which external forces can intervene, restring professional autonomy.

While in most cases respondents, both in private and public healthcare organizations, mentioned having to use technologies more as a result of management pressure, in some interviews doctors mentioned that there have been times when management also asked them to cut back on their use of technology. Whether they are pressured to increase or decrease their use of technology depends on organization's agreement with SGK and Communiqué of Healthcare Practices, which determine the price of each medical practice. In contrast to private hospitals, which profit from use of technology due to their reimbursement agreement with SGK, employees in public and university

hospitals are usually asked to limit their use of devices for cost efficiency. However, respondents described shifts in management's demands on increasing or decreasing use of devices as regulations and agreements are being modified. Changing financial conditions affect the management's instruction on the issue, which affects their decision on technology use.

*In our case, they do not say increase the tests, on the contrary, they say decrease them so expenses are less, the money we earn is more. You know, we are a business, in order to profit we need to cut the expenses; in the last few years there are restrictions saying the tests should be decreased. For example, the computer gives an alert, saying you have asked for this many tests, do you want to continue, this is the amount we will get from this patient. We get an alert for every patient. (R22, pediatrician, training and research hospital)*

*The other day we had a meeting, saying we are losing money et cetera. Ask for so and so, do not ask for these, these tests bring in profit, tomography, MRI, the others we have to pay out pocket, so on. There is something called a package; as for more of what is in the package, less of what is outside. (R6, urologist, public hospital)*

*When I worked at a private medical center, SGK paid 5 lira 5 kuruş for every test you asked for. Then there was the package. Until then, the approach was 'Hocam, ask for tests for patients, you are in internal medicine, ask for tests'. ... Then one day I arrived, we were told there is package, no matter what you do with the patient, the state is paying X lira. You are losing money. Then it was all about 'Hocam please do not ask for tests, do not do these tests, if you'll have to, stick with these tests, we are paid for these and not for those'. (R21, internist, private hospital)*

Although procuring and operating medical devices increase costs of the healthcare organization, their increased use is also indispensable to bearing this cost. Healthcare organizations profit from the variety of services and the number of procedures they provide (Goldstein Jutel 2011). Therefore, the management, especially in private organizations, demand that doctors use medical technologies and tests in order to compensate for their cost and in return, gain revenue. Directing doctors on the volume of use of medical technologies, which simultaneously a cost and profit tool, becomes a way for management to control expenditures, as well as medical practice by interfering in medical decisions.

Respondents in both sectors emphasized that one reason they have to rely on medical technologies even when they think it may not really be a necessity, is the

restrictions on the time they spend per patient. Automated standardized time intervals limit the time per examination, which results in insufficient time to communicate with patient to learn more about their problem, their medical history or even to conduct physical examination. This results in inadequate information to make a diagnosis, which leads them to request medical imaging procedures or tests in order to speed up the process.

Being obliged to see more patients requires being fast, which leads to increased reliance on technology, rather than physical examination, to make a diagnosis. This creates a contradiction for doctors. On the one hand they accept that medical technologies make diagnosis more efficient and faster, but on the other hand having little time to understand patient's medical history or conduct a physical examination blunts the fundamental skills required in medical practice.

*While previously physician examination was a more important method for diagnosis, it has been abandoned for a long time now. For example, I compare it with the time when I did my residency, we are pushed to use tests to diagnose many things we diagnosed with physical examination back then. Examination is also sense organ for the doctor. His eye and ear. When you blunt examination, you really become deaf and blind as a doctor. I think doctors are losing that sense in a place where they have to see 60-70 patients a day. Therefore, they double down on technology. (R2, physical therapist, private medical center)*

Taking patient's medical history conducting a thorough physical examination are among the first and most foundational skills taught in medical school. Respondents argue that they are being used less and less as reliance on technology increases. They have a complicated relationship with medical technologies since they view the decision to use them is not always in their control and it comes at the expense of the loss of very foundational skills of medical practice.

A point emphasized by respondents was that medical technologies distance medical practice from a holistic approach that views the body as a whole and evaluates the human as an organism with all its organs and within its natural and social environments. With specialties getting deeper, enabled and facilitated by



medical technologies that present images of detailed sections of human body, expertise of each medical professional has narrowed. The tests have allowed them to gather more extensive information that focuses on one area or organ of the body, rather than providing a general glance. Relying less on verbal communication and physical examination have inevitably reinforced this approach to medicine as well.

Some respondents also argue that the pressures and demands by management or patients to use these devices and tests more than the doctors view necessary, results in what can be considered unethical behavior by some of their colleagues. They point out that there is increase in unnecessary usage of medical technologies, which may result in unnecessary procedures or treatments. On the contrary, when there is pressure by the management to limit usage of technology to cut costs, they sometimes cannot perform actions they deem necessary to diagnose or treat a patient. They argue that their professional autonomy requires that they should not be restricted by financially motivated demands by management of consumerist oriented demands by patients when making these medical decisions.

*I mean, somethings can definitely not be lucrative, they may even cause economic losses for the business. But you have to do that test even if it is very important for the patient, even if it has a chance of one in a million. ... Or the treatment may be very expensive, but if it will help the patient even a little bit, and any other place is not doing it, if you have the staff for it .... what it will cost, whether it will have a monetary return should be the last factor in the medical decision making process. (R24, nuclear medicine, training and research hospital)*

Clinical autonomy requires being able to exercise judgement based on medical knowledge despite the action being in line with management's demands, which, according to respondents, take into account the financial considerations rather than medical.

## **6.5. Performance Based Payment Method**

Performance based payment system has been one of the most debated aspects of HTP, since its implementation in 2004 in all health care organizations affiliated with Ministry of Health. It is a dimension of managerial practices of new public management, which enables outside surveillance based on quantification of medical performance. Research conducted in different countries have presented that this kind of payment scheme have a negative impact on professional autonomy (Farsberg et al 2001; Larriviere and Bernat 2008). The system appoints certain number of points to each medical action taken by the doctor, which are then converted into financial reward paid to him/her in addition to his/her monthly fixed salary. The private sector has also adapted this model; although there are no standard payment schemes, many private healthcare organizations pay “premiums” to doctors based on their performance in addition to their fixed monthly salary. In fact, in some cases, premiums may exceed the salary which creates various financial and ethical problems. Most importantly, medical professionals being based on external assessment of quantified performance can direct their clinical decisions, leading to decline in their professional autonomy. One research conducted in the early years of the implementation of the system in Turkey shows that despite the increase in their income, a quarter of doctors were unhappy with the payment system because they believed it was unfair, open to exploitation and did not take into consideration the quality of the care they provide (Zaim 2007).

This implies that implications of the performance-based payment methods are more than financial. According to respondents, this method enables surveillance of medical professional’s activities. It is partly to observe their volume work, which includes the number of patients they see, procedures they form and tests they order. The system allows making a record of all actions, so management can follow doctors’ performance and financial indicators of their activities. In a way, through performance-based payment system, doctors are not only encouraged to work more to earn (and bring in) more, but also encouraged to report all their

actions in order to be compensated for them. This aspect of performance-based payment system makes it a very fundamental managerial practice in healthcare organization, allowing medical practice to be assessed by external actors. However, this assessment is focused on quantity of care, rather than wellbeing of patients, which is the actual indicator of performance of medical professional. Performance-based payment system is also an instrument which reinforces precarity and insecurity of medical professionals both in public and private sectors. In this sense, it is a practice that leads the two sectors to resemble each other. In both, doctors work for a base salary, according to which social security and retirement contributions will be deducted. However, respondents in both sectors argue that sometimes performance or premium payments amount to more than their fixed salary. In fact, in the private healthcare organizations, a low base salary accompanied by premiums may be the preferred type of labor contract. Relying on performance or premium payments for a substantial portion of the income leads earnings to be unstable, as well as informal. Since their volume of work may fluctuate from month to month, respondents argue that they do not know how much they will be earning next month, which makes it difficult to make financial plans.

Substantial amount of financial earnings being dependent on additional payments which rely on the number of patients they see, procedures they conduct or tests they order for patients leads to financialization of medical decisions, according to respondents. Financial concerns replace clinical autonomy. Respondents argue that the way their payment method is structured steers them towards thinking in financial terms, rather than medical; not only because they will earn more but also their job security is under threat if they don't "perform":

*No, it wasn't always like this. I graduated in 1984, it wasn't like this. It has gradually become worse. There are times when you feel remorse. I will tell you this, and I am really one of the people who do this least, I still look up what the patient's institution is when he walks in. This is horrible. And I really do this very little. You can be sure. But you do this, willingly or unwillingly. You ask for tests based on the institution he is affiliated with. If his institution is good [has good coverage], you comfortably ask for tests. But if he's paying himself, you take a pause, you cannot ask for it. I mean, you really think about the money*

*when you're looking at the patient. You think of it from the standpoint of the patient, and you also think what this patient will help you earn. This is a disgrace. It was not like this. (R20, internist, private hospital)*

When medical professionals are making decisions regarding diagnosis or treatment, performance-based payment leads them to prioritize financial indicators over clinical judgement. They are pressured into an ethical dilemma of professional autonomy and values on the one side and livelihood on the other. It also presents a paradox. While the overall concern of healthcare organizations is to cut costs and become financially efficient, performance-based payment system carries the danger of increasing healthcare costs, by enforcing more medical actions.

Respondents also argue that performance-based payment method has unethical consequences for medical practice. Two types of unethical behavior driven by performance-based payment method is described by the respondents. First, since the medical professionals are compelled to do more procedures and tests in order to earn, unnecessary procedures are to increase. Respondents argue that especially non-invasive tests and imaging procedures have seen a spike following implementation of this payment system. Respondents state that tests may be preferred where a simple physical examination may actually be sufficient to make a diagnosis.

*Of course, it can be misused in this sense, for example marketization, performance-based payment, health turning into a commodity that can be bought and sold, 'in this case, let me do something expensive'. Some of these are invasive and harmful, some not. Let me have him have an MRI; he is receiving any beams in MRI. There are unnecessary MRI being taken. Or unnecessary tests done. (R13, public health, public university hospital)*

Second, respondents have stated they have witnessed some colleagues tend to expand medical indications in order to be able to justify some procedures or treatments. Definitions and boundaries become blurred to facilitate and accommodate more procedures and tests. Operations and invasive procedures may be performed hastily in cases they were used to viewed as a last resort.

*It is called indication, the conditions under which you hospitalize a patient, the conditions under which you operate, there are rules. Now these rules have loosened and expanded. For example, a herniated disk operation. If the patient has no losses in his strength in foot, in his leg, you do not operate right away. You hospitalize him, have him rest, have him do physical therapy. If it doesn't improve and the pain continues, then you operate. Nowadays, they look at an MRI right away to say 'you've got hernia' and operate. This flexibility has turned into an advantage. More operations mean more money. (R1, neurology, private medical center)*

*The number of patients has increased, operations have increased a lot, they have increased because many of the operations are unnecessary. They have increased because the patient is not being treated. Noone has anything to do with treating the patient, everyone is after numbers. The more the patients, the more the points. (R6, urologist, public hospital)*

*There are truly unnecessary operations, applications being done. Although the guy has no complaints, no problems, he is told 'you need a prostate operation' just because his prostate is large. But when you assess him in detail, you see that he does not need a prostate operation. (R16, urologist, private hospital)*

*For example, if you've had a headache for 10 years and it goes away when you take a painkiller, neurologically there is nothing to worry about. But if you've had a headache for 10 days and if it has never hurt like this before, if you've taken medicine but it hasn't gone away, then you have to do tests. This is a simple rule. But that patient of 10 years also wants the same thing. Sometimes when your revenue is low, you also find fault with that 10 year old headache and say 'ok, come on, he hasn't had an MRI all these years, let him have his MRI.' There can be flexibilities. (R1, neurology, private medical center)*

Respondents point out to three steering factors that drive unethical or questionable medical behavior caused by performance-based payments. First, in the private sector, the demands of the management for more revenue causes the medical professionals to resort to these kinds of actions. Second, both in the public and private sector, the insufficiency of base salary results in having to rely on additional performance-based payments in order to have what they believe it a decent income their profession deserves.

*We see the results of a healthcare service based on performance. There are many unnecessary procedures done. If you force people to do bad job, if you force him to remove a harmless lipoma on the skin just so that he can earn the extra 1000 lira he wants to earn to pay his child's school fee, it is the biggest immorality to argue that people are doing it because they are immoral. ... You cannot equate a guy who steals a bread because he's hungry and a guy who has dollars coming out of his shoe box. (R11, radiologist, public university hospital)*

While these two factors are influenced by outside the profession, third driving factor is the greediness of some of their colleagues, who, they argue, willingly take advantage of the system and are not concerned about the unethical implications or possible negative consequences of their behavior. Taking advantage of the system to increase one's income is not only seen as unprofessional, but also as a heinous and dishonorable act contradicting with the altruistic and service orientation of the profession. It is demonstrated by the adjectives they use to describe these colleagues, such as “*kurnaz*” (R1), “*şahsiyetsiz*” (R10), “*şerefsiz*” (R14) or “*aşağılık*” (R23).

Therefore, while all respondents heavily criticize performance-based payment method and their colleagues who take advantage of this system regardless of ethical concerns, they also acknowledge that some of their colleagues are forced into complying with it since without these additional payments they will have financial difficulties.

Respondents also emphasized increased competition among medical professionals as another negative implication of performance-based payment method. They state that payment schemes rewarding volume of work impair one of the most important requirements of contemporary healthcare services – team work. Team work is also essential to workplace peace which maintains the quality of medical services. However, with professionals are incentivized to prioritize financial concerns rather than clinical judgement when making medical decisions, they may also leave aside cooperation with colleagues. Respondents argue that performance-based payment practices bring an atmosphere of self-interest, impeding cooperation among colleagues. This may even extend to doctors undertaking decisions which may actually be under the authority of their colleague who practices a different specialty. Doctors may end up taking on the responsibility of all aspects of the medical care in order to increase their volume of work, thus performance earnings, when instead s/he should be referring the patient to another specialist. Encouraging doctors to compete for patients may also be harmful for patients.

Financial incentives like payment based on volume work disrupts cooperation among colleagues, which is against the values of a profession that requires teamwork to provide high quality services. Therefore, as one managerialist principles embedded in HTP, performance-based payment method creates divergence of interest among professionals, which may even lead to hostility towards each other and potentially negatively affect the wellbeing of the patient.

Performance-based payment method also creates a challenge to the unity of the profession by further reinforcing diverging of interest among the members based on financial concerns. The different specialties of medicine have different volume of work, which includes different number of procedures or levels of risk, technology required to practice or duration of treatment. For example, while internists and pediatricians emphasized that they not performing many (or none) procedures, the volume of work for nuclear medicine is rare compared to other specialties, which leads them to receive less points compared to those specialties that have more procedures or faster pace of work involved, like surgery or dermatology.

*For example, I do not operate on patients, I only examine them, but this is my job. I'm also at the hospital from dusk till dawn. In this performance-based system, let me say, if I earn 10.000 points, a surgeon who conducts a half an hour operation earns 20.000 points. There are imbalances such as this. Or one pulmonologist earned 5000, while the other earned 2000. The hasn't been balanced. When the balance is not well, some people have expanded indications, they have expanded indications for tests. They started asking for that are not necessary. (R20, internist, private hospital)*

*There is performance in many countries but it has been fairly done here. There are practices that favor certain specialties. There are injustices. The shiftiest aspect is that there are big gaps between the performance based payments that doctors receive. This has to do with equipment. Performance does not only depend on me, but also on the equipment. If the gap is not as large, the business is not going to go after it as much. But this way a greed for points comes into existence, and that reflects on the patient. (R24, nuclear medicine, training and research hospital)*

The point-based system in the public sector or in the premium system in the private sector do not take into account the risk levels of procedures or the fact that some specialties do not conduct as many procedures as others. Respondents

argue that some specialties are financially disadvantaged in this sense, since not everyone is awarded equally for their work. Assessing medical professional based on their volume of work creates financial injustice and stratification among specialties, which further contributes to the cooperation among members of the profession.

While respondents argue that private and public healthcare sector start to resemble each other in many aspects, the narratives of respondents who work at private sector show that there are many differences within the private sector itself. While most respondents point at the common experience of declining clinical and economic autonomy, they describe differing work conditions, volume of work, payment methods. Their experiences demonstrate the lack of standard of labor contract, which leads to precarity, job insecurity as well as unfair competition among professionals. These differences come up even in the same healthcare organization. In most private healthcare organizations, each employee works under different conditions. Management may prefer a doctor who contributes more to the revenue of the organization.

*[The employer] would summon one by one and talk about revenues. Meanwhile he would say this and that, would speak ill of this person, would praise that person, some of the other doctors. That would be the usual conversation. I made a point of talking about these things, I would say, look, Ali Bey told me this and that. But not everyone would. Some of them left, we later learned that they received different kinds of payments, different things went down. The owner [of the medical center] was also a doctor, but with very much a businessman mentality... (R18, psychiatrist, private practice – private medical center)*

In many cases doctors are not aware of each other's salaries or premium payments, resulting in lack of cooperative resistance against the conditions imposed by the management. This prevents them from negotiating equal terms of work, and according to respondents, short employment period for many. Medical professionals move from one private healthcare organization to the other if they offer better conditions of work. This does not only affect their context of work, but also continuation of medical care for the long-term patient they may have.



## **6.6. Increasing Job Insecurity**

Another important change that accompanies prevalence of healthcare organizations as employers is the increasing in job insecurity for medical professionals. This is a significant since their obligations vis-à-vis organization's demands restricts their professional autonomy. Job security emerges as the most repeated reasons for choosing the medical profession by respondents in the interviews. They have stated that besides the goal of doing good for the society and its embodiment of service orientation, the perpetual need for healthcare services and the limited supply of individuals who are qualified to provide this service give rise the idea that medical practice is a respectable and lucrative profession with guaranteed job security. These have made the medical profession more attractive to respondents, compared to other professions. Therefore, restricted labor market was a factor in shaping in respondents' decision to choose the profession. The control of supply and demand in this narrow labor market has traditionally brought along social mobility (Larson 1977).

Professional autonomy also brought security to the profession. Since, traditionally, they had no external force or actor interfering in the clinical or economic dimension of their work. With healthcare organizations that were not designed to operate with managerial principles and with solo practice, there was also been no mechanism to threaten them to lose their employment if they did not practice in line with the externally imposed rules and regulations.

In the interviews, concerns over increasing job insecurity were especially apparent in respondents working in private sector. Being obliged with bringing in a certain amount of revenue to the organization makes their security vulnerable to financial terms. Respondents state that in the private sector in some cases labor contracts can even openly indicate a certain number of procedures that the doctor has to conduct in order to ensure a certain amount of revenue. It can be implied or stated overtly by the management that if they cannot reach the indicated target, their contract will no longer be valid.

*There are no rules, you're very vulnerable. You just sit there. If he says 'don't come in tomorrow', you won't. That's how it is. That's it. And that's what happened. My friend was told so when he was on dolmuş. (R2, physical therapist, private medical center)*

Threat of losing their jobs when the demanded volume of work is not achieved interferes in doctors' clinical autonomy, since, according to respondents it may lead to make medical decision in line with achievement of these targets. As they become increasingly insecure, they become obliged to practice according to the orders they are imposed to by management. As one respondent points out, having to reach certain financial targets may even have unethical consequences.

*I am a witness to something from up close, firsthand, here at a private hospital, they have made a deal on 6 brain surgeries a week, for example. This is not so simple, what does this mean, it means that he will expand the area of indications. He had been fired before because his performance was low, because he did not do this. I mean, they threaten you with being unemployed, and what do they ask for in return? They want you to operate patients who do not need to be operated on. In Exchange for unemployment. (R2, physical therapist, private medical center)*

In order to reach the targets set up for them by the management, doctors may choose to conduct medical tests or procedures on patients for diagnosis or treatment, even when they think they are not necessary. When they are forced to do more to earn more and their job depends on their contribution to the revenue, financial incentives may take priority over clinical judgement and constrain clinical autonomy.

*Professional autonomy has decreased. My permanency in this workplace depends on me being able to achieve the revenue the employer expects. This decreases my autonomy. There is a pressure on doctors to ask more tests. You have to make your employing organization money. (R1, neurologist, private medical center)*

That said, their income is also insecure, as some private healthcare organizations receive most of their income in form of premiums (additional payments based on their performance) rather than a fixed salary. Therefore, both their status of employment and the amount of income are determined by and dependent on the employer expectation of revenues. Private healthcare sector in Turkey, according

to respondents' experience, is largely characterized by informal employment. There are no standards for salary or social security benefits and no standards for labor contracts.

*I'm here today, but I may have to empty my room tomorrow. There is no security. Definitely. This is the biggest problem in private hospital. I know it from here, we've lived through this. We know that someone had appointments and patients in the morning and was told 'empty your room' in the afternoon. I cannot make plans for the future. I don't know what I will be paid. Our salaries are paid on 20<sup>th</sup>, it's surprise. (R20, internist, private hospital)*

Doctors' future security, as well as present job security, depends on what employer chooses to pay in social security contributions. Respondents emphasize that while some employers pay the contribution they are legally required to, others pay the minimum amount.

Respondents describe that there is usually an official salary indicated on the contract and the additional premium payment based on performance which is received by hand in an envelope. This method is preferred by some employers to that employer's social security contributions are low and that doctor can be pressured into increasing their "performance", which implies their volume of work.

Since they receive most of their income informally, doctors cannot prove when their employment rights are violated and therefore cannot sue their employers. The informal payment structure prevents them to make claims over their rights, which discourages them to seek any financial or legal compensation against their employers when they are wrongfully fired or not paid the amount that is pledged to them.

*The state very well knows that all of private sector is informal economy. In all of private sector there is an official salary, written, the one that is deposited to your bank account, and then there are those payments you receive in person, under the table. Although the state knows this, when you're fired and go to court, it asks 'how much is the salary?' What nonsense, you know it. What is more, it also tells the doctor 'report your workplace', since you're paid under*

*the table. You say 'this is how much I am paid', it says 'well, prove it'. What am I supposed to prove? (R4, internist, private medical center)*

*TMA has prepared a booklet on what kinds of contracts private medical professionals have to sign. It was prepared in 2008. .... None of the private doctors sign those kinds of contracts. Because private hospital bosses do not sign contracts that include those kinds of social benefits. Usually they agree on high salaries, but official payments are minimum wage, therefore the income of these doctors that reflect on to their retirement benefits are based on minimum wage. Some months they are paid, some months they are not. When you object, you don't have a signed contract in your hand. Therefore, they work at gunpoint. I think they work very precariously. (R13, public health, public university hospital)*

The increasing job security and not being able to seek compensation leads the respondents to feel insecure not only because they do not have income or benefit security, but also because they feel easily replaceable. They feel threatened by ever increasing supply of doctors (implied by their use of the concept of “new graduates”); larger pool of recent medical school graduates and specialists provides employers with an increasing supply of cheap labor. An important dimension of professional autonomy is composed of the ability of the profession to control and determine the supply of professionals and the fees. The doctors no longer have the monopoly over market for healthcare services or market for professional labor which implies they have lost this autonomy. As the health and higher education authorities of the Turkish state increase the number of medical schools and students continuously since 2000s, the relatively small labor market has expanded, threatening the security, high social status and financial rewards that medical professionals had attained as practitioners of a rare craft that deals with matters of life and death.

*Once they were dependent on you, now you are put in a position where you need them. Therefore, work conditions of medical professional are very bad, both in the public and private sector. There is a salary that is imposed on you, if you don't accept it... Because medical professional's salary cannot be this cheap. But instead, a new graduate says 'I'll do it for this amount of money'. Therefore, you're disqualified and he gets the job. Who benefits from this? Private sector benefits from this. Because you get cheap doctor, low salary. (R4, internist, private medical center)*

Respondents argue that since they are older, more experienced and more qualified, employers view them as more expensive. The older doctors shy away from objecting the employers even when they actually want to oppose the work conditions that are imposed on them by the employer, since, as one respondent puts it “there is always someone who will do it for cheaper”. Respondents state that employers preferring cheap labor over experienced labor also leads them to feel that their expertise and professionalism is devalued. Feeling replaceable and high level of circulation in the sector restricts their clinical autonomy, and leads them to abide by the directions of the management with regards to volume of work in order to achieve the expected financial targets.

Contrary to the past when their public or even private sector jobs were more secure, due to fewer number of medical professionals and healthcare organizations and less profit motive in healthcare domain, they now feel their employment status is hanging by a thread. The insecurity brought on by larger labor market and market for healthcare services leads them to constantly keep an eye for work elsewhere. This contrasts with their original expectation of guarantee of a life-long lucrative secure employment.

While threat of job insecurity is more dominant in the private sector, it is important to point out that respondents who work in the public sector also feel insecurity financially. This is one way in which the employment structure and work conditions in the public and private sector have started to resemble each other. Performance based payment structure in the public healthcare system creates an insecurity in the public sector, since it resembles the larger premium payments accommodating the smaller fixed salary model in the private sector. In the public sector system, it is often that the additional payments they receive based on performance surpasses their fixed salary, which makes their monthly income inconsistent. Performance based payments are also not reflected in their retirement benefits, which respondents argue are unfair since they make up, in some cases, most their income.

Therefore, both in the private and the public healthcare organizations, the medical professionals are increasingly financially insecure both in terms of present and the future. Additional payments based on their volume of work brings inconsistency in their income and also does not reflect into their retirement funds. Several respondents have stated that they cannot make substantial plans even into the next few months since they do not know what their total income will be. Respondents in the private sector have added job insecurity to their financial insecurity, saying they may be fired any time.

Performance based payment structure in both sectors becomes predominant in the composition of their monthly income, which implies that organizations are based on an operation model in which employees are encouraged to work without taking any leave, absence or vacation days. This results in some to avoid using their most basic right of annual leave or continue working even when sick:

*If they take time off, they have to find someone for their place. [In private sector] I know of place which have very mafia-like organizations in place. This probably doesn't happen in very established organizations, but I've heard that in places that are not very institutionalized, places like family enterprises they say 'where are you going without finding someone to replace you, you have an agreement'. (R25, nuclear medicine, public university hospital)*

*You won't find a doctor who uses one month of vacation time in any organization. They leave for a week and come back because they think their performance payments will be cut. (R13, public health, public university hospital)*

*The performance doctors receive is more than their base salary. This is very virtual, because when you don't work, when you go through an appendectomy operation, when you have lung cancer, you don't receive it. I had a thyroidectomy operation, they said you have to take 3 weeks off. I was at X University at that time, they said your revolving fund will be suspended. Even I did something stupid, did not use my sick days, I crawled in and out of work. We have a lot of examples, I know a general surgeon who had lung cancer, had an operation and continued to work during chemotherapy. He later died with his boots on. His motive was: My son is preparing for the university entrance exam, if I don't get performance payment, I can't afford his dersane fees. (R13, public health, public university hospital)*

The insecure payment and employment structure has also created what can be described as precarity under the disguise of entrepreneurship. One respondent

states that managers in the organization he works at try to motivate new hires by saying that while their salary is fixed to a certain amount, they can earn up to four times that amount if they'd like. While the payment structure brings instability both for their present and their future financial standing, being mostly based on the volume of work, which is termed by management as "performance", doctors are pressured into working more by employers. Employers conceal this pressure behind encouragement implying that the more they work, the more they can earn.

Under HTP, medical professionals, in increasing numbers, have become employees in bureaucratic organizations, as a result of expansion of the private sector and therefore the increase in the number of private health care organizations. Medical professionals' employment in bureaucratic organizations affect their economic autonomy negatively, since they have no or little control over decisions about fees, their volume of work and distribution of resources, which have now fall under the authority of managerial staff who audit and assess professional performance by quantitative indicators. Physician performance is not evaluated based on quality of care, but rather based on how much revenue is brought to the organization. Priority given to efficiency, cost control, profitability, impacts the time medical professionals can spend per patient, the number of patients they have to see, and in some cases, even the diagnostic tests and tools they can use. This restricts their clinical autonomy since their choice of diagnostic tools or treatment is inevitably delineated by financial considerations. Performance-based-payment schemes, which have almost become the norm both in private and public sectors and increasing insecurity and informality of employment in the private sector, also affect their autonomy, subjecting them to non-professionals' criterion to stay in employment based on financial profitability. The instruments of financial reward based on increasing volume of work or punishment of unemployment may lead to unethical choices made by professionals in order to earn more or keep their jobs. Violating professional ethics or values can also be seen as restriction of their autonomy, since, according to respondents, in some cases their colleagues are left financially

desperate and have to resort to action which they would normally avoid. How much pressure is placed on the professional by management to increase volume of work or make certain diagnostic or clinical choices varies from organization to organization. Economic and clinical autonomy are inextricable, however may present variations in extent based on the organization the medical professional works at. This also negatively impacts the professionals' perception of a unified profession, causing rifts among colleagues based on lines of employment conditions, type of organization and specialization.



## **CHAPTER 7**

### **PROFESSION-PUBLIC RELATIONSHIP AND PROFESSIONAL AUTONOMY**

This chapter is going to analyze how the changing public view of the medical profession and the doctor-patient relationship under HTP affect autonomy of medical professionals, through interviews conducted in the field work. Doctor-patient relationship is important since it contributes the quality of care the patient will receive depending on the extent of trust and communication involved in their interaction. When trust in this relationship is eroded, patients may question or challenge decisions of the medical professional, which impacts the quality of care, as well as job satisfaction of the medical professional. Doctor-patient relationship also determines patient's satisfaction with care and attitude towards the doctor. Eroding of trust may result in the medical professional losing their authority over patient, affects medical professional's ability to practice according to his/her clinical judgement, but also, in connection, declining his/her clinical autonomy.

According to Light (2010), public emerged as one of the significant countervailing powers against the medical profession in the domain of health as a result of restructuring of delivery, organization and financing of healthcare services since 1970s. At the same time, public's perception has been changing as a result of this restructuring, as authority over the health domain started to shift from medical profession to other actors, which include the public as an influential power that is reconceptualized as "the consumer"; state agencies like social security institutions or ministries, and market actors like public and private healthcare organizations and their management, third-party payers like insurance companies and pharmaceutical and medical device companies. Skepticism of medical profession has increased among public, with increasing healthcare costs,

litigation actions on malpractice cases and medical profession's image as unwilling to exercise its privilege of self-regulation and discipline its members as medical scandals occur in different countries around the world, including Turkey (Dixon-Woods et al 2001; Hatun 2012; Hafferty 2006; Speed and Gabe 2013). Healthcare organizations, state agencies and public started demanding more accountability from the medical profession, resulting in health care reforms that prioritize cost-efficiency measures and managerial practices that calculate, evaluate and reward medical performance based on productivity. In addition to changing public view, patient-centered healthcare services and consumerist health policies, managerial principles, increased access to knowledge (especially through Internet) and advancement and widespread use of medical technologies have all contributed to transformation of the doctor-patient relationship on a daily basis. Increased access to information about healthcare services, treatments and medical technologies have also contributed to the changing character of doctor-patient relationship.

On an individual level, the circumstances in which healthcare is provided affects this relationship, namely how often the doctor and patient see each other, the resources available in the healthcare organization, and the time doctor can spend on patient (Gabe et al 2004). Some scholars also argue that the character of doctor-patient relationship may vary according to kind and severity of patient's condition, or based differences of gender, class, education and culture (Boulton et al 1986; Fisher 1984; Haug and Lavin 1978).

As a result of these developments, it has been argued that the fundamental characteristic of the doctor-patient relationship has started to shift from "paternalistic" to "democratic". The relationship between doctor and patient has traditionally been characterized as "paternalistic", as it resembles the relationship between a parent and a child due to patient's vulnerability and inequality of knowledge and power between them (Neuberger 2000). This asymmetry in power and knowledge and vulnerability on the part of the patient also makes this relationship open to abuse. In a way, some scholars have resembled the

relationship to a “social contract” that requires both sides to have rights and duties and requires patient’s trust in doctor’s authority and skills while the doctor’s trust that patient is going to follow his/her guidance which s/he offers considering only what benefits the patient (Cruess and Cruess 2008; Sullivan 2000; Allen et al 2005). Medical profession with its long training, specialized skills and knowledge and credentials to practice in a domain where human life is concerned, has earned public’s trust and respect with the state’s support that legitimized its professional autonomy in practice. The public has trusted the medical profession to treat patients without considering any outside factors or interests, solely based on their medical knowledge, skill and clinical judgement. Trust does not only allow the medical profession to maintain its professional autonomy and gain public’s respect, but it is also the cornerstone of the doctor-patient relationship on a daily basis.

Scholars who studied changes in professional autonomy and authority were concerned with doctor-patient relationship as an important dimension transforming this fundamental professional value. In 1970s and 1980s, public’s increased access to information attracted attention of scholars who studied professions, who argued that this access leads to loss of medical professions’ monopoly over information and knowledge and its autonomy as well as authority over patients. This development was termed Deprofessionalization (Haug 1973; Haug 1988). Deprofessionalization was also used to imply a shift towards formal rationalization through principles of productivity, efficiency, accountability, calculability and predictability, from exercising clinical judgement and professional values (Ritzer and Walczak 1988).

However, in 1990s, this question was addressed by a contrasting approach that supported patients to become more active, autonomous and responsible in the diagnosis and treatment processes. It implied a shift from a paternalist relationship to a more democratic one, encouraging more patient participation in relationship model that is more equal and inclusive (Mead and Bowen 2000). In this approach, patients are attributed more power in decision making; they may

require more information in consultation and to be more actively involved in the choice of treatment. These insights into changing doctor-patient relationship lead paternalist relationship to be viewed as a contrast to the patient-centered relationship reinforced by a consumer model (Goodyear-Smith and Buetow 2001). There are also scholars who argue for not making an absolute distinction between paternalism and patient autonomy, that paternalism is not necessarily to the disadvantage of the patient, since the motivation behind it is to improve patient's health and that the two approaches should be practiced together (JJ Chin 2002). Doctor-patient relationship has also been studied in the context of changing healthcare context in Turkey, examining trust and communication between the two parties (Ertong 2011; Atıcı 2007; Kutlu et al 2010; Gülcemal 2015; Çorbacıoğlu 2020).

In this chapter, I analyze the trajectory of change in doctor-patient relationship, discussing it with another interrelated issue, the change in the public image of the Turkish medical profession. I examine the elements that shape the changes in the relationship between doctors and patients and how it reflects on professional autonomy. The findings also present that clinical dimension of professional autonomy is most affected by the changing public view of medical profession in society and changing doctor-patient relationship in the individual level. The changing public perception of the medical profession and in return, how medical professionals view the public and how the doctors perceive the past and present of their profession emerges as an important theme. The findings also present that the most fundamental cornerstone of the relationship and the guardian of professional autonomy, trust, is eroding between doctor and patient, resulting in declining professional autonomy. Increased access to information and medical technologies and prevalence of medical devices in medical practice have become important factors in explaining the transformation of the doctor-patients relationship. Violence against healthcare workers, although widespread around the world, has become almost epidemic in Turkish society and also emerges as a significant factor that results in decline in the extent of medical professionals' autonomy. As a result, defensive medicine practices have become prevalent, as

friction between patients and doctors increase on a daily basis, as well formal litigations for malpractice suits and consumerist assessment practices that evaluate medical performance.

### **7.1. Declining Respectability and Status of the Profession**

Respectability of the profession is an indicator of its high status and prestige in society. It is reflected in public's trust for the profession as a collective group, and defines the relationship between individual members of the profession and the patients. It is important for the profession to be acknowledged by the public as the sole competent authority in a specific domain, since in order to for the public to consume the services of the professional group and trust their competency, it has to recognize and acknowledge its authority. In extension, authority over public and the patients is an important dimension of professional autonomy. The profession is consulted by the public as the competent and credible party, and it also facilitates patient compliance in face-to-face doctor-patient interactions.

However, in order to gain credibility and legitimacy to achieve professional authority over public, the professional group has to have a unified identity in the eyes of the public. A standardized professional training, a professional association which is able to represent and negotiate in the name of its members, conduct social control over them and self-regulate the profession, and an image of homogeneity of competence among its members is required for the practitioners to hold equal authority over public and patients. Authority the members of the profession have over patients stem from being a member of this specific profession that has authority in public, in most cases (as seen in Turkish history) extending over to non-medical spheres, such as social or political, as well. It also allows practicing autonomously, without any direction or control of any other actor.

Respectability had played a significant role in why many of the respondents in this study wanted to become medical professionals. Medicine being a

“respectable”, “most exalted”, and in extension, “most in demand” and “swanky” profession are several of the reasons mentioned by respondents to explain why they chose medical school over any other university course. Respectability and exaltedness were also the most important factor for those whose parents had interfered in their career choice. The selection process to medical school plays a significant role in medical professions’ “respectability”. Medicine has preserved its status as one of the most difficult faculties to get into in the Turkish university exam system, in which all students that aim to study any kind of undergraduate degree has to take a centralized standardized test. Good students can achieve the high points required for entrance to medical school; “being a good student” was another main reason why many of the respondents in this study were inclined towards this profession. Their statements reflect that several did not seriously consider what a medical career would entail, but wanted it or were directed towards it, because they academically could achieve it.

*Yes. I was a hardworking student. It was one of the nice professions at the time that was being glorified. It was imposed to us. You would enter the school of medicine with the highest points [in the university entrance exam]. You would either become an engineer or a doctor. I felt that being a doctor was more divine. I aspired to wear the white coat. (R1, neurologist, private medical center)*

*I don't know why [I chose it]. My father was a doctor, perhaps it was his influence. Apart from that, it was a profession I found myself close to. I don't know, that was what you chose when you were a hardworking student back then. (R2, physical therapist, private medical center)*

*Honestly, what was it that took you to being a doctor? You're still in high school, you are smart, what was the most in demand profession back then? Which requires both knowledge and intelligence... (R10, general surgeon, private hospital)*

Other respondents have more seriously considered what being a medical profession would entail; for them its altruistic character was significant in their choice to become a doctor. They mentioned being of service to the public as a reason they preferred medical profession over other occupations. While those who chose to become a doctor because they were “good students” did not consider the outcome of their choice, those who chose it because they wanted to

“serve the society” actually considered what they would accomplish by their career choice.

*Of course, in the context we were raised in, in family environments, it was an approach that stem from being useful. (R15, emergency/family medicine, private hospital)*

*When I was in junior high school, I went through a serious illness. I hadn't thought about [the medical profession] prior to that. I was hospitalized. I was inspired by the doctors who came in there every day, how they helped the patients. There were people who died, where I was. (R18, psychiatrist, private practice – private medical center)*

*In the beginning the driving force behind being a doctor was about employment benefits, I thought I would earn well. Furthermore, earning well along with having a profession that brings service to humanity, to society... (R12, public health, public university hospital)*

Service orientation and altruism are two important characteristics that maintain profession's status and authority in society. Respondents' desire to help the patients and serve the public also reflects an awareness that this profession would be an instrument to achieve their goal, and have a respectable place in society at the same time. As a respondent's statement highlights, even when expectation of high financial rewards is the priority in one's career decision, service to the public is perceived as an added value that distinguishes medical profession from others.

The importance of “respect” of the public is also demonstrated in respondents' comparison of their contemporary relationship with the patients and how the profession was perceived in society in the past. A recurrent theme in all interviews was the nostalgic view of their profession. This was expressed not only as reminiscence for their personal professional history, but also as a nostalgia, as well as a mourning for the authority and high status the past generations of medical professionals held in Turkey, which is now lost. Difficulty in accessing healthcare services and medical professionals had contributed to this high status, as the scope of healthcare services were narrower. A respondent who came from a rural background and had little access to medical

doctors when he was growing up in 1970s mentioned how his community was doctors as demi-gods, a typical public image of doctors in decades prior, especially in areas with difficult access to health services

*... first, I could not imagine that I would be able to go to medical school. It was a major source of happiness in 70's. ... I was thinking, I will become a doctor. I was a person who did not go to doctor. I was a person who could not access the doctor. In the area I lived in, you would have to go to county to reach a doctor. I come from a village. ... The doctor was inaccessible. Knowledge, accumulation, well-equipped... (R4, internist, private medical center)*

While one aspect of the public recognition of status and prestige of the professionals were related to technical competence, knowledge and skills, the other aspect was the leading cultural and political position they held in communities. Their authority was not simply constrained to the medical realm, but extended to other social realms, setting them next to other social and political authority figures, especially in smaller communities and provinces:

*In a county, in a town, its administrative authority, its doctor, its prosecutor. [The medical professional] has always been one of these three people. It used to be very important." (R22, pediatrician, training and research hospital)*

The prestige and authority held by the profession in the past, is tied by respondents to the social and financial distance between the doctors and the public. The social distance between the doctors and their patients in particular is defined as the major factor that resulted in the profession to be considered "privileged" by the respondents. Due to the change in the public image of the profession, and therefore, the loss of respect for and status of medical professionals in society under HTP, respondents argue that these distances have narrowed. The deteriorating public image and increasingly hostile relations with the public are exclusively mentioned as factor that led the profession to become an occupation that is no longer highly regarded in society:

*Back then, you would have this status difference between you and the public you were taking care of. You were "the doctor" at least, now there is no such thing. ... It used to everything in the before the society, now it has become a nothing. (R4, internist, private medical center)*



*Being a doctor had something. ... Being a doctor was an advantage, was a status. What has become in time, that's quite another story. (R8, pediatrician)*

*... I don't think I'm a person who has a such a prominent place in society anymore. (R12, public health, public university hospital)*

*So, when we first graduated, the medical profession had quite an air about it. It was a very respected profession, but it's not like that anymore. It's now in shambles. (R20, internist, private hospital)*

One respondent suggested how doctors are presented in popular culture could be an indicator of the shift in the public view of the profession:

*Look at the doctor typecasting of doctors in the old Turkish movies, and then look at doctor characters in the current TV series, you'd understand it. In the old Turkish movies, he is extraordinary, like a semi-god. Look at the TV series at the moment, he rents an apartment with three other people, he clowns about, and he is not taken very seriously. In the past, dignified, white coated, semi-god. (R2)<sup>5</sup>*

According to this respondent, the declining social prestige and financial privileges of the medical professionals can be identified in this shift in public image of the professionals through popular culture representation of the profession. The medical profession is no longer represented by elderly, respectable gentlemen on TV and movies. The specific TV show which the respondent describes also contains younger actors and actresses who play the role of medical doctors. Therefore, there is also gendered and younger representation of doctors as a group that is no longer viewed as privileged or respectable in society. Instead, the gap is narrowing in the public imagination as doctors are increasingly portrayed as younger (and female) individuals who no longer have financial advantages the older generations retained.

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<sup>5</sup> Older, respectable male actors like Nubar Terziyan, Ekrem Dümer, or Muammer Gözalan had often portrayed the medical doctor (usually small appearances) in the Turkish cinema, until the decline of Yeşilçam in 1980s. They appeared as figures of authority, respected by everyone involved in the scenes. On the other hand, the respondent is referring to popular TV show "Doktorlar", with the phrase "TV series nowadays" in this quote. "Doktorlar" is the Turkish adaptation of the American TV series Grey's Anatomy, the reruns of which also been regularly broadcast on TV since its premier in 2006. The show portrays the early career struggles and love interests of young, attractive medical residents who have to share an apartment.

While the profession's high authority, prestige and status in the past decades have been reminisced with a sentiment of nostalgia by the respondents, two distinct concerns have emerged in interviews, which implied a cautious stance towards this nostalgic narrative. One respondent pointed out that the high regard shown to the doctors in the past decades was the result of their demand of authority through a paternalist approach in their relations to the patients and the general public. The respondent argues that the unequal nature of this kind of relationship may have led to the current resentment of the profession among the public. While the traditional asymmetrical and socially hierarchical relationship is remembered with nostalgic ideas about how the profession was highly regarded and was considered an authority, the distance between the public and the profession may actually have resulted in a dangerous tension; and therefore, should be approached with caution when reminiscing.

*Maybe until now, there was a very paternal approach where the doctor was seen very hierarchically in medicine. In mean the doctors before us. The doctors were above all, like masters to servitude. The people were below. And doctors could not be asked anything, they were not even touchable. They were 'doktor bey', 'doktor hanım'. These people did not talk, they knew, but when they said something was to be done in a certain way, it would be done as if it was Allah's word. It wouldn't be questioned no matter the result. There was a one-way relationship. There were upside and downside to this paternal approach. One of the downsides was that I think in society, among the people who are not doctors, there has developed an unbelievable negative aspiration. I mean, a secret grudge. Maybe we would see doctor as a person who you would thank when you need him, but never look at his face again, someone who you would never establish a social relationship with, someone who sees himself superior to you, a know-it-all. I mean, it was as if doctors were not a part of this society, but maybe were seen as different, as if they came from space. This was actually very wrong, wrong from the point of both sides. (R25, nuclear medicine, public university hospital)*

Another cautious stance came from a respondent who has pointed out that the highly prestigious place held by the medical professionals in society did not simply only come from their social authority and healing powers, but also from the high financial rewards they gained mostly through their private practices. In the decades before HTP was implemented, private practice was a widespread form of health care provision. According to this respondent, the social power and prestige older generations gained as a result of their financial power has caused

them not to be concerned for their profession's future, potential conditions of work, financial status and employment rights. The respondents held responsible the contentment of past generations with their social and financial position for why the profession currently struggles with low retirement benefits and violation of employment rights:

*The doctor drives the best car, lives in the best neighborhood, his children go to the best school, doctors lived like an elite class. They never dealt with the problem of medical profession today, the employment rights of the medical profession. That's why a doctor who is retired from the public sector does not get a retirement pension as much as a colonel or a judge does. Although he has to go through a longer and more difficult education. ... After 30 years I still question why I cannot have as comfortable retirement life as judge would have. The reason is our older brothers, older sisters in the past did not have worries about their livelihoods in the future, they had earned a lot of money from private practice, therefore did not have anxiety for the future, they were not even interested in the retirement pensions. (R1, neurology, private medical center)*

The nostalgia and mourning for the past public image of the medical profession demonstrates the significance of change in the expectations and definitions by the public in the self-perception of the medical profession. The shifts in the lived experiences through interactions with the public as a countervailing power lead to a mourning for a past where the professionals were socially and financially privileged, had more professional authority in society and professional autonomy in practice. However, respondents also refrain from purely idealizing the older generations, since they believe that the challenging character of their relationship with the public in the present has origins in the way older generations presented themselves to and distanced themselves from the public. Decline in respectability of the profession results in deliberation of the social distance between the public and the profession and negative qualities attributed to the medical professionals such as arrogance, conceit and superiority not only by the public, but also the medical professionals themselves.

## **7.2. Conflict between Professional and Lay Knowledge**

Advancements in medical technologies and information sciences emerge as an important dimension which perpetuate a more active patient that challenges the doctor's decisions and interferes in his/her clinical autonomy. The consumerist orientation of the system that prioritizes patient's satisfaction is further reinforced through prevalence of these technologies. As a result of these developments, a "impatient patient" has emerged, who expects the fastest treatment with the latest technology through an individualized approach (Akerkar and Bichille 2004). Also, development of information technologies allows standardization of diagnosis and treatment through algorithms used in forming individualized treatment plans (Timmermans 2005). Technological advancement and medical sciences result in medical technologies from the simplest devices such as syringes and bandages to medical imaging devices and AI applications, robotics, genetic and biomedical applications that transform not only medical practice but also how patients view medicine and its practitioners.

One very important technological change that has affected social and cultural realm of doctor-patient relationships is the easier access to knowledge provided by Internet and media outlets. Patients have diverse point of access to medical information through health and lifestyle TV programs, newspaper columns, and the limitless capacity of the Internet. Internet enables patients to access an overwhelming amount of information (Mechanic 2008), In a way Internet and traditional media demystify the medical knowledge for ordinary citizens (Hardey 1999; Hardey 2001). However, respondents argue that in most cases this allows patients to challenge doctors' orders and decisions. They demand certain options of diagnostic or therapeutic methods from doctors, because they have seen in on TV, social media or websites, or in some cases, heard about them from their acquaintances. The media allows the knowledge asymmetry to be narrowed between patient and the doctor, although the quality of the knowledge patients have can be questioned.

Respondents argue that while access to information is beneficial for patients to gather information about their conditions, organizations or doctors, it also poses a danger to the public, since not all of the information on media is scientifically verified. Information patients receive also includes advice and recommendation that is not scientifically proven, about alternative and complementary medicine, folk remedies and opinions of people whose credentials sometimes can be questioned. While the information patients come equipped with may be questionable, they arrive at their appointment with this information, may make an effort to direct medical decisions made by doctors.

*They can even come with demands about tests, or demands about medicine. They come saying 'I want to have an MRI taken', or 'it would be good if I had angiography, my neighbor also had one'. It may certainly be the response to a necessity sometimes, but only the doctor can decide that. (R13, public health, public university hospital)*

*He enters his complaint on the computer before he comes to the doctor, so I may have this, he says. There are all these verified, unverified information which he expects to be diagnosed with when he arrives at the doctor's. Because in his own opinion, he has become a doctor. When you say something, he says 'but isn't it possible that I have this?'. (R4, internist, private medical center)*

While patients' increased access to information is acknowledged by the doctors as a positive development, since they see it as "democratization" of what used to be a "paternal" relationship, they also define a boundary which they find inappropriate for patients to cross. Some respondents emphasized that while the traditional paternalist doctor-patient relationship is outdated and had sometimes operated to the disadvantage of the patient, their clinical autonomy is constrained and their professional competence is disrespected when the patient starts to interfere in, or question, their decision. They appreciate the knowledgeable patient until their orders and decisions are beginning to be challenged. The boundary is set as a line that separates mutual understanding on the competency and power of professional autonomy of medical professional on the one side and patient questioning and ignoring doctor's decisions and insisting on his own demands on the other.

*[The Internet] is actually a good thing when used well. Because it also enables patient to reach the right place. What is said about the Internet is also valid in this situation. For example, I'm someone who believes in the Internet, despite everything. Of course, there's information pollution, as there is every in every issue. There is in medicine, as well. But it depends on how you use the information. Or on how well you know yourself. I think as long as people know their place, information will not do any harm. (R25, nuclear medicine, public university hospital)*

Professional autonomy is not only the biggest privilege the doctors have, but it is also a major part of their professional ideology. They cherish them as the most significant values that pertain to their practice. Not being allowed to control the content of their work, as a result of patients' increased access to information, hinders their job satisfaction. They feel their professional competence, expertise, clinical judgement and medical opinion is disrespected. Trying to persuade the patient about questionability of information and inappropriateness of their demands also increases their workload and makes the treatment process more difficult (Fox and Rainie 2002).

*For example, she tells you her problem, that's one side of it; you're trying to explain some stuff, do this and that, you try to guide them, but ultimately, she says: 'but I read on the Internet, it doesn't say that'. If the potentials that can give this answer increases, why should I spend extra effort, why bother? The person across from you does not take you seriously as the expert of the issue. (R3, radiologist, private medical center)*

*He doesn't think much about what you think or the healing you'll achieve for him. They have also learned that for headaches you have MRIs, you go to the doctor, you have it taken. My personal opinion as a doctor regarding his headache does not interest the patient, that's how I feel. This creates a feeling of dissatisfaction for me, it makes me sad. (R1, neurologist, private medical center)*

Respondents' statement present that a more informed patient does not necessarily translate into improved doctor-patient communication, but rather, may hinder it if patient tries to use the information to interfere in doctor's clinical autonomy. In return, doctor may make an effort to exclude the patient from decision making, further deteriorating the relationship (Broom 2005).

One of the biggest impacts of patients' access to information is reflected in how the medical technologies mediate the relationship between patients and doctors.

The medical profession has a complex relationship with medical technologies. The advances in medical science and technologies, especially after the second half of 20<sup>th</sup> century, has enabled medical professionals to diagnose and treat conditions previously left undetected or untreated. This has contributed to the profession's credibility and legitimacy in the eyes of the public, which in turn contributed to the extent of their professional autonomy. On the other hand, based on the findings of this research, it has also transformed their relationship with the patients in negative ways. This impact is not independent from the influence of other countervailing powers, such as state or the market. State mediation as a form of institutional control leads the regulations defined by state agencies, such as Ministry of Health or SGK, to determine the extent of technologies that will be available through trade and procurement regulations, taxes, or indirectly through remunerations for utilizing these technologies which will finally be provided by healthcare organizations. Therefore, the market determines the extent of technology, the price and type of technology that will be available.

Medical technologies include everything from the most basic tools such as injections and bandages to imaging technologies, biomedical and genetic applications. In this study, “medical technologies” covers the most prevalent and more advanced technologies used in Turkish health care organizations, such as lab tests and imaging technologies such as X-rays, Magnetic Resonance Imaging (MRI) tomography, computerized tomography (CT), ultrasound, mammography, and coronary angiography. This limitation was made due to the large extent of the term “medical technologies” covers, and also because the access to these specific technologies have increased under HTP. While they were scarce and expensive in the pre-HTP area, their numbers have increased both in the private and public health care organizations. In 2002, there were only 58 MRI machines in Turkey whereas in 2018 this number has increased to 2011. While there were 1005 ultrasound machines in Turkey in 2002, in 2018 there were 5846 in public and private sector combined (Sağlık Bakanlığı 2021). Turkey has become the country in which most MRI exams are being conducted and third among the

countries in which most CT exams are taking place among the 31 OECD countries (Sağlık Bakanlığı 2021).

Easier access to information about medical technologies may lead patients to demand more care (Coulter and Fitzpatrick 2000), as the amount of information available on TV channels, Internet, newspapers, combined with the consumerism embedded in HTP, foster public's demand for the treatments, tests and technologies they often hear or read about. The increased accessibility and pervasiveness of these medical technologies and information about them has led to a perception of necessity among patients who also have more access to information about them. Respondents have stated that even when they make the decision not to use the imaging tools or tests since they could diagnose patient's condition without them, patients still demand these technologies. According to respondents, the widespread opinion in public that these technologies are now indispensable part of medical practice leads to a belief among patients that they will be better treated if they are utilized.

*Patient satisfaction is being pushed to the forefront. A big fraction of the patients is illiterate and they think 'the more blood is drawn from me, the more ultrasounds, tomography I have taken, the better examination I have'. (R3, radiologist, private medical center)*

The idea that these technologies are necessities, especially in the diagnostic process, affect how the patient assess the quality of the doctor. A medical professional's choice to use or not to use these technologies also affects patients' conception of what a "good doctor" is; they evaluate the medical professional as a "good doctor" when s/he chooses to use these technologies. The more a doctor consults medical imaging tools or lab tests, the "better doctor" he is, in the eyes of the patient. The respondents contest being evaluated on the basis of the extent that they use these technologies. They argue that while the patients may have more "information about" medical technologies, they do not have the "knowledge of" them. Medical professionals are the only experts who have the skill to evaluate the data that is received from these tools and technologies. However, this notion of "necessity", perpetuated through the information



patients gather through different channels of media, leads patients to challenge their authority and intervene in their clinical autonomy.

*If you don't do what the patient wants, it doesn't matter what he wants, it only matters that what he wants does not get done, he can very easily get in a fight with you and you cannot do anything about it. You cannot even touch him. He can easily say 'get this test and that test done to me'. Why do you want those, first tell me your problem. It's my diploma after all. Let me decide, it's an art. Let me choose them. No. The moment you say that, he curses, shouts, bangs the door, goes outside, talks outside, everyone says 'what a horrible guy this doctor is, what have I done to him.' Then they put it in writing. Look at this, a complaint from the emergency service again, I assess these. (R6, urologist, public hospital)*

Respondents also emphasized that patients insist on seeing “concrete evidence” on their diagnosis, which is another reason for why there is increased demand for imaging tools or lab tests. They require output of medical technologies as a visual aid to confirm the doctor’s diagnosis. Respondents interpret this as a result not only of patients’ view of the technologies as necessities, but also as an indication of erosion of patients’ trust in the profession and in competence of the doctors.

*I know a lot in my own specialty, but it is very difficult for me to convince the patient that 'you have nothing wrong, you do not need a tomography' in ten minutes. Many of them want tests done and relax right away. This is a difficulty in professional practice for me. Evidence based medicine truly exists. Every patient wants evidence. That is not enough, they also want medicine. (R1, neurologist, private medical center)*

Another negative impact of the medical technologies, according to all respondents, is that they have quit practicing the traditional preliminary diagnostic techniques such as physical examination and taking oral medical history from patients. While one reason for this is the convenience of the medical technologies in making diagnosis process faster and more efficient, the other one is the organizational structure of healthcare organizations which provide insufficient time for the doctor to conduct a thorough physical examination and communicate with the patient. They also argue that their physical and verbal contact with the patients is limited, and that this contributes to the perception that

medicine has almost become a mechanical and technical occupation. While the medical professionals themselves express this opinion as their own perception of trajectory of the medical profession, they also argue that medical technologies have perpetuated the patients' view of medicine as deskilled, technical occupation.

*In the past they wouldn't do angiogram done to anyone who has a chest pain the next day, but now, I'm not saying whether the angiogram is right or wrong, it's done very hastily. Therefore, they tell you whether you are a patient that will have an MR or not very quickly. Before you'd try to understand what type of pain he has from his history, through indirect methods. Angiogram was an important thing. But today say you have a chest pain, and your blood pressure is a little high, they say 'Come by in the evening, let's do an angiogram'; that's not a bad thing though, it's a good thing. (R1, radiologist, private medical center)*

*They come and want MRIs. For example, this can make you really mad, depending on [patient's] style. It's like you're a salesperson and he demands a product from you. 'Sell me this' or 'I want that'. Maybe this is actually related to how the doctor is perceived. You're someone who writes tests. The test will tell it. You're just a mediator that asks for the test. (R2, physical therapist, private medical center)*

Therefore, the increased role of technologies in medicine leads the patients to view medical professionals as lower status, deskilled employees, which is usually denoted by the respondents with the term “technician”, rather than a highly trained and qualified profession. “technician” is placed in contrast to the fundamental medical skills of interpreting complex and uncertain data and using clinical judgement. Respondents argue that the patients believe the results derived from medical imaging tools or lab tests are not data that can complement doctors' opinions, but rather tools that can replace their clinical judgement. Medical decision making by way of using devices and output is viewed as a mechanical occupation including standardized practices. While they do not think of themselves as deskilled workers, it is how patients view them. This is the result of image of a seemingly standardized practice that emerges as an extension of increased use of technology. The view of doctors as “technicians” facilitates challenges to and questioning of their clinical judgement, hence hindering their clinical autonomy.

Until the last quarter of 20<sup>th</sup> century, the diagnosis relied on medical professional's conduct of physical examination, observation and clinical judgement. He would touch the patient with his hands or small tools, which would almost be seen as an extension of his body. According to respondents, medical technologies make touching and speaking to the patient redundant, and therefore resulting in medicine losing its "human dimension". This is a mutual process in which the doctors are seen by patients as "technicians" who conduct routine, standardized tests, and patients are seen by doctors as "case numbers" or for example, "a case of tomography". This affects the doctor-patient relationship, reflecting negatively on the diagnosis and treatment processes.

### **7.3. Eroding of Trust Relationship between Doctors and Patients**

The respectability of the profession in society also reinforces the relationship of trust between the doctors and the patients. The public trusts the profession because it is respectable since it is traditionally viewed as competent and legitimate as a result of training and credentialing and its perception as an altruistic practice that makes fundamental and existential decisions on matters of life and death. This trustworthiness in return reinforces its high, respectable status in society. Trust is an indispensable aspect of profession's interaction with the public, and in extension, individual doctors' interaction with individual patients on a day-to-day basis. Trust is necessary to attain patient's compliance and thus, therapeutic success. The patients will only do what the doctors order if they trust them. Trust facilitates professional autonomy, allowing the medical professional to make decisions based solely on clinical judgement, excluding all interference, restriction and direction by external actors and factors, including demanding patients.

Nevertheless, various social, economic, cultural and technological developments are leading to an erosion of the trust relationship between doctors and patients. While some of these factors, such as technological advancement or accessibility of information are affecting doctor-patient relationship in many countries, some

others are specific to country's social, economic and cultural context. These factors are related to organization, financing and delivery of the healthcare services and to profession's relationship with service providers and mediators which, in Turkey's case, is the state agencies and government officials.

Respondents' statements also reflect that they have a conception of a "certain type of patient" (as used by some of them) that challenge their authority or interfere in their clinical autonomy, creating obstructions to their work. Although findings present that restrictions to autonomy is the result of intricate web of relationships between the profession, state, organizations as well as the patients, some respondents overemphasize the effect of patients with certain qualities, namely with low education levels and lower socio-economic background. An important aspect of the deprofessionalization thesis, which emphasized impact of technology and information with regards to doctor-patient relations, highlighted professionals' loss of monopoly of knowledge. It argued that this was a result of not only easier access to knowledge, but also due to increased level of education in public (Haug 1973; Haug 1988). In a similar line, Haug and Lavin (1978) found that better educated and younger patients are more challenging of doctors' opinions. In their study on chronically ill people's use of complementary and alternative medicine, Brink-Muinen and Rijken (2006) also found that socio-economic background, education level and age play a role in the extent of trust people have in medical professionals. They argue that while older and less educated chronically ill patients tend to trust medical professionals more, the younger and higher educated a patient is, the higher their level of trust in alternative practitioners will be.

The statements by the respondents in this study contradict these findings. The respondents do not identify challenging of authority with higher education levels, higher socio-economic background or a specific age group. Instead, they argue that state officials' discourse on the increased availability of healthcare services, and on doctors being "servants to the public" have led less educated (or in some respondents' words "illiterate" (*cahil kesim*)) populations to question them more.

Their view was also echoed in a report published by Ankara Chamber of Medicine, where lack of education is also stated by medical professionals as one of the main reasons for violence against healthcare workers (Ankara Tabip Odası 2011, 19). The way respondents describe the people who challenge their authority and intervene in their clinical autonomy by highlighting their lack of education or lower social status reflects the social distance between these patients and themselves.

*Because in the past 10 years people have no respect left. This is done on purpose. You know as well, it is done on purpose. I wish I could hide you in the corner and you could see, an elementary school graduate comes and meddles with the test I will do or medicine I will prescribe. If you don't do as he says he can file a complaint. And we have to officially respond to these complaints, I mean we struggle. It wasn't like this in the past. (R6, urologist, public hospital)*

*I'm trying to explain to you the way they look at you, maybe this goes for all of the services sector, but it is a bit different in ours. In the past 10 years it has become a disgrace. The guy would walk in saying 'you'll examine me man!' in [the previous public hospital he worked at]. There is the frustration of coming from a lower stratum; during this government it has turned into insolence. I will say this vulgarly, I don't know how you will reword this but, the mob started to emerge to the top, as the saying goes. I will have a lot of explanations for this but, ultimately there two out of 10 patients come to quarrel with you, what is actually underlying this is the feeling of inferiority. (R23, ENT, private hospital)*

*[View of the medical profession] depends on the section of the population. If the education level is above a certain level, they can see it as intellectual, if it is below a certain level, they see it as 'well well well, how much many they make'. (R3, radiologist, private medical center)*

*[We are not respected anymore] corresponds to the increase in feeling of self-confidence of %50. With the increase in their self-confidence. For example, now they bump into you and run over you in the hallways. In the past they would step aside to yield. (R8, pediatrician, training and research hospital)*

The 50% mentioned by Respondent 8 in the second statement implies the AKP voters, who initially composed of rural, lower-class populations who previously had difficulty in accessing health care services. This group is situated in contrast to the medical profession, whose reach, social status and authority Turkey had always exceeded that of the medical sphere, as an extension of their roles as modernizing elites since the Early Republican era. They were traditionally seen as possessing cultural, social and symbolic capital. However, state officials'

emphases on the potential high financial rewards provided to doctors under HTP (through performance-based payment methods), has contributed to the change in the public's view of the profession. This was accompanied by state and AKP government officials' statements about the flaws of the old healthcare services, blame for which they placed solely on the medical profession. AKP officials have used discrediting statements about doctors in order to appeal to the rural, lower class and less educated voters, which has led the public image of the medical professionals to transform from "elites to be respected" to "elites to be challenged".

Although most of the medical professionals that worked as a civil servant did not often achieve high financial rewards until HTP, some who owned private practice on the side had higher levels of income in the past. Respondents state that while the extent of mistrust and skepticism in public towards their financial status and motives have increased since the beginning of implementation of HTP, there had always been a subtle, unvoiced hostility towards the profession. However, they argue that it was never loudly expressed, according to respondents, as a result of their highly regarded status in society. Accessibility of medical professionals and medical care has also contributed to the hostility and deterioration of public image, according to respondents. Increase in the number of healthcare organizations and medical school graduates, as well opening up of different kinds of public and private hospitals to the whole population through GSS and private insurance schemes, has enabled more access to healthcare services. Doctors were no longer inaccessible, unapproachable rare elites who patients saw if they could financially afford it, if they had the means to travel to the nearest major city or were insured by certain public security schemes based on their occupation.

*In the past there was more of an admiration, 'how wonderful is your profession' they would say, and I felt like that. I don't feel that way recently. I think they act as if it's insignificant when they hear [what I do]. Maybe more people come across more doctors. This can be a one aspect of it, the other can be the discourse that decreases respect for the doctor, which is heard a lot. And there is also this, in a country where economy is bad, doctors are always presented as*

*rich and well-off. Therefore, public may not empathize with you in this sense, they see you as 'they already swim in money, they earn easy money' and do not feel the need to love or respect you. (R1, neurologist, private medical center)*

*The rate of dissatisfaction is very high. I think that has to do with change in Turkish people's character. In the past the feeling of respect they had for you was high. Now they say, 'who cares? If it's not this doctor, there's another one'. In a way, they are right. (R16, urologist, private hospital)*

The claims by state officials on doctors' "selfish" actions, emphasizes on flaws of the old healthcare system and medical malpractice as a result of these actions, and variability in medical professionals' fees and practices have led the public to view the doctors as self-interested and greedy elites, according to respondents. The asymmetry of power and information and the abstract, complex and uncertain nature of medical practice makes it difficult for outsiders to evaluate the worth of medical services. This character of medicine also makes the doctor-patient relationship open to exploitation. Respondents argue that these factors combined are the reason why it is easier for the public, which is the more vulnerable party in the relationship, to believe unrealistic or false claims by state officials about financial rewards of doctors, or underestimate the worth of their services.

*They called doctors who have private practice 'swindlers', they said they take knife money, they called them 'degenerates, ticks', said they suck blood. (R23,*

*For example, I see a negative trajectory when I compare the image of the medical profession in the years I started practicing medicine and the image now. When we talk about this, we hear 'there are doctors who do this and that, for instance, there are doctors who get knife money' and so on. I got sick and tired of this stuff, because there are people like that in every profession. (R25, nuclear medicine, public university hospital)*

*Look, a person can choose what shoe or pencil he'll buy, and there are no schools for either of those. These are not areas of expertise. You may hear people say 'shoe expert' and so on. That's not how it goes. But a person cannot evaluate how, to what extent, for how much or in exchange for what he is going to have his health problem solved. This is a moment where expertise can exploit, deceive, trick. ... 'We'll do an angiogram, we'll place a stent, I will get your 5000 dollars, the equipment used in angiogram is an additional 700 lira.' 'Of course Hocam, whenever you say'. 'Or else you'll die, you'll have a heart attack. Now I'm not a cardiologist, if you tell me this, even I get worried as a medical professional. If I was a brain surgeon and a cardiologist told me this, I would be worried. If the brain surgeon told the cardiologist 'brother, I tell you*

*what, that mass is not benign, we have to remove that'. Of course a doctor does not ask for 10000 dollars from another doctor, but I would be worried if I heard these words, that's what I'm trying to explain. 'I'll do the operation, I'll do it right away, our price is 15000. That's how it is. We do it at M. [private] Hospital, we do it Ç. [private] Hospital'. What could anyone say to this? He would give the shirt off his back. (R19, pathologist, public university hospital)*

*Customer relations decreased respect. The doctor earns twice as much compared to the past, but in patient's view it's 20 times as much. ... Patient and the doctor should not be pitted against each other. Service providers can declare how much the doctors are making. Then the patients would also be informed. In the past it was a respectable, trustworthy profession. When you were selling a care, or among neighbors it implied 'this person is honest, he tells the truth', now it became 'this person is greedy for money'. It became 'The doctor earns well because of me', it became 'he better care for me'. There was envy, admiration, now it turned into violence. (R24, nuclear medicine, training and research hospital)*

Traditionally, the professional group in society has been characterized as involving ideological support connected with anti-market structures (Larson 1977). Selflessness and altruism of the profession have been important aspects of public trust. The significance of professional autonomy is that it is both “a privilege and a responsibility” (Sandstrom 2007). The profession does not have to maintain autonomy only as its right and privilege but also as responsibility, which is a part of its ‘social contract’ with the public. Social contract based on reciprocal relationship in which the profession commits to being trustworthy and competent convinces the public that it will act in public’s best interest, and in return attains public trust and compliance. The loss of public’s belief in profession’s possession of service orientation, altruism and selflessness leads to a decline in trust in the doctor-patient relationship, which hinders the quality of medical practice as well as professional’s own view of self-worth.

*But where the relationship is democratic, respectability of the profession carries a lot of significance, because everything between the patient and the doctor begins and ends with trust. If that trust does not exist, you can't properly inform the patient or conduct a procedure nor properly guide the patient. It wouldn't even be possible to have something done to the patient which you know is going to definitely work. Without that respect, feeling of trust, there will be no medical practice. (R11, radiologist, public university hospital)*



Eroding of trust in medical profession, its competence and altruism in the public view in society and in the daily interaction between doctor and patient is damaging because it can cause professional autonomy to be challenged. Medical professionals attribute this change in the relationship to a certain patient profile, however it is not simply caused by a change in patients' characteristics or behavior. Underlying this change is the changing public perception of the profession which is triggered by government officials' approach, increased polarization in society and increased access to information and technologies. While the respondents explain the change in doctor-patient relationship with patients' low education levels or socio-economic background, at times they do not consider the particular social context in which the patients react negatively to medical professionals. Besides the political atmosphere, changes in healthcare provision which restrict time with the patients, overwhelming demand on technologies, long lines and even the hefty fees the patients have to pay are sometimes ignored by medical professionals who instead focus on particular characteristics of patient profiles. Yet, as a result of these social factors, a patient who does not trust the medical professional and his/her decisions can try to assert his own demands, cease following doctor's orders or even simply abandon treatment. These all have a negative impact on their quality of care he will receive. Therefore, decline in trust does not only affect medical professionals' job satisfaction or self-worth, but also the general quality of care in the healthcare environment.

#### **7.4. Violence Against Healthcare Workers**

While scholars are writing about the changing doctor-patient relationship in the face of decline in professional autonomy and authority, a new issue has emerged in Turkey that does not only threaten their autonomy, but also puts their safety in danger. Daily instances of violence against healthcare workers have become an important problem all healthcare workers, including doctors.

Violence against healthcare workers has been on the rise in the last two decades around the world. Studies have shown that its characteristics can vary based on countries social, economic and cultural context, and that some healthcare workers are affected more by it than others (di Martino 2002). Many studies have been conducted around the world, focusing on different kinds of healthcare workers in diverse settings. The studies show that violence takes place most in emergency wards and psychiatry wards, and that nurses and those working in the emergency are affected most by it (Hesketh et al 2003; Arnetz et al 1998; Kwok et al 2006; Adiba et al 2002; Kamchuchat et al 2008; Gacki-Smith et al 2009; Fernandes et al 1999; Gates et al 2006; Coverdale et al 2001).

As violence against healthcare workers became a major problem in healthcare services in Turkey, it has become hotly debated not only healthcare setting but also as a political issue. While all healthcare workers are affected by the issue, the focus has mostly been on doctors, as the violence they are subjected to make the news regularly. What makes Turkish context distinct among others regarding this problem is that, while physical, verbal and psychological violence has become widespread around the world, murders have also taken place in Turkey. Seven medical doctors have been murdered in the healthcare organizations they work in between 2005 and 2018, by patients or people who accompany the patient, who are, in most cases, their relatives. Tens of thousands more have been subjected to one of the three kinds of violence as defined. While most common forms of violence Turkish healthcare workers face are verbal and psychological, physical violence is the form that is most commonly reported to authorities (Keser Özcan and Bilgin 2011). At least 30 healthcare workers experience violence in some form every day.

All respondents in this research have stated that they have been subjected to verbal and psychological violence by patients or people who accompanied them. While none had been subjected to physical violence, they have all either witnessed a case, or know of a colleague who has been physically attacked. Verbal and psychological violence they have experienced includes scolding,

humiliation, cursing, peremptory attitude, insisting on unreasonable demands, verbal threats, or official complaints.

*Of course, I have been a doctor for so many years, I have lived through it, I have witnessed it. Verbal, psychological pressure. He brings his patient, 'if he dies, I will come after you'. (R4, internist, private medical center)*

*Threats... I haven't been subjected to physical violence but I have been subjected to threat of violence when I was working at the medical center. I have also been subjected to verbal abuse. For instance, some of them happened because I wouldn't write a prescription for patients I have not seen. Maybe these people were right in their own way. They were patients' relatives. They had a problem but since it wouldn't be right for the patient... I have been shouted at, cursed at, insulted many times for patients I haven't seen at all. I haven't been subjected to physical violence. (R18, psychiatrist, private practice – private medical center)*

*It is more psychological, with verbal bullying. Once someone attempted physical violence but eventually nothing happened. He was pushed away. (R22, pediatrician, training and research hospital)*

According to respondents, HTP reforms directly contribute to the increase in violence against doctors. The most frequent aspect of the reforms that contributes to violence is the consumerist orientation embedded in the way financing and organization of the services are structured. Respondents argue that patients have internalized their positions as customers, which result in sudden and hostile reactions against the doctors unless their demands are met. In addition to problems in service delivery, AKP governments' and state officials' attitude towards medical professionals have contributed to violence. Some respondents even argue that it has "promoted" violence against medical professionals, by provoking the public with their disparaging statements about doctors' and their incomes, as well as blaming them for the flaws of the system. Combined with increased access to services, patients' expectations from healthcare services are raised in a way that is unfit, according to respondents, with the actual capacities of professionals and organizations.

*There's a system which affects the doctor-patient relationship very negatively, and where healthcare workers are presented as sole culprit responsible for all kinds of problems patients have due to marketization. It comes back to us as*

*violence. Processes that lead to battering doctors, healthcare workers, that go as far as murder. (R13, public health, public university hospital)*

*I'm talking in terms of this hospital, the place where most violence takes place and can potentially take place, is this emergency room. It is relatively less in private hospital. But it is relative. It doesn't mean it does not exist. It is less than public hospitals. But it is also the same here, feeling an artificial power in themselves, not feeling where it actually comes from, with demands that emerge due to misleading suggestions by politicians or by wrong offers, patients want a service from us which we cannot deliver here. We come across unnecessary things. Even when you politely explain that it is not possible, it gets a bit harsh most of the time. (R15, emergency/family, private hospital)*

*What I'm saying is that you can go to any hospital, any doctor anytime you want. When they started shouting this out loud, patients started thinking that doctors are slaves, like donkeys, sometimes you can take out the whip and hit them, make them work better, you can make them serve you. With this assumption, look at the level to which violence has come to in 10 years. (R19, pathologist, public university hospital)*

*For instance, last year one of our residents has been attacked with a knife. It happens a lot. We hear it a lot here. First of all, there is a lot of verbal violence. There a lot of abuse. This is the abuse I'm talking about: They want things done right away. They want tests to be reported right after they get the appointment, when their demands are not met, they can response very harshly. First to the assistant healthcare staff, secretaries, technicians, then to the doctors. Or unfortunately we get directly attacked for what we do. For example, we get unfairly filed complaints. (R25, nuclear medicine, public university hospital)*

Although violence takes place both in public and private healthcare organizations, as respondents have also emphasized, it is more common in public sector. The motivation behind attacks against healthcare workers in private sector is mostly interpreted as triggered by the consumerist orientation of the services which prioritize customer satisfaction. In accordance with the same approach, the neoliberal restructuring of healthcare services has implemented a discourse that frames public services as inefficient, which extends to public sector employment to be devalued and public sector employees to be viewed by the public as, greedy, undeserving and idle. This perception plays a significant role in escalation of violence in public healthcare organizations, where emergency rooms are especially at risk. While the Ministry of Health has put in place certain measures to prevent violence, such as *Beyaz Kod* application established in 2012, through which the healthcare worker who is being subject to violence can alert authorities and security forces instantly; respondents argue that

these measures are not effective, since they do not focus on preventing the violence attacks, but rather address the aftermath.

*If there is a physical attack, we dial something called Beyaz Kod. A security guard comes. If you've been beaten then, they arrive. 000, I think, you have to dial that. By then whatever happens, happens. After this there is a very lengthy procedure, you go to the police station altogether and so on. They have made it a very grueling, maybe so that we don't file complaints. So it has no practical use. Now it has become, let him get out, let him leave, as long as he doesn't mess with me. (R6, urologist, public hospital)*

Between 2012 and May 2018, 68,375 cases have been reported to the application. %30 of the reported were physical violence cases. Most of the verbal and psychological violence cases go unreported. It is also important to note that *Beyaz Kod* application does not include subcontract laborers who work in cleaning or food services, or the intern doctors. Therefore, besides being an ineffective measure, the figures *Beyaz Kod* attain do not accurately reflect the extent of violence in the healthcare organizations since it excludes some key workers in healthcare organizations.

Respondents also describe self-protection measures they have taken on their own, cooperating with the colleagues, rather than relying on official security measures taken by the healthcare organization or Ministry of Health. They come up with their own solutions to protect themselves, which range from simple to more drastic. While one respondent mentions hanging signs in the emergency ward he works in as a measure, another respondent mentions young doctors in the emergency ward carrying pepper sprays.

*Although I don't approve of it, and you usually don't have [violence] in private hospitals, we hung warning signs. Last year, they acted as if they were taking some precautions, there was a circular. Its name was something like "Security of the Healthcare Worker". There it stated we should hang signs on the walls which said "be aware, if something happens, a prosecutor will assess the situation, a complaint will be filed against you, so don't do it". So, we prepared a warning sign and hung it in a place where patients can see. I think it's a hideous expression but we now need to warn people this way, because people do not have much awareness. It is not our duty to raise awareness, but you become subject to their lack of awareness. (R15, emergency/family, private hospital)*

*The other day we lived through a very heavy act of violence in outpatient clinic. Polyclinic room was destroyed, the computer was destroyed. Then people who did this were released. We just lived through this recently. [Resident doctors] have come to the point of leaving the profession, they needed support, they cried. They circulate pepper spray among each other. The location of the hospital also has an impact here, that is in Ç. neighborhood. But they say 'we give each other pepper spray, what can we do'. There is a lot of violence in the emergency room. At night. (R8, pediatrician, training and research hospital)*

The protective measures the respondents describe are mostly for protecting themselves against an anticipated physical attack. Verbal and psychological violence are viewed as a daily occurrence; the frequency with they come across verbal and psychological violence causes them to normalize this kind of violence as “a part of the job”.

*We are subjected to verbal violence almost every day, we don't even care that much anymore. Every patient says this very easily, 'people who murder you are doing good' and just leave. It doesn't constitute a crime in prosecution office even when it's put in writing. I see a lot of writing, about complaints. Violence has become very ordinary. (R6, urologist, public hospital)*

Respondents also classify official complaints by patients are a form of violence, arguing that the complaint system is structured to act as a form psychological pressure on healthcare workers, making it a conventional form of violence in the perception of doctors. Since patients are free to make complaints about any issue regarding the doctor, and doctors in return have to reply to investigation by management, this becomes a process which acts a coercion to act in a manner that will satisfy the patients.

*Of course this also an act of violence for us, being unfairly sued, complained about to the administration or patients' rights office, complaining without comprehending what's what. Even these can be counted as elements of violence. Because these things abolish one's work performance completely. You have no desire left, you don't want to see a patient, your feeling compassion towards people goes away for a short while. (R21, internist, private hospital)*

One of the strong emphases of HTP was on patients' rights, instructing patient's rights centers to be opened in the health care organizations, as well as establishing a complaint call center. SABİM (Sağlık Bakanlığı İletişim Merkezi)

system was set up 2004 by Ministry of Health, which enables patients to call in their complaints and issues with health services, organizations and healthcare staff, express their demands and recommendations. While it seems like it operates to the advantage of the patient, it has become a mechanism of oppression for healthcare workers. According to respondents, it is an extension of the consumerism, aiming for “customer satisfaction”, while ignoring the safety of the healthcare workers. Patients can make anonymous calls when they are expressing their complaints, however there aren’t any detailed investigative mechanisms to verify the claims. Nevertheless, healthcare workers are obliged to answer to every claim, which creates tremendous amount of pressure and tension on them.

*Mentally, my feet go backwards, every morning I’m tired when I wake up. We have become scared of the patient. Because they complain about everything and these complaints find command. The patient can meddle in my choice of treatment and this is funny, he can complain when I don’t do the treatment he suggests. And I have to write a reply to this complaint. The patient clearly states in his complaint, ‘he did not do the treatment I wanted’, it’s like a joke. (R6, urologist, public hospital)*

*I don’t know if it has to exist, certain offices, complaint centers have been opened. But they haven’t been managed well. If the patient is waiting in line, he held the doctor responsible for that, if he pays too much, he held the doctor responsible for that. He held you responsible when he had a fight with another patient at the door, he held you responsible if the patient inside went outside late, he complained ‘she doesn’t smile at me’, he complained ‘she doesn’t look at my eyes when she talks’. We’ve seen all this. Complaints are not filtered, no matter what, you are asked for a response for any kind of complaint that comes to the patient’s rights [office]. Be right or wrong. Of course, this demoralizes you. If the complaints are filtered, they should of course exist; but when you are asked to respond to complaints that say ‘she did not look at me in the eye when she talked’ or ‘I didn’t like her today, she wasn’t pretty’.... For instance, a patient here complained about me. She wrote letter to complain, in the latter she wrote ‘I don’t want to give my real name’, she used a fake name. Management sent this letter to me and asked for a response. I said ‘I don’t know the name of the patient, I have to go to my files and look up the patient, in order to respond to the complaint, I have to know the patient, what am I supposed to write here?’ How am I supposed to know which patient it was? You go now, say ‘I didn’t like N. Hanım’s shirt today, it bothered me’, they’ll ask me to respond. This is the rule. No matter what you complain about, it comes back to us, and we have to respond to it in writing. (R20, internist, private hospital)*

The most disturbing aspects of the complaint system for the respondents is that the patients are able to complain about anything regardless of their relevancy to the quality of medical attention they are getting, and that they are able to do this anonymously. The complaint system is a mechanism of performance control, which aims to shape doctor's behavior in line with consumerist principle. Prioritization of "customer satisfaction" results in medical professionals feel unprotected by authorities which are also obliged to defend them. They argue that Ministry of Health leaves them to their own devices for their protection and encumbers them with responsibility of the all problems patients may face in service delivery.

*He'll snarl at you, he'll throw out his grudge, he knows that Ministry of Health is behind him. Ne matter what you do, it has happened to me couple of times, you're asked to respond, but it is demanded in such a way that you're seen as guilty head on. They know this so they treat us like dogs. They quarrel with us, they call us idiot, he says damn it, isn't there another doctor? (R23, ENT, private hospital)*

While violence against healthcare workers has become an issue for the safety of the healthcare workers, it is also a factor that profoundly affects clinical autonomy of the medical professionals. Threat of potential violent attacks prevents them from making decisions based on their clinical judgements; instead, their decision making may be based simply on protecting themselves, by submitting to patient's demands or by avoiding risky and complicated procedures which may cause medical complications, which are part of what is referred to as defensive medicine.

Defensive medicine practices include avoiding risky or complicated procedures, referring patients to other colleagues or recommending tests or procedures that are not the necessary. Although his/her clinical judgement advices otherwise, the medical professional may choose to opt out of a risky operation, use other means of treatment or depend heavily on unnecessary diagnostic procedures. While defensive medicine is usually identified with avoiding procedures by respondents, overtreatment and overdiagnosis are also two other ways in which it



emerges. These are caused by conducting unnecessary tests or procedures to ensure every ground is covered when diagnosing the patient, in order not to overlook any factors or conditions. Respondents state that defensive medicine is getting widespread to avoid violence against medical professionals; as a response to performance assessment and payment schemes that do not differentiate between routine, simple procedures and complicated, risky procedures; and prioritization of customer satisfaction in organizations, which enforces sanctions on medical professionals when a complaint is filed against them.

Violence affects medical practice in profound ways, by becoming a central pressure posed against clinical autonomy. Respondents state that they may yield to patients' demands when they perceive a potential threat, or resort to defensive medicine practices. In order to protect themselves against violence, to avoid confrontation with patients and relatives, or in some cases, avoid malpractice lawsuits, they may reevaluate their decisions and choose an option that is less efficient and costly.

*Sometimes it goes like this, he has heard about it, he comes saying 'let's have my MRI taken'. So therefore, the ability to decide comes before us with pressure by the patient, and comes even as this pressure turns a bit into violence. To prevent bickering and quarrel, most of the time we send the patient saying 'okay, let's do it'. Noone attempted to hit me but many have raised their voice. (R1, neurologist, private hospital)*

As respondents often emphasized, the performance assessment and performance-based payment schemes in the public and private sectors do not differentiate between routine, simple procedures and complicated, risky procedures. Since they are not financially rewarded accordingly, respondents feel their skills and experience are devalued and go unacknowledged. As the threat of malpractice suits or patient complaints are also hanging over their head, they state that many colleagues prefer to avoid procedures that carry the risk of medical complication more than others since they believe their efforts will not be worth the risk they are taking. However, this results in difficulties in finding an experienced and skilled medical professional to administer the treatment, especially in the area of

surgery, as a result of skilled surgeons avoiding risky operations. One respondent state that as a very experienced and skilled transplant surgery professor, this system which does not acknowledge specialized skills, risk and complication was the reason why he decided to retire early from his post and switch to employment private sector instead.

Prioritization of customer satisfaction is another reason why doctors may choose to resort to defensive medicine practices. Since they want to avoid having complaints filed by patients, they may choose to avoid risky procedures, which increases the chances of complications and therefore, complaints to management or malpractice suits in courts. However same approach may also result in conducting unnecessary tests or examinations; as one respondent states, they may choose to do all possible examinations available to them in order to not miss out any possible diagnosis, even when they do not see necessary. These actions carry the threat of overtreatment or overdiagnosis which not only decreases the quality of care patient receives but also increases healthcare costs.

Inevitably, interacting with “potentially” dangerous patients affects their relationship with all patients. Decline of trust for the profession increase the likelihood of a medical professional to be subjected violence, but on the other hand, it also leads the medical professional to lose trust in the patient, as well. Violence against healthcare workers damage the “social contract” based on a mutual trust between the professionals and the public. As trust and authority erodes, violence emerges as a form of patient behavior that causes intervention in clinical autonomy of the professional. The medical professional seeks to prioritize his/her own safety and make decisions based on protecting him/herself, rather than based on his/her own clinical judgement, by practicing clinical autonomy and choosing what is best for the patient.

The dimension of professional autonomy that is most affected in the changing doctor-patient relationship is the clinical. Trust is eroding between the two parties, resulting in declining professional autonomy. It is affected by the

changing public view of medical profession in society and changing doctor-patient relationship in the individual level. The change in how the public and professionals view each other is mutual. Respect towards the profession declines among the public, which leads them to question whether they can maintain their social status in society. In this sense, how the doctors perceive the past and present of their profession also emerges as an important theme, as they question the role their own older colleagues and their status in society play has played in the trajectory of these relationships. Nevertheless, the responsibility of declining trust and respectability falls upon the challenges by less educated population, who, according to respondents are being provoked by AKP governments' discrediting rhetoric about medical professionals. AKP has utilized the social and economic distance to polarize the patients and professionals in a way that does disservice to the medical professionals, to the extent that their autonomy can be challenged by the patients. Increased access to information and medical technologies and prevalence of medical devices in medical practice have also become important factors in explaining the transformation of the doctor-patients relationship, as they encourage patients to question and challenge clinical decision making by medical professionals. The challenges and intervention to professional autonomy have also taken a violent turn under HTP, as the emphasis on consumerism and accessibility have led to demanding patients that may sometime resort to violence when faced with medical professionals who they view as the indifferent elites that pursue their own self-interest. Violence against healthcare workers also emerges as a significant factor that results in decline in the extent of medical professionals' autonomy as it leads medical professionals to resort to patient demands or practices they would otherwise view as unnecessary in order to avoid confrontation and violence. Findings in this study present that the relationship between the professionals and patients is influenced by the relationship between the state and the profession, how healthcare services are regulated and organized and how the healthcare market and labor market is structured. The transformation of professional autonomy takes place within a web of relations between powers who want to restrict this autonomy by counteracting against the medical profession.

## **CHAPTER 8**

### **CONCLUSION**

This study aimed to examine the transformation of professional autonomy of the Turkish medical profession under Health Transformation Program (HTP), implemented by AKP governments since 2003, which entailed changes in the organization, financing and delivery of healthcare services. In this context it addressed autonomy of the medical profession as a group and medical professionals as individual members of this group, using concepts of political, economic and clinical autonomy.

Main research questions that were addressed by the research are as follows: How did the extent of professional autonomy change after HTP from the perception of medical professionals? How do their relationship with the state, the healthcare services and professional labor markets and the public have impact on professional autonomy? What are consequences of the changing extent of their professional autonomy on their daily working lives? Do medical professionals experience political, economic, clinical dimensions of professional autonomy as independent or interrelated values? Is the case of professional autonomy of Turkish medical professionals distinct from other explanations in literature?

In order to answer these questions and achieve the research aims, a theoretical framework that has the explanatory power for the Turkish case was necessary. Looking at the Anglo-American models of professions and professional autonomy that dominate the literature, I found the theories and explanations that emphasize professional autonomy as a stable, inherent and absolute quality insufficient. They viewed the state's relationship with the profession as free of conflict and market as in coherence with the profession's interests. When state and market are mentioned, it is to emphasize profession's independence from

them, its domination and authority over them, to explain how these actors support and legitimize profession's power and status. The traditional explanations of professional autonomy overemphasize profession's power, its unity as a group with collective interests and not much internal stratification.

However, professional autonomy of the Turkish medical profession was institutionalized under what can almost be characterized as the patronage of the state, fluctuating based on how this relationship has changed throughout history which also affected profession's relationship with the public and the market. Therefore, a dynamic system approach that addresses the power struggles and different actors in society proved to be more useful. Light's Countervailing Powers Approach that emphasizes the importance of looking at the tensions, struggles, negotiations and alliances between the profession, state, market and public was fruitful to understand how professional autonomy of the Turkish medical profession was institutionalized and transformed in interaction with these other actors. Also, in order to study the factors that affect the professional autonomy of Turkish medical profession under HTP and their impact, perceptions of practicing medical professionals were important. Therefore, a field work consisting of in-depth-interviews with medical professional in Ankara was conducted.

In order to conclude this study, an overview of each chapter and findings of the research will be summarized. Then, the contributions main contributions of the research will be presented, indicating how it addresses the existing gaps in research and how it challenges them. This will be followed by limitations of the research and propose opportunities for further research on this topic.

In order to answer these questions, first a theoretical overview of professions and professional autonomy were provided. Professional autonomy has traditionally been regarded as the most important and prized professional value of the medical profession. How it was approached reflected the social and political context the specific study was located in. The plethora of studies from United States and

United Kingdom, has resulted in the theories based on American and British medical professions to be approached as the general models that dominate the literature on sociology of professions. The theories based on Anglo-American history of professions presented a formulation of independently established, absolute professional autonomy with the state as an external actor which legitimizes and sanctions profession's privileges and public as the supporter of legal domination of the profession. the legitimizer and the public as supporter. However, studies that focused on other countries and regions have demonstrated that professions have developed and institutionalized in much more close, intricate and dynamic relationship with the state and that in some cases state can even become an obstacle to acquiring professional autonomy. nevertheless, there has been a consensus that reforms taking place in healthcare systems around the world since the second half of the 20<sup>th</sup> century, have been unfavorable for professional autonomy. Changes in the organization, financing and delivery of healthcare services have affected the character of healthcare market, professional labor market, patients' role and their relationship with medical profession and the state's role in regulating and providing healthcare. It was argued in this chapter that the notion of dynamic system approach embodied in Light, Abbott and Johnson's work allows the abstraction of this network of relations between profession, state, market and public in understanding the transformation professional autonomy. A conceptual framework to operationalize dimensions of autonomy was also presented. Political (collective), economic (individual) and clinical (individual) autonomy were defined to elaborate on medical professionals' experiences and perceptions. These categories are essential to be able to answer whether the medical professionals perceive these dimensions as separate or intertwined through their daily experiences, and to understand how much professionals' individual experiences and their perception of their group's experience coincide.

Second, a historical account of institutionalization of Turkish medical profession, its relationship with the state and its status in society were presented. This account has demonstrated that the Turkish medical profession had profound

influence and power in society, which was not limited only to the medical but also social and political realms. It developed in a very close relationship with the state, which did was not only the enabler or supporter of the profession, but played a very active role in institutionalization of profession by establishing its institutions, becoming the main provider of healthcare services, main employer of medical professionals through public services and promoting their power in society as modernizing and rationalizing leaders in social and political life. Therefore, the Turkish medical profession never had absolute autonomy unlike the model of autonomy suggested by most Anglo-American narratives.

In the founding years of the Turkish Republic, modern citizens were no longer seen as subjects of a religious-political authority, but rather as citizens whose rights were protected and served by the state. Health services were an important element of this transforming relationship between state and citizens. State's priority of public health as its responsibility allowed doctors to gain a new authority over citizens. Doctors emerged as social and political leaders due to their role in sustainability of the welfare and wellbeing of the population, as implementer of reforms, as diffusers of state's message to citizens. This has led them to come to be seen as embodiment of "the state" especially in rural provinces, along with other appointed authority such as teachers, district governors, military officers and police commissioners. Their authority and power were not gained as members of a group that is independent from the state, but rather from their position as dutiful elites embedded in and working for the state. However, state's role as the sole authority over any issues of medicine and health care, has led to some strains in the relationship between the state and the profession, despite the fact that some of their members were also state leaders. The medical profession only had partial clinical autonomy (through inadequacies in infrastructure and state's emphasis on public health), and partial economic autonomy (since most were civil servants whose salaries were determined and paid by the state), and lacked political autonomy (since they lacked associational mechanisms that would enable bargaining and negotiating with the state). The state was keeping conduct of professional work under control by enforcing full

time act, by determining the fees of civil servants and not allowing the profession to bargain this issue effectively. Beginning in the 1960s, the profession increasingly rejected the state's mandate, with efforts to achieve political autonomy. The relationship strained as TMA became more influential among doctors, and found itself a place in the sphere of political opposition. Its rhetoric and course of action became more politicized and radicalized throughout 1970s, not constraining itself into its own debates, but spilling over to other areas of struggle in society. While the relationship was never fully smooth, and the profession never had absolute autonomy, the collective discontent on their relationship with the state had started to be voiced more often and in a more organized manner throughout 1960s and 1970s.

1980s and 1990s were a period of strain not only in the relationship between the state and the profession, but also between patients and profession, and profession and the market. The changes in health care services, expansion of private sector and increased number of medical schools have led to loosening of the ties between members of the profession by diversifying the context and conditions of work and training. Diverging interests within the profession have emerged through work under different conditions and increasing competition. The discrediting discourse of the state officials about medical profession and putting the blame of dysfunctional aspects of the system on doctors strained the relationship between the profession and the state as well. First steps for reforms that aim to privatize and commercialize healthcare services were taken by governments in early 1990s.

The tension between the state and the profession has reached its pinnacle under AKP rule, as HTP was put into effect in 2003, as soon as it came to power. The developments that took place in financing, organization and delivery of health services under HTP has profoundly affected the relationship between the medical profession, markets and the public. However, this was only one dimension of AKP's efforts to restructure healthcare policies. AKP regime is characterized by neoliberal populism which presents a specific juxtaposition of neoliberal policies



and populist discourse that denounces secular, educated groups with a Western outlook as part of the elite against the general will of the common people. Neoliberal populist character of AKP governments gained mass support from vulnerable, economically and socially disadvantaged groups who previously felt excluded from political participation and representation through constant emphasis on duality between values and morals of what it presented as greedy, selfish elites and the “common people” from whom it claimed to be representative of. Medical profession became a target in this discourse as emblematic of the former, a rhetoric which became a fundamental tool in legitimizing AKP’s policies to subdue the medical profession. AKP governments’ constant ambition to take the medical profession under its control culminated in legislative changes that will further weaken the political autonomy of the profession. Doctors have increasingly been constrained to working in healthcare organizations, the numbers of which have profoundly increased with the expansion of private sector. The public sector has become increasingly managerialized, affecting conditions of work for medical professionals. The attitude of the AKP governments and promotion of consumerist services has negatively affected the relationship between the doctors and the patients, patient demands and challenges rising to a point where violence became a daily reality in work lives of healthcare workers, including doctors. Therefore, concerns have been raised for the political, economic and clinical autonomy of the profession, in the context of increasing tensions and power struggles with these other Countervailing Powers of state, market and public. Medical profession’s autonomy began to be challenged by these other actors, who have interests in constraining discretion and decision making power of the medical profession in political, economic and clinical terms.

In order to understand how these changes were perceived by the medical professionals today, in-depth interviews were conducted with medical professionals working in Ankara. The findings were presented in three different chapters, each focusing on professional autonomy as a result of medical

profession's changing relations with one particular Countervailing Power – market, public, and state.

First chapter that analyzed findings of the field work pertained to the medical profession's relationship with the third countervailing power, the state. Until 2003, governments granted (partial) autonomy to the profession in return for authority over health policy and budgeting. Even when their clinical decisions were affected by drawbacks and shortages in financing, budgeting or delivery of health services, medical profession saw it as a result of scarcity of resources and not as a direct intervention into their clinical autonomy by the state. This mutually consensual relationship had been interrupted after 1980 Coup, as medical profession was deprived of its political autonomy when TMA was shut down, and as Kenan Evren and other government officials have expressed mistrust in the medical profession. However, according to respondents, state's attitude turned into true hostility on when AKP came to power.

The respondents argue that they are discredited in the eyes of the public due to AKP governments' hostile and disenfranchising rhetoric and attitude towards the medical profession, which they argue to be political and ideological. This is part of a strategy of AKP governments to gain or maintain votes from its traditional voter base of urban and rural poor. The result of AKP's pitting of the "educated elite" against the disadvantaged poor and by showing them as the main culprits of malfunctioning in the healthcare services is the eroding of trust between the public and the profession. This reflects on the daily interactions between doctors and patients, resulting in increase in violence against healthcare workers, in formal complaints made by patients about medical professionals and in malpractice lawsuits which financially damage the medical professionals. AKP governments and particularly Recep Tayyip Erdoğan himself are singled out as responsible for these three developments that significantly affect economic and clinical dimensions of respondents' professional autonomy.

Targeting, disenfranchising and discrediting the medical profession is not only seen as AKP's political strategy to earn votes but also a part of its economic project of privatization and marketization. AKP's efforts to devalue the medical profession in order to turn it into cheap labor was a common theme in interviews. According to respondents, this would also be achieved by creating obstacles to private practice and constraining medical professionals into organizations where they do not have economic autonomy. However, respondents do not only see becoming "cheap labor" in economic terms, but also use it to imply that their rare expertise is becoming "ordinary", "devalued", losing its status and respect in society, two privileges which have helped legitimize their autonomy. They view their loss as bigger than any financial loss.

Interviews present that the respondents receive four main messages from AKP governments' and its officials' statements to the public: First, the medical profession has thus far exploited the public financially, misusing their privileged position; second, there is a division in society between the educated elite and the illiterate poor and AKP governments side with the latter; third, the medical profession is responsible for all failures in health services, past and present; fourth, medical professional are, now thanks to AKP's reform efforts, obliged to comply with the demands of the patients, who are customers receiving a service. AKP governments have also passed legislation to take control all aspects of professional autonomy. Two major pieces of legislation that is often brought up were those known as the Full Time Act and Gezi Act, which are viewed as a restriction on the political, economic and clinical dimension of autonomy of the profession. They are also viewed as strategic extensions of the hostile attitude of AKP governments.

Doctors' lack of professional autonomy is also reflected in their bleak view of future of medical profession. Since the medical education and supply of medical professionals is not under the control of the profession but rather the state agencies, they have a pessimistic view of the future of profession and are skeptical of next generation of colleagues. Not having control over internal

professional issues is a loss of the important and highly valued privilege of self-regulation. This loss causes the medical professionals to doubt their own.

The extent of medical professionals' support for and identification with TMA, the representative of political autonomy, showed variation based on their definition of professional values and what they thought of TMA's conflictual relationship with the state. Findings present that medical professionals do not have a unified definition of "professional values", since some believe that it should be limited to what matters to the profession only, while others support a definition of values that encompasses a wider scope of political and human rights. While some medical professionals take pride in the political identity of TMA and see it as an important locus of opposition against the oppressive practices of AKP governments, others believe its place in opposition in the Turkish political landscape incapacitate it, preventing its ability to negotiate with other countervailing powers.

Second chapter analyzed the relationship between the profession and the market. With HTP, professions have increasingly become employees of health care organizations who have now become the organizer and provider of services. This affects profession's economic autonomy in terms of determining their own fees, volume of work or distribution of resources. These are now determined by organization's management, which take into consideration organization's budget, reimbursement by third-party payers and regulations of Ministry of Health. Field work reveals how professional autonomy is impacted by the factors that are related to medical professionals' position in the market for health care services and professional labor market. The prominent factors which have an impact on their autonomy were time restrictions, increase in job insecurity, non-professional assessment criteria, use of medical technology and the payment method.

Findings present that it is crucial for understanding professional autonomy that medical professionals have become employees in bureaucratic organizations in

public and private sector, as well as the diversity of their terms of conditions of work and salaries they offer, managerial structure and infrastructure. What is common the public and private sectors is that professionals are accountable to other actors, who are not medical professionals. Under HTP, medical professionals have become subject to managers, who are non-medical administrators who have non-medical criteria for operating health care organizations.

One of the most important findings of these research is that in clinical decision making, medical professionals' clinical judgement is being replaced by financial considerations. Managers control doctors' behavior by practices such as increased surveillance through record keeping, performance-based payment schemes, determining volume of work based on financial criteria and non-medical assessment indicators such as standardized performance indicators and customer satisfaction. Although clinical autonomy requires and enables the medical profession to diagnose and choose the best treatment for the patient based solely on their clinical judgement, regardless of financial or any other non-medical concerns, the structure of the market for health care services imposes financialization of medical decisions. Being obliged to abide by management's demands therefore having to consider the financial aspects of their actions contrasts with their professional values and ethics. Financialization of medical decisions is placed in opposition to professional autonomy since it restricts their ability to conduct and control their work based on their clinical judgement.

Their time with patients is restricted through standardized appointment intervals determined by management, which aims to have them see a standard number of patients every day. This is a limitation of their economic autonomy, which also reflects to a decline in their clinical autonomy, since they cannot practice in a manner they see suitable with the limited time they are provided.

Increasing job insecurity emerged as an important theme that affected respondents' professional autonomy in relation to structure of healthcare services

market and labor market. Precarity and job insecurity affects those working in the private sector, with their employment status depending on how much they contribute to the revenue earned by the organization. In order to keep their jobs, respondents have stated that in some cases doctors may be involved in unnecessary, unethical or questionable practices to increase their volume of work, such as conducting unnecessary procedures or tests when not necessary. Informal employment is also prevalent in private health care organizations, according to respondents, with lower base salaries and higher premium payments which are not reflected to retirement benefits. Being paid based on their (quantified) performance causes an unstable, fluctuating income, creating insecurity for both their future and present.

How the market for health care services is shaped also has an impact on the labor market for medical profession. The increased number of medical professionals and the profession no longer having autonomy to determine the supply of professionals means market closure is now weak, making their labor cheaper and more precarious. Organizations seeking out cost efficiency measures leads medical professionals to feel replaceable and devalued.

Consumerism is another practice that has an impact on professional autonomy, both in the public and private sector. Having to comply with patient demands in order to keep patient content decreases their clinical autonomy, since they have to behave in ways they view unfit with their clinical judgement. This is also another dimension of managerial practices which contributes to their feelings of devaluation of their skills and expertise.

Medical technologies are an important part of medical practice in healthcare organizations which affect both clinical and economic dimensions of professional autonomy. The extent of professional's use of medical tests and medical imaging devices are related to financial conditions and distribution of resources, which they do not have direct authority over. They are controlled and directed by external actors such as management of the health care organization

and SGK. Dictating their use based on financial concerns lead to indirect interference in medical professionals' clinical autonomy by management. It affects the decisions they have to make on how they diagnose or treat patients. Patients may also demand certain tests or devices be used in their diagnosis and treatment, interfering in clinical autonomy.

A final factor in relation to health care services market and labor market that has an impact on professional autonomy is the performance-based payment scheme, which financially rewards doctors based on their volume of work in addition to their fixed salary. This payment scheme, which exists both in public and private sector, does not reward doctor's work based on risk, complexity or expertise, but rather the quantity of procedures conducted and number of patients seen. This leads professionals to be obligated to increase their volume of work; having to do more in order to earn more leads to financialization of medical decisions. It causes decline of clinical autonomy, since in order to earn an income, which in most cases relies more on performance-based additional payment rather than fixed salary, may lead them to choose certain methods of diagnosis or treatment over others due to financial concerns. This also leads to unethical and questionable medical practices by doctors.

Third chapter analyzed medical profession's changing relations with public, which has implications for professional autonomy in the doctor-patient relationship on a daily basis. The findings of the field work demonstrate that there are four major factors that have a significant role in changing the character of relationship between profession and the public in a way that affects professional autonomy. These are, the change in the public image of the medical profession which results in declining respectability in society and eroding of trust between doctors and patients; increase in access to information and to advancing medical technologies and violence against healthcare workers. The recurrent theme that underlies all four factors is the consumerist orientation of the HTP. The changes in the delivery, financing and organization of the system emphasizes a patient-centered approach to services, which prioritize "customer

satisfaction”. Doctor-patient relationship has now transformed into a “service provider-customer” one, through which they are being scrutinized for their performance by organizational management. In a consumerist structing of healthcare services, health becomes a commodity to be exchanged between “service provider” (the medical professional) and the “customer” (the patient), roles which doctors and patients are expected to adopt to. Consumerist orientation leads to (and promotes) increased skepticism of the profession.

The findings present that changing public perception of medical professionals have a profound impact on the doctor-patient relationship on a daily basis and that the changes in the character of this relationship mostly affects clinical dimension of professional autonomy. While there are other elements of healthcare provision, administration and financing that affect the relationship between the two individuals, which are also addressed in this chapter, the change in the extent of trust and respect towards professionals in public opinion has implications for the mutual -increasingly negative- attitude of doctors and patients.

Respectability of the profession in society plays an important role in why medical professionals chose this profession. The respect towards and trust in the profession has declined as the profession is increasingly viewed as self-serving group members of which pursue their own (financial) self-interest. This is the result of the profession being targeted as the sole actor that is responsible for the flaws and wrongdoings in the healthcare system by the governments. Since the individual practitioners maintain their status and prestige because they are members of a profession that has a unified identity in the eyes of the public, any discrediting and denigrating statement against the profession as a whole also extends to how individual patients react to individual practitioners on a day-to-day basis. The status and privileges that public attributes to individuals for being a member of a professional group, are also stripped as the professional group loses trust and respect. Change in the public perception of the profession leads respondents to have a nostalgic view of the past of the profession when they



were more privileged and had more autonomy, which is also expressed as mourning for the lost status and respect in society.

Decline in respect is also a factor in erosion of trust in the doctor-patient relationship. Since trust is necessary for patient compliance and therefore achieving success in treatment, erosion of trust also affect the quality of care the patient receives. Contrary to existing research on the issue, respondents in this study claim that they are mostly challenged by less educated population. They relate this directly to AKP government and state officials' discrediting rhetoric about the medical professionals which, according to respondents, they strategically use in order to appeal to voters. The way they are presented as greedy elites who are concerned with their own interests exacerbates the skepticism and mistrust of the public. This is combined with easier access to healthcare as a result of which the medical professionals are no longer the rare species which are only available to the urban elite and the privileged.

Increased access to information and medical technologies emerges as significant factor that have an impact of professional autonomy in doctor-patient relationship. Patients become more demanding as they have more information about medical procedures, technologies and treatments. Although the information they gather may be scientifically questionable, their demands based on this information may end up as interference into doctors' decision making. Increased access to and use of medical technologies also emerges as a significant factor that has an impact on professional autonomy. Accessibility and prevalent use of medical imaging devices and tests under HTP have led to more information about these devices, resulting in increase in patients' demands that these devices to be used in diagnosis and treatment. Increased use of medical technologies resulted in a belief among patients that these technologies are necessary and indispensable for medical care, which in turn lead to patients' efforts to control professional decision making regarding how the diagnosis and treatment will be conducted. Their decision to use or not to use medical technologies will affect how their performance and competence is evaluated by

the patients. They will be considered good doctors if they choose to use more technologies. Patients' perception of medical professionals begin to resemble a technician operating a kind of machinery, someone who conducts a standardized and mechanical process that does not use any individual clinical evaluation or interpretation. This results in an attitude that challenges professional autonomy by disregarding clinical judgement and interfering in their decisions about their diagnosis and choice of treatment.

Finally, violence against healthcare workers emerges as another factor that decreases professional autonomy of doctors by directing their clinical decisions. Emphasis on consumerism and erosion of trust to the medical profession results in patients to view doctors as having to comply with their demands. Violence in all forms emerge as a threat if they do not comply; therefore, in order to protect themselves from being attacked, they may do what the patient has demanded even when they found these demands unreasonable or unnecessary for providing best care according their clinical judgement.

Findings of the three chapters based on the field work demonstrate that it is not possible to distinguish collective and individual autonomy, especially in state-centrist societies. Freidson (1970a, 1970b) argued that loss of socio-economic autonomy does not affect clinical autonomy. However, looking at profession's relationship with other countervailing powers in a historical light, the clinical autonomy is closely connected to economic and political dimensions of autonomy. As Johnson (1972) has argued, the shift in power relations in society impact the amount of control the profession has in society and over its work. Control over resources or legal restrictions may shape medical decisions by controlling resources available for treatment and diagnosis or ability to practice. However, the Turkish case presents two contrary points. The first point is that loss of economic and political autonomy also affects clinical autonomy. Second, when the medical profession was viewed as influential and powerful with much leverage in society, as it was in pre-1980s Turkey, not having absolute political and economic autonomy did not lead to a perception of lack of clinical

autonomy. Nevertheless, in the present context, under HTP, a perception of decline in political and economic autonomy also leads to a decline in clinical autonomy, as countervailing powers find opportunities to challenge the medical profession whose privileges are weakened by new arrangements and actors in the realm of health care. Turkish medical profession has low, or almost non-existent-political autonomy, almost every dimension of their work is under the control of government and state agencies. It is not allowed to influence health policies, financing, governing or delivery of health services or their own professional matters, this also affects other dimensions of their conditions of work. The conditions include how they are paid, how resources are allocated, how services are financed, where and when they work. State policies are shaped by government rhetoric and approach to the medical profession; which results in political sphere having a substantial influence on healthcare and medical profession. This leads to political autonomy restricted by government actions, policies and regulations to have a direct impact on the extent of clinical and economic autonomy.

This study presents that while political, economic and clinical dimensions of professional autonomy are intertwined and cannot be viewed as completely independent of each other, political autonomy has a determining power over the other two dimensions in Turkey, since central decision making power with regards to matters related to healthcare services and the medical profession belongs to the state. As the medical profession has a very small amount of political autonomy, it lacks the power to control the financial aspect of its work, distribution of resources, or the context in which it works. Although there may be no apparent direct involvement in clinical decisions on a daily basis, the efforts to manipulate these decisions based on financial concerns based on regulations made by governments and policy actors or legal arrangements by government that aim to interfere in actions of medical professionals demonstrates that lacking professional autonomy has consequences for economic and clinical autonomy, as well. As Hoffman (1997) argues, the ability to control and direct application of their clinical knowledge is political autonomy and it is

fundamental to achieving clinical and economic autonomy. Traditional Anglo-American theories of professions characterize state-profession relationship as stable and without conflict, positioning the state as supportive in legitimizing and institutionalizing profession and its autonomy. The findings in this research present that this is different from Turkey where this particular relationship is complicated and dynamic. The profession is integrated within the state, almost as its agent, which in turn allows it a high status in society. It almost acts as the patron of profession; their embedded and complicated relationship has not been devoid of constant conflict. This conflict also reflects on profession's social status, which is being undermined by the state and its efforts to restrict its autonomy.

This study presents that under conditions where the profession lacks full political and economic autonomy, and therefore experiences limitations to its clinical autonomy, it is also experienced more as an individual value, rather than common value of a group. The findings in this research present that clinical and economic autonomy are declining in the face of increasing dominance of market forces and actors, state and the public. However, medical professionals subjectively define the extent of their autonomy in relation to their specific conditions of work, rather than as a staple of their practice and inherent value of their profession. This echoes the shift from occupational professionalism to organizational professionalism as defined by Evetts (2004), who argued that occupational professionalism is under threat by bureaucratic logic of organizational structures. While working as employers in bureaucratic organizations is not a new reality for Turkish medical professionals, declining autonomy is a result of how private and public organizations operate, the principles which dominate management of organizations and how much power medical professionals have in these matters. Diversity of healthcare settings, condition of work causes the extent to which professional autonomy is perceived is also diverse. Practice setting determines performance and professional goals (Hafferty 1988, 208). Under HTP professional autonomy has a negotiated character; the structure of employing organization and conditions designated by

it have a significant impact on defining it. Professional autonomy is no longer a homogeneous, unifying, stable value of profession, although continues to be seen as the ideal. Decline in their autonomy impacts their identification with their group. Their different perceptions of autonomy cause it to be experienced as an individual and organizational value. Autonomy being experienced more as an individual value also causes professionals to question others' ethical principles.

Under HTP, professional autonomy is declining because non-medical economic decisions have an impact on clinical decisions. Actors who hold authority over economic and logistic matters cause financialization of medical decisions by imposing pressure on the medical profession, whose clinical autonomy is also restricted by being obliged to accommodate these pressures to earn income, keep their job and prevent friction with management and patients. Being in possession of qualifications and expertise do not necessarily lead to the privilege of high financial rewards and job security that have been traditional identified with medical profession. It is not the medical professionals who determine the structure or rules of the health care market, but rather the market and other actors in this domain that determine the conditions of work for professionals. The findings also present that consumerist policies challenge professional autonomy by allowing patients to try to interfere in clinical autonomy. The changing public perception of the profession has consequences on the character of daily interactions between doctor and patient, affecting doctors' clinical decisions which previously were unchallenged by patients.

Profession's social status is also being undermined by the changes in the nature of its work, and the nature of its relationship with the patients. As the medical profession's work becomes increasingly open to external assessment and control by organizations' management, state agencies and insurance companies, practices to standardize and routinize it are imposed in order to make it more accessible to non-professionals without medical expertise. The increased accessibility of medical knowledge challenges its social status which is based on its long training, credentials and the complex nature of its knowledge. As

medical professionals have to make clinical decisions based more on clinical guidelines, algorithms rather than their clinical judgement, are assessed based on customer satisfaction and paid based on their volume of work rather than quality of service they provide, the status that is based on the power and knowledge gap between the laymen (both the managers and the patients) begins to erode. Social distance between the professional and the patient, the power inequality, has allowed their privileged social status to be maintained. Therefore, their high social status was directly related to the information gap between them and the public, based on the nature of their work and knowledge. Medical professional's accessibility, both in terms of information and corporeally, leads to demystification of the medical knowledge and practice, negatively affects their social status, both in their own view and the public's view. The latter finds its expression as challenges to professional autonomy by trying to control doctor's decision, not following doctor's orders and finally, as violence.

This study contributes the sociology of professions literature by presenting an examination of professional autonomy of medical profession in Turkey from a sociological perspective. The Turkish case demonstrates the importance of taking into consideration the power struggles, conflicts and negotiations in society and viewing the professional autonomy as a fluctuating and dynamic value rather than a stable and absolute one. In a context in which healthcare settings are diverse, it highlights the heterogeneous and organizational character of professional value. The extent of professional autonomy, and how individual medical professionals perceive it depends on the social, economic and political context in which they practice. Even the most clinical decisions are made within a context where there are personal, ethical, economic, political and legal constraints. This research presents a unique case in which while the profession had been institutionalized in close relationship with the state and has been deemed powerful and influential in society with the state's support, it was also not granted much political and economic autonomy by the state. It is also unique since the state not only willingly curtails professional autonomy but also withdraws its support in an effort to delegitimize the medical profession in the

eyes of the public. This has been reinforced by governments' rhetoric and attitude towards the medical profession, which also negatively affects its relationship with the public and the patients, eroding trust between doctor and patients and discrediting the profession in the public's perception. Professional autonomy does not only transform as a result of technological changes, change in cognitive base or economic activities, but also as a result of government policies and objectives. In Turkey, professional autonomy has not declined only as the result of bureaucratization, managerialism or consumerism. The policies the state implements in healthcare have also negatively affected profession's relationship with the market, restricting its economic autonomy, which directly impacts doctors' clinical decision making on a daily basis. Governments may extend or retract professional autonomy. The state and the political sphere have profound impact on professional autonomy in Turkey where the state historically has a patronizing relationship with the profession and is the central decision making actor in matters related to healthcare and medicine. While power sharing has been more or less mutual until early 2000s, neoliberal HTP policies and hostile populism of AKP governments have resulted in efforts to restrict professional autonomy of medical profession. In the Anglo-American approaches, the relationship between state and profession has been viewed mostly as unproblematic and nonconfrontational. However, the Turkish case shows us that they may be in economic or ideological conflict. Technical matters may become economic or ideological matters (Starr 1982).

The state comes across as an ideological countervailing power, against the profession that is traditionally viewed as composed of elites who were agents of modernization and rationalization. This antagonism fueled by AKP's neoliberal populist regime provoke public's, especially of lower classes, sentiments of hostility towards the medical professionals who are portrayed as greedy, indifferent and self-interested elites. Rhetoric used by AKP governments and officials that discredit the medical professional are in juxtaposition with neoliberal restructuring of healthcare services which aim to control and direct actions of medical professionals. Economic interests, as well as clashing

ideologies and status concerns motivate the countervailing powers in healthcare domain against the medical profession. Therefore, the profession's changing relationship with the state, public and market are intertwined in a way that declines its political, economic and clinical autonomies.

Although the medical profession in Turkey is stratified and diversified over lines of employment conditions, type of organization, sector, specialization and even perception of autonomy, the attacks on the profession by the state creates a solidarity and cohesion. The existence of different types of employment (private practice, academic professionals, civil servants in public organizations, employees in private enterprises), may result in different control mechanisms and even eventually, different value orientations. Performance-based payment scheme in public and private sector creates a division within the profession based on specialty, favoring those that include more procedures, regular or frequent examinations; growing insecurity and informality of employment in private sector creates divisions and competition among the professionals, causing ethical concerns; while the hostile rhetoric of AKP governments creates a dangerous tension between the public and the medical profession, the policy discourse that devalues public employment increases the threat of violence more for the professionals working in the public sector. The level of identification with the professional association has also become diversified among professionals, based on their affinity with TMA's political stance and activities. While it is the main representative professional association, polarized political atmosphere and government's constant efforts to debilitate and push TMA to the opposition affects how its actions and authority is perceived by professionals as well as their feeling of belonging. However, despite the differences in perception and experience of professional autonomy, the emphasis placed on its importance and necessity presents the existence of a shared understanding of professional values and a yearning for conditions to be able to practice common principles of ideology of professionalism.



A contribution of this research is that it presents the importance of profession's relationship with state, market and public in their impact on medical professionals' perception of autonomy. The individuals' perceptions are important since they reflect power of values and privileges the group has. The professional values and privileges do not have a meaning if they are not felt and internalized and practiced by the individual members of the group on a daily basis.

While examining professional autonomy from a social science perspective can be an important contribution to understanding and improving quality of healthcare as well, this research has certain limitations that can also provide new opportunities for future, complementary research. This research focuses on medical professionals who are specialists and who practice in a capital city. Research on general practitioners, or medical professionals who practice in rural areas would complement this research since the extent of professional autonomy they experience may be different based on the very different social and economic conditions they work under. Similar research can also be conducted with younger members of the profession who more recently started practicing medicine. Since they would have no experience prior to HTP and other governments, it would be interesting to see whether they perceive their professional autonomy is declining under these circumstances.

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## APPENDICES

### A. CURRICULUM VITAE

#### PERSONAL INFORMATION

Surname, Name: Çorbacıođlu Aksak, Gül

Nationality: Turkish (TC)

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#### EDUCATION

Degree	Institution	Year of Graduation
MS	METU Sociology	2008
BS	Bilkent U International Relations	2004

#### WORK EXPERIENCE

Year	Place	Enrollment
2018- Present	TBMM	Policy Advisor
2015-2018	Bilkent University POLS	Part-time Lecturer
2013-2013	UNDP	Short Term Associate Expert
2006-2009	METU Sociology	Project Assistant

#### FOREIGN LANGUAGES

Advanced English, Intermediate German

## PUBLICATIONS

1.Çorbacıoğlu, Gül. (2021). “Tıbbi Görüntüleme Cihazları ve Hekimlerin Mesleki Bağımsızlığı: Çelişkili bir İlişki [Medical Imaging Devices and Physician Autonomy: A Conflictual Relationship]”. *Sosyoloji Araştırmaları Dergisi*, 24(1), 18-44.

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3.Çorbacıoğlu, Gül. (2017). “Şiddet ve Değişen Hekimlik: Türkiye’de Sağlık Çalışanlarına Karşı Artan Şiddetin Şiddet Algısı ve Hekimlik Pratikleri Üzerindeki Etkileri”. In G. Yenimahalleli Yaşar, A. Göksel, Ö. Birler (Eds.), *Piyasa Hakimiyetinde Sağlık ve Sosyal Güvenlik*. Ankara: Nota Bene Yayınları.

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6.Saktanber, Ayşe and Gül Çorbacıoğlu. (2008). “Veiling and Headscarf-Skepticism in Turkey”, *Social Politics*, 15(4), 514-538.

## B. TURKISH SUMMARY / TÜRKÇE ÖZET

Bu çalışma, Türkiye’de tıp mesleğinin mesleki bağımsızlığının Sağlıkta Dönüşüm Programı (SDP) altında dönüşümünü konu almaktadır. Adalet ve Kalkınma Partisi (AKP) hükümetleri tarafından 2003 yılından beri uygulanmakta olan ve Sağlıkta Dönüşüm Programı adı verilen sağlık reformu uygulamaları, sağlık hizmetlerinin örgütlenmesi, finansmanı ve sunumunda pek çok değişikliğe yol açmıştır. Çalışma, bir grup olarak hekimlik mesleğinin ve bireyler olarak hekimlerin mesleki bağımsızlıklarının bu bağlamda nasıl değiştiği, siyasi, ekonomik ve klinik bağımsızlık olarak üç kavramsal boyutta alınmaktadır.

Çalışmanın şu araştırma sorularını yanıtlamayı hedeflemektedir: SDP’nin uygulamaya koyulmasından hekimlerin mesleki bağımsızlıklarının düzeyi nasıl değişmiştir? Mesleğin devlet, sağlık hizmetleri piyasası, profesyonel emek piyasası ve halkla olan ilişkileri, mesleki bağımsızlığı nasıl etkilemiştir? Mesleki bağımsızlığın düzeyindeki değişikliğin gündelik çalışma yaşamları üzerindeki etkileri neler olmuştur? Hekimler, mesleki bağımsızlığın siyasi, ekonomik ve klinik boyutlarını nasıl deneyimlemektedir? Türkiye’de hekimliğin mesleki bağımsızlığı, literatürdeki diğer örneklerinden farklı mıdır?

Bu soruları yanıtlamak için ilk olarak profesyonel meslekler sosyolojisi alanındaki kuramlara dair eleştirel bir literatür taraması gerçekleştirilmiştir. Bunu takiben Türkiye’de tıp mesleğinin devlet, piyasa ve halkla ilişkisine dair daha geniş bir çerçeveye sunmak için tarihsel bir arka plan verilmiştir. Bunu takiben, Ankara’da uzman hekimlerle yapılmış derinlemesine görüşmeler aracılığıyla gerçekleştirilmiş olan saha çalışmasından edinilen veriler, üç ayrı bölümde analiz edilmiş ve yukarıdaki araştırma sorularına yanıt aranmıştır.

Başta mesleki bağımsızlık olmak üzere uzun süren zor eğitim, özdenetim, karmaşık kuramsal bilgi, özel sosyalleşme süreçleri, grup aidiyeti ve kendi alanlarında önemli ölçüde güç ve otorite sahibi olmaları gibi birtakım özelliklerle

diğer mesleklerden ayrılan profesyonel meslekler, tarih boyunca Batı toplumlarında önemli aktörler olmuşlardır. Bu da özellikle Amerika ve İngiltere özelinde, toplumsal alanda oynadıkları sosyal, siyasal ve ekonomik rollere ve tarihlerine dair geniş bir literatürün ortaya çıkmasına neden olmuştur. Literatüre bu iki ülkenin hakim olması, kuramların ve modellerin genellikle bu iki ülkedeki profesyonel meslekler üzerinden üretilmesine, diğer ülkelerle karşılaştırma için bu örneklerin kullanılmasına yol açmıştır.

Kurumsallaşma tarihi, nitelikleri ve işlerinin biçim ve içeriğine atfedilen değer nedeniyle tıp mesleği literatürde ideal profesyonel meslek olarak görülmüştür. Araştırmacılar, profesyonel mesleklerin en önemli ve en kıymetli niteliğinin mesleki bağımsızlık olduğunu ileri sürmüşlerdir. Mesleki bağımsızlık, profesyonel meslek sahiplerinin, mali konular, alanlarına dair politikalar, alandaki diğer çalışanlar dahil olmak üzere, işlerinin içeriğini ve koşullarını, başka aktörlerden ve etkenlerden bağımsız bir biçimde kontrol etme özgürlüğüne sahip olmalarını sağlamaktadır. Profesyonel mesleklere dair 20. yüzyılın başında ortaya çıkmış erken dönem kuramlar, tıp mesleğinin toplumsal rolüne ve diğerkamalık gibi bu mesleklere içkin olduğunu ileri sürdükleri birtakım özelliklere odaklanırken (Carr-Saunders ve Wilson 1933; Goode 1957), 1960'lerden sonraki kuramlar dikkatlerini tıp mesleğinin gücünü verili olarak kabul etmek yerine incelemeye ve açıklamaya çevirmiştir. Tıp mesleğinin işinin tüm boyutlarını kontrol edebilmesine odaklanan mesleki hakimiyet yaklaşımı (Freidson 1970a; Freidson 1970b) ve piyasa kapaması ve bilişsel dışlayıcılığa öncelik veren yeni-Weberci yaklaşımlar (Larson 1977), bu alanda etkili yaklaşımlar olmuştur.

1970'lerden itibaren dünya çapında neoliberal ideolojinin ilkeleri çerçevesinde sağlık sistemlerinde reformlar uygulanmaya başlamış, bu durum dünyanın diğer bölgelerinde de tıp mesleklerine olan ilginin artmasına yol açmıştır. Bu örneklerde, tıp mesleğinin toplumdaki yeri ve mesleki bağımsızlığına dair Amerika ve İngiltere örneklerinden farklılıklar sergilediği ortaya çıkmıştır. Mutlak mesleki bağımsızlığa sahip, devletten tümüyle bağımsız bir tıp

mesleğinin evrensel bir durum olmadığı, Almanya, Fransa ve İskandinav ülkeleri gibi örneklerin ortaya koyduğu gibi bazı durumlarda tıp mesleğinin devlet bürokrasisinin önemli bir parçası olduğu veya Sovyetler Birliği gibi örneklerde olduğu gibi devletin hakimiyeti altında çalıştığı görülmüştür (Schulz ve Harrison 1986; Erichsen 1995; Le Bianic 2003; Jones 1991). Profesyonel mesleklerin yörüngeleri ve niteliklerindeki farklılıklara dair çalışmalar, dünyada değişen sağlık sistemlerine dair çalışmalarla paralel biçimde gerçekleştirilmiştir. 1970'ler itibariyle gelişmiş ve gelişmekte olan ülkelerde değişen ideolojik ve ekonomik koşullar, sağlık hizmetlerinin finansmanı, sunumu ve örgütlenme biçimlerinde ve bu alandaki aktörlerin arasındaki ilişkilerde değişikliklere yol açmıştır. Kamu harcamaları üzerindeki baskılar ve artan sağlık harcamaları, sağlık reformların arkasında yatan temel itici güçtür. Sağlık sistemlerinin karşı karşıya kaldığı diğer meseleler ise sağlık kuruluşlarının şirketleşmesi, tıp teknolojilerindeki ilerlemesi, yaşlanan nüfus, hastaların müşterileşmesi ve bunun sonucu olarak halk arasında artan beklentiler ve taleplerdir (Stevens 2009; Green ve Thorogood 1998; Robingson ve Stiener 1998; Blank ve Burau 2004). Bu gelişmelerle birlikte hekimler, çeşitlenen klinik kararları ve pahalı tedavilerle birlikte sağlık harcamalarını şişiren temel aktör olarak suçlanmıştır. Mesleki bağımsızlık hekimlerin bu güce sahip olmalarını sağlayan bir ayrıcalık olarak eleştirilere maruz bırakılmıştır. 1970'ler ve 1980'lerde devletler açısından sağlık politikalarındaki değişimlerin temel amacı maliyetleri kontrol altına almakken 1990'larda verimliliğe kaymış ve mesleki bağımsızlık da buna paralel olarak kontrol altına alınmaya çalışılmıştır (Whiteford and Nion 2000; Blank and Burau 2004).

Bu politikalar 1980'ler boyunca küresel bağlamda hükümetlerin neoliberal ideolojiye kayışın bir yansıması olmuştur. Bu çerçevede içinde kamu hizmetleri verimsiz olarak sunulmuş, verimliliğin kamu işletmeleri ve sanayilerinin özelleştirilmesiyle, devletlerin kontrolündeki sektörlerin deregülasyonu ve sağlık harcamaları da dahil olmak üzere kamu harcamalarının kısıtlanmasıyla sağlanacağı ileri sürülmüştür. Gelişmekte olan pek çok ülkede benzer reformlar Uluslararası Para Fonu (IMF), Dünya Sağlık Örgütü (WHO) ve Dünya Bankası



tarafından teşvik edilmiştir. Bu değişimler, sağlık sistemlerinde tıp mesleğinin gücünün sorgulanmasına da yol açmıştır. Maliyet kontrolü ve üretkenlik çabaları, hekimlerin hesap verebilirliğini artırmayı ve kontrol altına alınmalarını hedeflemiş, mesleki bağımsızlık kaçınılmaz olarak kısıtlanmaya başlamıştır. Bu dönemden itibaren tıp mesleğine ve mesleki bağımsızlığa dair kuramsallaştırma çabaları mesleki bağımsızlığın sağlık hizmetlerinin finansmanı, sunumun ve örgütlenmesindeki değişikliklerin sonucunda nasıl etkilendiğini açıklamaya odaklanmıştır. Bu yaklaşımlar, hizmet sunumunda müşterileşmenin, halkın bilgiye erişiminin, tıp teknolojilerindeki gelişmelerin ve bu teknolojilere erişimin artmasının, sağlık kuruluşlarında işletmeciliğin ve bürokratikleşmenin sonuçlarını incelemektedir. Bu tartışmalar, mesleki bağımsızlığa dair değişimin farklı boyutlarına odaklanan yeni perspektiflerin ortaya çıkmasını sağlamıştır. Profesyonelleşmenin yitimine dair incelemeler (Haug 1973; Haug 1988) bilgiye ve teknolojiye erişim ve hastalarla ilişkilere odaklanırken, proleterleşme yaklaşımı (McKinlay ve Arches 1985; Oppenheimer 1973) sağlıkta şirketleşme ve bürokratikleşmenin mesleki bağımsızlık üzerindeki sonuçlarına odaklanmıştır. Bu çalışmada Türkiye’de hekimlerin mesleki bağımsızlığının dönüşümünü açıklamak üzere kullandığı yaklaşım olan dinamik sistemler yaklaşımları ise 1990’larla birlikte ortaya çıkmıştır. Bu yaklaşımlar profesyonel meslekleri ve mesleki bağımsızlığı toplumdaki farklı aktörler arasındaki tarihsel ilişkilerin ürünü olan, sürekli değişim içindeki dinamik kavramlar görmektedir (Abbott 1988; Light 1995, 2000, 2010; Krause 1996). Amerika ve İngiltere dışındaki ülkelerde profesyonel mesleklere dair artan ilgi, profesyonelleşme ideolojisinin ve mesleki bağımsızlığının belirli bir toplumda belirli bir tarihsel dönemde ortaya çıkan sosyal, siyasi ve ekonomik ilişkilerin bir sonucu olarak inşa edildiğini ortaya koymaktadır. Bu yaklaşımlara göre profesyonel meslekler ve mesleki bağımsızlık, içinde buldukları toplumsal ilişkiler ağı içinde incelenmelidir. Bu yaklaşımlar, mesleki bağımsızlığın bu ilişkilerin değişen niteliğinin sonucu olarak, tarih boyunca aktörler arasında müzakereler, çatışmalar, ittifakların sonucu olarak gözlemlenmesine olanak sağlar. Bu analizler, ilişkileri ve süreçleri analiz için başlangıç noktası olarak almakta, belirli bir alanda profesyonel mesleğin karşısındaki diğer aktörlerin

hareketlerinin önemini ve etkisini de göz önünde bulundurmaktadır. Devlet, halk ve piyasa, özellikle 1980'lerden itibaren sağlık ve tıp alanında hekimliğin hakimiyetini dengelemeye çalışan diğer temel üç karşı aktördür. Light (1995), hekimliğin sağlık alanında 20. yüzyıl boyunca süregelen hakimiyetinin, bu alanda çıkarları olan bu diğer aktörler tarafından karşı hareketlerle aşılmaya çalışıldığını belirtmektedir. Yeni değerlendirme, gözetleme ve standardizasyon teknikleri ve mekanizmaları tıp mesleği üzerindeki kontrolü artırır, dolayısıyla mutlak mesleki bağımsızlığın varlığı üzerine kurulu profesyonel meslek kuramlarının yeniden değerlendirilmesi gerekmektedir. Ayrıca dinamik sistemler yaklaşımları, mesleki bağımsızlığın dönüşümde devlet ve tıp mesleği arasındaki ilişkinin oynadığı rolün önemini vurgulanmasını sağlamaktadır. Amerika ve İngiltere örnekleri devleti hekimliğin çatışmasız bir destekçisi olarak sunarken dünyadaki diğer örnekler bu ilişkinin çatışmadan azade olmadığını, özellikle merkezi sağlık sistemine sahip ülkelerde devletin tıp mesleğinin eğitimi ya da istihdamında, mesleğin icrasının düzenlenmesinde çok daha büyük bir oynadığını, bunun da iki aktör arasında çatışmalara yol açabileceğini göstermektedir.

Mesleki bağımsızlığı dinamik ve değişken olarak gören kuramsal çerçevenin yanı sıra, çalışmada mesleki bağımsızlık iki düzeyde ve üç farklı boyutta ele alınmıştır. Çalışma hem kolektif hem bireysel mesleki bağımsızlığı incelemektedir. Kolektif bağımsızlık, mesleğin bir grup olarak sahip olduğu bağımsızlıktır. Devletin mesleğin yasal otoritesinin ve piyasa tekelinin meşruiyetini desteklemesi ve halkın mesleki yetkinliği tanınması ile kazanılır. Bireysel mesleki bağımsızlık ise meslek mensuplarının bireyler olarak gündelik yaşamda tecrübe ettikleri bağımsızlıktır. Bireyler, mesleki bağımsızlığa yalnızca yasal olarak tanınmış, kamuoyu nezdinde de meşruiyete sahip meslek grubunun üyeleri olarak sahip olabilirler. Dolayısıyla kolektif ve bireysel mesleki bağımsızlık birbiriyle doğrudan bağlantılıdır.

Çalışmanın içerdiği üç mesleki bağımsızlık boyutu ise siyasi, ekonomik ve klinik bağımsızlıktır. Literatürde mesleki bağımsızlığın kökenleri ya da nasıl

sürdürüldüğüne dair tartışmalar olsa da, bu üç boyut üzerinde genellikle bir konsensüs olduğu söylenebilir. Siyasi bağımsızlık kolektif bağımsızlığa, klinik ve ekonomik bağımsızlık boyutları ise bireysel bağımsızlık düzeyine atıfta bulunmaktadır. Siyasi bağımsızlık mesleğin kendi iç meselelerini, mesleğin işleyişine ve eğitimine dair düzenlemeleri, mensuplarının disiplin süreçlerini, mesleğin alanına dair politikaları ve süreçleri kontrol edebilmesidir. Rakiplerini faaliyet alanından elimine edebilme otoritesine sahip olmasıdır. Tıp mesleği özelinde, sağlık politikaları ve tıp alanında yasal düzenleme ve politikalarda söz sahibi olabilmektir. (Elston 1991; Schulz ve Harrison 1986; Gabe ve arkadaşları 2004). Bireysel bağımsızlığın boyutlarından ilki olan ekonomik bağımsızlık, bireysel olarak profesyonelin ücretini, hizmetinin karşılığını, iş yükünü, ihtiyacı olan kaynakların dağılımını, hasta sayısını, çalışma koşullarını kontrol edebilmesidir. İkinci boyut olan klinik bağımsızlık ise profesyonelin işinin teknik boyutlarını kontrol edebilmesidir. İşinin içeriğini, niteliğini yalnızca kendisinin belirleyebileceğini, tıp mesleği özelinde hastanın kabulünden taburcu edilmesine kadar teşhis ve tedaviye dair kararları yalnızca klinik akıl yürütmeye, kendi bilgi ve deneyimine dayanarak yapabileceğini ima etmektedir (Elstron 1991; Freidson 1988; Harrison and Schulz 1984; Funck 2012). Buna hangi tetkikleri, cihazları, teknolojileri kullanacağı, hangi ilaçları yazacağı, ne zaman ve nasıl operasyon yapacağı gibi kararlar dahildir.

Bu çalışma, tıp mesleğinin devlet, piyasa ve halkla ilişkilerinin, mesleki bağımsızlığın SDP bağlamında dönüşümü incelemek için önemli olduğunu ileri sürmektedir. Bu alanda mesleğin devletle ilişkisinin, bu ilişkinin aynı zamanda piyasa ve halkla ilişkilerin şekillenmesinde önemli sonuçları olduğu için öncelik taşıdığını da ileri sürmektedir. Bunun nedeni, devletin sağlık hizmetlerinin düzenlenmesinde, örgütlenmesinde ve sunumunda ve tıp mesleğinin kurumsallaşmasında oynadığı önemli roldür. Bu nedenle, mesleğin SDP altında siyasi, ekonomik ve klinik bağımsızlığının dönüşümünü anlamak için önce devletle, sonrasında piyasa ve halkla ilişkilerinin incelenmesi gerekmektedir.

Türkiye’de 1980’ler ve 1990’larda sağlık hizmetlerini özelleştirmeyi ve ticarileştirmeyi hedefleyen sağlık reformu çabaları olmuş, bunlar gelişmekte olan diğer pek çok ülkede olduğu gibi Dünya Bankası, IMF ve Dünya Sağlık Örgütü tarafından desteklenmiştir (Belek 2012). Fakat bu planlar Adalet ve Kalkınma Partisi’nin (AKP) iktidara geldiği 2003 yılına kadar hayata geçirilememiştir. AKP ise 2003 yılından başlayarak sağlık hizmetlerinin her alanında olduğu gibi, hekimlerin çalışma koşullarında, diğer aktörlerle ilişkilerinde ve toplumsal statülerinde değişikliklere yol açan SDP’yi uygulamaya koymuştur.

Araştırmanın temel sorularını yanıtlamak için teorik çerçevenin sunumundan sonra Türkiye’de hekimlik mesleği ve mesleki bağımsızlığına dair bir tarihsel arka plan sunulmuştur. Tarihsel kaynaklar, Türk Tabipleri Birliği ve Tabip Odaları’nın yayınları, anlatılar, Türkiye’de hekimlerin anıları, biyografi ve otobiyografileri, mesleğin statüsünün, hekimlerin mesleklerine aidiyetlerinin, halk arasında mesleğe dair algının ve ilişkilerin dönüşümünü anlamak için önemli kaynaklar olmuştur.

Hekimlerin bir meslek grubu ve bireyler olarak mesleki bağımsızlığının devlet, piyasa ve halkla ilişkilerinin sonucunda nasıl dönüştüğünü anlamak için bir niteliksel metodolojik yaklaşımı seçilmiş, derinlemesine görüşmelere dayanan bir saha çalışması da gerçekleştirilmiştir. Ankara’da çalışan çeşitli branşlardan uzman hekimlerle gerçekleştirilmiş yarı yapılandırılmış derinlemesine görüşmeler analiz edilmiş ve üç karşı aktörle ilişkilerin sonucunu inceleyen bulgular üç bölüme ayrılmıştır. SDP’nin uygulamaya geçirilmesinden önce ve sonrasını karşılaştırabilmesinin mesleki bağımsızlığın dönüşümünü anlamak için önemli olması nedeniyle, görüşmeciler en az 10 yıldır uzman olarak çalışan hekimler arasından seçilmiştir. Hekimlerin 11’i özel sektörde (özel tıp merkezi veya özel hastane), 12’si ise kamu sektöründe (devlet hastanesi, eğitim araştırma hastanesi veya tıp fakültesi hastanesi) çalışmaktadır. Niteliksel araştırma yöntemi, görüşmecilerin mesleki bağımsızlığa dair öznel yaklaşımlarının ve algılarının, aralarındaki farklılıkların, deneyimlerinin karmaşıklığının yorumlanmasına imkan vermektedir. Nesnel çalışma koşullarını öznel olarak

nasıl algıladıklarını ortaya koyulmasına yardımcı olmakta, statülerinde ve bağımsızlık düzeyindeki değişikliklere dair değişikliklere atfettikleri duyguların, gündelik çalışma yaşamında kullandıkları baş etme mekanizmaları, kısa yollar, müzakere ve pazarlık süreçlerinin açığa çıkarılmasını sağlamaktadır. Meslek içindeki sektörlere ve branşlara bağlı bölünme ve verilen kararların çeşitliliği arttıkça meslek heterojenleşmekte, mesleği bir arada tutan mesleki kültürün, ideolojinin ve en temeli bağımsızlık olan mesleki değerlerin akıbetini incelemek önem kazanmaktadır.

Türkiye’de tıp mesleğinin devletle olan ilişkisine dair tarihsel arka plan, hekimlerin toplumda büyük ölçüde gücünün ve etkisinin olduğunu ve bunun yalnızca tıp alanıyla sınırlı olmadığını göstermektedir. Hekimler toplumsal ve siyasi alanda büyük etki sahibi olmuş, bu gücü kurumsallaşmasında büyük rol oynamış olan, sağlık hizmetlerinin en büyük sunucusu ve hekimlerin en büyük iş vereni olan devlet sayesinde edinmişlerdir. Hekimlerin toplumdaki gücü ve otoritesi, onların sosyal ve siyasi yaşamda modernleştiren ve rasyonelleştiren liderler olarak sunulması ve desteklenmesiyle mümkün olmuştur. Bu koşullu güçle Türkiye’de tıp mesleği Anglo-Amerikan modellerin ileri sürdüğü gibi mutlak bir mesleki bağımsızlığa sahip olmamıştır.

Türkiye Cumhuriyeti’nin ilk yıllarında sağlık hizmetleri devlet ve modern vatandaşları arasındaki ilişkinin dönüşümünde önemli bir öge olmuştur. Devletin halk sağlığına verdiği öncelik, doktorların vatandaşlar üzerinde otorite kurmalarını sağlamış, doktorlar nüfusun refahını sürdüren ve devletin mesajını taşıyan grup olarak oynadıkları rol sayesinde sosyal ve siyasi liderler olmuşlardır. Bu, özellikle kırsal alanlarda devletin temsilcisi ve taşıyıcısı olarak görülmelerine neden olmuştur. Otoriteleri ve güçleri, devlet için çalışan ve devletin içinde yer alan sorumluluk sahibi seçkinler olarak pozisyonlarından ileri gelmektedir. Fakat, devletin tıp ve sağlık hizmeti alanlarında tek otorite olması devlet ve meslek arasındaki ilişkide bazı gerginliklere yol açmıştır. Bu dönemde tıp mesleği yalnızca kısmi klinik ve ekonomik bağımsızlığa sahipken, hiç siyasi bağımsızlığı bulunmamaktadır. 1960’lardan itibaren ise meslek devletin

hakimiyetine giderek daha çok karşı çıkmakta, siyasi bağımsızlığını kazanmaya çalışmaktadır. 1953 yılında kurulmuş olan Türk Tabipleri Birliği (TTB) hekimler arasında etki alanını büyüttükçe devletle meslek arasındaki ilişki gerginleşmiş, TTB kendine toplumsal muhalefet alanında bir yer kazanmıştır. 1970'ler boyunca söylemi ve eylemleri siyasallaşmış ve radikalleşmiş, kendisini yalnızca tıp mesleği ile ilgili meselelerle kısıtlamamış ve toplumdaki diğer mücadele alanlarına taşımıştır. Her ne kadar meslek ve devlet arasındaki ilişki hiçbir zaman sorunsuz olmamış ve meslek hiçbir zaman mutlak bağımsızlığa sahip olmamışsa da 1970'ler boyunca mesleğin kolektif memnuniyetsizliği ve itirazları daha örgütlü bir biçimde seslendirilmiştir.

1980'ler ve 1990'lar yalnızca meslek ve devlet arasındaki ilişkide değil, hastalar ve meslek ve piyasa ve meslek arasındaki ilişkide de gerginliklere şahit olmuştur. Sağlık hizmetlerindeki değişiklikler, özel sektörün genişlemesi ve tıp fakültelerinin sayısının artmasıyla meslek mensupları arasındaki bağlar gevşemiştir. Çalışma koşullarının çeşitlenmesiyle rekabet artmış ve çıkarlar ayrılmaya başlamıştır. Devlet ve hükümet yetkililerinin tıp mesleği ve mensupları hakkındaki kötuleyici söylemleri ve sistemin aksaklıklarının sorumluluğunu onların sırtına yüklemeleri, devlet ve meslek arasındaki ilişkilerin daha da gerilmesine yol açmıştır.

Bu gerilim 2000'lerin başında AKP'nin SDP'yi uygulamaya başlamasıyla artmıştır. SDP'nin bazı temel öğeleri şöyledir: Kamu sağlık kuruluşlarının idari ve mali açıdan özerk hale getirilmesi; sağlıkta özel sektörün genişlemesinin desteklenmesi; kamu-özel iş birliklerinin teşviki; bir genel sosyal sağlık sigortasının kurulması; Aile Hekimliği sisteminin kurulması; Tam Gün Yasası; performansa dayalı ödeme sistemi. SDP'nin temel hedefleri verimlilik, etkinlik ve hakkaniyet olarak belirlenmişti (TC Sağlık Bakanlığı 2003). Sağlık hizmetlerinin örgütlenmesi, finansmanı ve sunumundaki değişiklikler tıp mesleğinin piyasa ve halkla ilişkilerini de etkilemiştir. Hekimler giderek daha çok sağlık kuruluşlarında çalışanlar haline gelmiş, bu kuruluşların sayısı özel sektörün genişlemesiyle önemli ölçüde artmıştır. Kamu sektörü, kamu sağlık

kuruluşlarının bütçelerinin özerkleşmesi, yöneticilerin atanması, performans ödemesi sistemiyle işletmeleşmiş, hekimlerin çalışma koşulları değişmiştir. Sağlık hizmetlerine erişimin artmasıyla hizmet talebi artmış, müşteri rolü atfedilmiş hastaların taleplerinde ısrarları kimi zaman sağlık çalışanlarının yaşamını tehdit eden şiddet halini almıştır. AKP'nin neoliberal popülizm olarak nitelendirilebilecek siyasi rejimi, bunun uzantısı olarak tıp mesleğine karşı çatışmacı tavrıyla, mesleği sürekli kontrol altına alma çabası, mesleğin siyasi bağımsızlığını daha da azaltan yasal değişikliklerle pekiştirmiştir. Hekimlerin siyasi, ekonomik ve klinik bağımsızlıklarına devlet, piyasa aktörleri ve hastalar tarafından müdahale edilmeye, hekimlerin karar alma mekanizmaları kontrol altına alınmaya çalışılmaktadır.

Bu gelişmelerin hekimlerin gündelik çalışma koşulları ve bunun sonucunda mesleki bağımsızlık algıları üzerindeki etkilerini anlayabilmek için, Temmuz 2013 ve Şubat 2014 tarihleri arasında Ankara'da 12'i kamuya ait, 11'i ise özel sağlık kuruluşlarında çalışan, en az 10 yıllık uzman hekimlerle derinlemesine görüşmelere dayanan bir saha çalışması gerçekleştirilmiştir. Görüşmelerde ilk olarak yaş, eğitim ve çalışma geçmişi gibi demografik ve kişisel bilgiler, sonrasında meslek tercihlerinin nedeni ve mesleğe ilk başladıkları zamanla şu an arasında mesleklerine dair hislerinde değişim olup olmadığı sorulmuştur. Bunu gündelik çalışma pratiklerine dair sorular takip etmiştir. Bu bölümde günlük hasta sayıları, hasta başına harcadıkları zaman, iş yükü, bu konularda SDP öncesi ve sonrası değişiklik olup olmadığı, kuruluşlarındaki yönetsel değişiklikler, ödeme biçimleri ve bunlara dair görüşleri, Tam Gün Yasası, teknolojik gelişmelere dair görüşleri sorulmuştur. Üçüncü bölümde hastalarla ilişkilerine dair sorular sorulmuştur. Burada hastalarla karşılıklı tavırlarında değişiklik olup olmadığı ve şiddet konusu incelenmiştir. Ayrıca toplumdaki sosyal statülerine, saygınlıklarına ve otoritelerine dair bir değişim hissedip hissetmedikleri sorulmuştur. Dördüncü kısımda mesleğin devletle, mevcut ve geçmiş hükümetlerle ilişkilerine dair görüşleri sorulmuştur. Beşinci kısımda TTB ile ilişkilerine dair sorular sorulmuştur. Altıncı kısımda SDP ile açılan yeni tıp fakülteleri ve mesleğin geleceğine dair ne düşündükleri son kısımda ise hala

mesleki bağımsızlığa sahip olup olmadıkları ve güncel sağlık ortamında “iyi doktor”un ne anlama geldiği sorulmuştur. Bu saha çalışmasının verilerinin analiz edilmesiyle elde edilen bulgular, mesleğin sağlık alanında hakimiyet kurmaya ya da tıp mesleğinin hakimiyetini dengelemeye çalışan diğer aktörlerin her biriyle ilişkilerine odaklanan üç bölümde sunulmuştur.

İlk bölüm, tıp mesleğinin devletle ilişkisine odaklanmaktadır. 2003 yılına kadar hükümetler sağlık politikası ve bütçesinde otorite sahibi olmasının karşılığı olarak kısmi bir mesleki bağımsızlık sağlamıştır. Klinik kararları bütçenin ve maddi kaynakların sınırlı olması nedeniyle kısıtlandığında bile hekimler bunu klinik bağımsızlıklarına müdahale değil, bir kaynak sorunu olarak görmüştür. Bu karşılıklı anlaşmaya dayalı ilişki 1980 yılındaki askeri darbeyle birlikte zarar görmüş, tıp mesleğinin TTB'nin kapatılması ve dönemin siyasetçilerinin tıp mesleğine karşı güvensizlik ifade etmeleriyle siyasi bağımsızlığı kısıtlanmıştır. Fakat araştırmada görüşülen hekimler, devletin mesleğe karşı tavrının, AKP'nin iktidara gelişiyle düşmanlığa dönüştüğünü düşünmektedir.

Görüşmeciler, AKP hükümetlerinin hekimleri kötüleyen düşmanca söyleminin ve mesleğe karşı tavrının siyasi ve ideolojik olduğunu düşünmekte ve bunun halkın gözünde saygınlıklarını yitirmelerine neden olduğu ileri sürmektedir. Bu, onlara göre, AKP hükümetlerinin kentsel ve kırsal yoksullardan oluşan geleneksel seçmen tabanının oylarını kazanma stratejisinin bir parçasıdır. AKP'nin “eğitilmiş seçkinler”i dezavantajlı yoksulları karşı karşıya getirmesinin ve onları sağlık hizmetlerindeki aksaklıkların temel sorumlusu olarak göstermesinin sonucunda halk ve meslek arasındaki güven aşınmaktadır. Bu da hekimler ve hastalar arasındaki gündelik etkileşimlere yansımakta, sağlık çalışanlara karşı şiddetin, hekimler hakkında hastalar tarafından yapılan şikayetlerin ve hekimleri maddi olarak zarara sokan malpraktis davalarının artışıyla sonuçlanmaktadır. AKP hükümetleri ve özellikle Recep Tayyip Erdoğan'ın kendisi görüşmecilerin mesleki bağımsızlığının ekonomik ve klinik boyutlarını önemli ölçüde etkileyen bu gelişmelerin temel sorumlusu olarak gösterilmektedir.



Hedef göstermek ve kötülemek, AKP'nin yalnızca oy kazanmak için yürüttüğü bir siyasi strateji olarak değil, aynı zamanda sağlığı özelleştirme ve piyasalaştırma projesinin bir parçası olarak da görülmektedir. AKP'nin tıp mesleğini ucuzlaştırmak için değersizleştirilmesi, görüşmeleri sırasında sıkça ortaya çıkan bir tema olmuştur. Görüşmecilere göre muayenehaneciliğin önüne engeller koyarak ve hekimleri ekonomik bağımsızlığa sahip olmadıkları sağlık kuruluşlarında çalışan haline getirerek de değersizleşmeleri sağlanmaktadır. Fakat görüşmeciler “ucuz emek” haline gelmeyi yalnızca ekonomik anlamda görmemekte, bu tanımlamayı aynı zamanda uzmanlıklarının “sıradanlaştırıldığını”, “değersizleştirildiğini”, toplumda mesleki bağımsızlıklarının meşruiyetini sağlayan statülerini ve saygın pozisyonlarını kaybettiklerini ima etmek için de kullanmaktadır. Kayıplarını herhangi bir maddi kayıptan daha büyük olarak değerlendirmektedirler.

Görüşmelerin analizi, görüşmecilere göre AKP hükümetlerinin ve resmi yetkililerinin halka vermeye çalıştığı dört temel mesaj olduğunu göstermektedir. Bunların ilki, hekimlerin bu zamana kadar halkı maddi olarak sömürdüğü ve ayrıcalıklı pozisyonlarını suiistimal ettiği; ikincisi, toplumda eğitimli seçkinler ve “cahil” yoksullar arasında bir bölünme olduğu ve AKP'nin ikinci grubun yanında olduğu; üçüncüsü, tıp mesleğinin geçmişte ve şimdiki zamanda sağlık hizmetlerindeki tüm aksaklıkların sorumlusu olduğu; dördüncüsü ise hekimlerin, AKP'nin reformları sayesinde, artık hizmet alan birer müşteri haline gelmiş hastaların taleplerini yerine getirmekle yükümlü oldukları mesajıdır.

AKP hükümetleri mesleki bağımsızlığın tüm boyutlarını kontrol altına almak üzere yasal düzenlemeler yapmıştır. Görüşmelerde sıklıkla bahsi geçen iki yasa, Tam Gün Yasası ve Gezi Yasası olarak bilinen düzenlemelerdir. Bunlar mesleğin siyasi, ekonomik ve klinik boyutlarının kısıtlanması olarak görülmektedir. Aynı zamanda AKP hükümetlerinin mesleğe karşı düşmanca tavrının stratejik birer uzantısı olarak da görülmektedir.

Hekimlerin mesleki bağımsızlıklarının azaldığını düşünmeleri, tıp mesleğinin geleceğine dair umutsuzluklarına da yansımaktadır. Tıp eğitimi ve hekim arzının mesleğin değil devlet kurumlarının kontrolünde olması, mesleğin geleceğine dair karamsar görüşlere sahip olmalarına ve gelecek nesil meslektaşlarına karşı şüpheyile yaklaşmalarına neden olmaktadır. Mesleğin kendi iç meseleleri üzerinde kontrol sahibi olmamak, mensupları tarafından çok önem verilen özdenetim ayrıcalığının kaybı anlamına gelmektedir.

Hekimlerin siyasi bağımsızlığının temsilcisi meslek örgütü TTB'ye verdikleri destek ve onunla kurdukları aidiyetin boyutu, mesleki değerlerin tanımını nasıl yaptıklarına ve TTB'nin devletle çatışmalı ilişkisine dair fikirlerine göre değişiklik göstermektedir. Bulgular, hekimlerin müşterek bir "mesleki değerler" tanımı olmadığını, bazılarının bunun sadece mesleğe dair meseleleri içerdiğini düşünürken diğerlerinin daha genel anlamda siyasi haklar ve insan haklarını da içerdiğini düşündüklerini göstermektedir. Bazı hekimler TTB'nin siyasi kimliğiyle övünürken diğerleri Türkiye siyasetindeki muhalif yerinin onu güçsüz kıldığını, diğer aktörlerle müzakere etme yetisini kısıtladığını düşünmektedir.

İkinci bölüm, mesleğin piyasayla ilişkisinin mesleki bağımsızlığı nasıl etkilediğini analiz etmektedir. SDP içinde hekimler artan bir biçimde artık sağlık hizmetlerinin temel sunucusu olan sağlık kuruluşlarında çalışanlar haline gelmektedir. Bu durum mesleğin kendi ücretini, iş yükünü ve kaynakların dağılımını belirlemesini sağlayan ekonomik bağımsızlığını etkilemektedir. Bunlar artık kuruluşun yönetici kadrosu tarafından belirlenmektedir. Bu yöneticiler, karar alımında kuruluşun bütçesini, üçüncü şahıs ödemelerini ve Sağlık Bakanlığı düzenlemelerini göz önünde bulundurmaktadır. Saha çalışması, mesleki bağımsızlığın hekimlerin sağlık hizmetleri piyasasında ve profesyonel emek piyasasındaki pozisyonuyla bağlantılı faktörler tarafından nasıl etkilendiğini göstermektedir. Bu faktörlerin en önemlileri, zaman kısıtlamaları, iş güvencesizliğindeki artış, tıbbi olmayan değerlendirme kriterleri, tıp teknolojilerinin kullanımı ve ödeme yöntemidir.

Bulgular, mesleki bağımsızlığı anlamak için, hekimlerin özel ve kamu sektöründe bürokratik kuruluşlarda çalışanlar haline geldiğini, bu kuruluşların çalışma koşulları, ödedikleri maaş, yönetim yapısı ve altyapı açısından çeşitlilik içerdiğini göz önünde bulundurmanın önemli olduğunu göstermektedir. Kamu ve özel sektörler açısından ortak olan, hekimlerin tıp mesleği dışındaki aktörlere hesap vermek zorunda olmasıdır. SDP’de hekimler yöneticilere tabidir; bu yöneticiler, sağlık kuruluşlarını işletmek için tıbbi olmayan kriterler kullanan, tıp dışındaki alanlardan idarecilerdir.

Araştırmanın en önemli bulgularından biri, klinik kararların alımında, klinik akıl yürütmenin yerini mali hususların almasıdır. Yöneticiler, hekimlerin davranışlarını, kayıt tutma gibi gözetim yöntemleri, performansa dayalı ödeme biçimleri, iş yükünün finansal kriterlere göre belirlenmesi, standart performans kriterleri gibi değerlendirme yöntemleri ve müşteri memnuniyeti gibi pratiklerle kontrol etmektedir. Her ne kadar klinik bağımsızlık hekimlerin teşhis ve tedaviyi, tüm finansal ya da tıp dışı endişelerden bağımsız olarak, yalnızca klinik akıl yürütmeye dayanarak gerçekleştirmesini sağlasa da, sağlık hizmetleri piyasasının yapısı, tıbbi kararların finansallaşmasını empoze etmektedir. Yönetimin taleplerine tabi olmak ve eylemlerinin maddi sonuçlarını göz önünde bulundurmak zorunda kalmak, hekimlerin mesleki değerleri ve etikle çatışmaktadır. Tıbbi kararların finansallaşması, işlerini klinik akıl yürütmeye dayanarak yürütme ve kontrol etme becerisini kısıtladığı için mesleki bağımsızlığın karşısında konumlandırılmıştır.

Hekimlerin hastalarla geçirdikleri zaman, yönetim tarafından belirlenmiş standart randevu aralıklarıyla kısıtlanmıştır. Bu, onların her gün belirli sayıda hasta görmelerini hedeflemektedir. Bu hekimlerin ekonomik bağımsızlığını kısıtlamakta ve klinik bağımsızlığının azalmasına yol açmaktadır; onlara tanınan sınırlı sürede mesleklerini uygun gördükleri biçimde icra edemediklerini söylemektedirler.

Artan iş güvencesizliği, sağlık hizmetleri piyasası ve emek piyasası bağlamında görüşmecilerin mesleki bağımsızlıklarını etkileyen önemli bir tema olarak ortaya çıkmaktadır. Güvencesizlik, istihdam edilmelerinin pek çok durumda kuruluşun cirosuna katkıda bulunmalarına bağlı olması nedeniyle en çok özel sektörde çalışanları etkilemektedir. Bazı görüşmeciler, bazı hekimlerin istihdam edilmeye devam edebilmek amacıyla iş yüklerini artırabilmek için gereksiz, etik olmayan veya tıbbi doğruluğu sorgulanabilir eylemlerde bulduklarını ileri sürmektedir. Bu eylemlerin arasında gereksiz işlemler veya tetkikler uygulamak bulunmaktadır. Görüşmeciler kayıt dışı istihdamın özel sağlık kuruluşlarında yaygın olduğunu, bunun yansıması olarak düşük maaş ve üzerine emekli maaşına yansıması olmayan yüksek performans ödemeleri verildiğini söylemektedir. Nicel olarak ölçülen performanslarına bağlı olarak ödeme almak, istikrarsız, dalgalı bir gelire sahip olmalarına neden olmakta ve hem şimdi zaman hem gelecekları için güvencesizlik yaratmaktadır.

Sağlık hizmetleri piyasasının şekillenışı, tıp mesleğinin emek piyasasını da etkilemektedir. Hekimlerin artan sayısı ve mesleğın hekim arzını belirleme konusunda otoritesi ve bağımsızlığının olmayışı, piyasa kapanmasının zayıf olduğunu anlamına gelmekte, emeklerini ucuz ve güvencesiz hale getirmektedir. Maliyet verimliliği tedbirleri arayışındaki kuruluşlar, hekimlerin değersiz ve yeri doldurulabilir hissetmelerine yol açmaktadır.

Tüketimcilik kamu ve özel sektörde mesleki bağımsızlığı etkileyen bir başka pratiktir. Hasta memnuniyetini sürdürmek için hastaların taleplerine ve ısrarlarına uygun hareket etmek, klinik akıl yürütmeyle uyuşmayan şekillerde teşhis ve tedavi uygulanabileceği için, klinik bağımsızlığı kısıtlamaktadır. Kendi bilgi ve tecrübelerinden yola çıkarak işlerini icra edememek, görüşmecilerin uzmanlık ve becerilerinin değersizleştiği hissine katkıda bulunmaktadır.

Tıp teknolojileri, sağlık kuruluşlarında tıbbi uygulamaların klinik ve ekonomik mesleki bağımsızlığı etkileyen önemli bir boyutudur. Hekimlerin tıbbi testleri ve tıbbi görüntüleme cihazlarını kullanma düzeyi, üzerinde doğrudan kontrollerinin

olmadığı finansal koşullara ve kaynakların dağılımına bağlıdır. Bunlar sağlık kuruluşunun yönetimi ve SGK gibi dışsal aktörler tarafından kontrol edilmekte ve yönlendirilmektedir. Bu teknolojilerin kullanımını yönlendirmek, hekimlerin klinik bağımsızlığına yönetim tarafından doğrudan olmayan bir şekilde müdahale edilmesi anlamına gelmektedir. Nasıl teşhis koyacaklarına ya da hastaları nasıl tedavi edeceklerine dair kararlarını etkilemektedir. Aynı zamanda hastalar da teşhis ve tedavilerinde belli testlerin ya da cihazların kullanılması konusunda taleplerde bulunabilir, ve klinik bağımsızlığa müdahale etmeye çalışabilmektedir. Tıp mesleğinin sağlık hizmetleri piyasası ve emek piyasasıyla ilişkisinin mesleki bağımsızlık üzerindeki son etkisi, performans dayalı ödeme biçimleriyle ilgilidir. Bu ödeme biçimi SDP çerçevesinde kamu sağlık kuruluşlarında yürürlüğe koyulduğu gibi, özel sektör tarafından da benzer ödeme biçimleri uygulanmaktadır. Bu ödeme biçimde hekimler temel ücretlerine ek olarak yaptıkları iş miktarına bağlı olarak maddi kazanç sağlamaktadır. Tıbbi uygulamanın içerdiği risk, karmaşıklık düzeyi ya da hekimin tecrübesi göz önünde bulundurulmamakta, görülen hasta ve yapılan işlem sayısı ödüllendirilmektedir. Bu durum hekimlerin iş yüklerini artırma ihtiyacı hissetmelerine neden olmaktadır; daha çok kazanabilmek daha çok iş yapmak, normalde tercih edilmeyecek teşhis veya tedavi yöntemlerinin tercih edilmesine, etik olmayan ya da gereksiz işlemlerin yapılmasına yol açabilmektedir. Görüşmecilere göre yaptıkları işin niteliğine değil niceliğine göre gelir elde etmek, tıbbi kararların finansallaşması anlamına gelmektedir.

Tıp mesleğinin halkla ve hekimlerin gündelik olarak hastalarla değişen ilişkilerinin mesleki bağımsızlık üzerindeki etkileri, üçüncü bölümde ele alınmaktadır. Saha çalışmasının bulguları, meslek ve halk arasındaki ilişkinin niteliğini mesleki bağımsızlığı etkileyecek biçimde değişmesinde rol oynayan dört etken olduğunu göstermektedir. Bunlar, tıp mesleğinin toplumdaki imajının, saygınlığının azalmasına ve doktorlar ve hekimler arasındaki güvenin aşınmasına neden olacak biçimde değişmesi; bilgiye ve ilerleyen tıp teknolojilerine erişimin artması; ve sağlık çalışanlarına karşı artan şiddettir. Dört etkenin de altında yatan ortak tema, SDP'nin tetiklediği tüketimcilik ve sağlık hizmetlerinde

müşterileşmedir. Sağlık hizmetlerinin sunumunda, finansmanında ve organizasyonundaki değişiklikler, “müşteri memnuniyeti”ne öncelik veren hasta merkezli bir yaklaşımı vurgulamaktadır. Hekim-hasta ilişkileri artık “hizmet sunucu-hizmet alıcı” ilişkisine dönüşmüştür. Sağlık, doktor ve hastanın uyum sağlaması gereken roller olan satıcı ve müşteri arasında alınıp satılan bir meta haline gelmiştir. Müşterinin her zaman haklı olduğu tüketimci yönelim, hekimlere karşı şüpheciliği de tetiklemekte, hatta teşvik etmektedir.

Bulgular, hekimlerin değişen kamusal imajının gündelik olarak doktor-hasta ilişkisi üzerinde büyük etkisi olduğunu ve bu ilişkinin niteliğindeki değişikliğin en çok mesleki bağımsızlığın klinik boyutu etkilediğini göstermektedir. Her ne kadar sağlık hizmeti sunumu, organizasyonu ve finansmanının iki birey arasındaki ilişkiyi etkileyen başka boyutları olsa da, kamuoyunda hekimlere karşı saygı ve güvenin düzeyinde yaşanan değişikliğin, hekimler ve hastaların birbirlerine karşı (giderek olumsuzlaşan) tavırları üzerinde sonuçları bulunmaktadır.

Mesleğin saygınlığı, görüşmecilerin hekimliği seçmelerinde önemli bir rol oynamıştır. Mesleğe karşı saygı ve güven, hekimlerin kendi maddi çıkarları peşinde bir grup olarak görülmesiyle azalmıştır. Bu, daha önce de belirtildiği gibi, mesleğin hükümetler tarafından sağlık hizmetlerindeki her türlü sorunun sorumlusu olarak gösterilmesinden kaynaklanmaktadır. Bireysel olarak hekimler statü ve prestijlerini halkın gözünde tek bir kimliği olan bir mesleğin üyeleri olarak sürdürebildikleri için, mesleğe karşı her türlü kötileyici ifade de gündelik yaşamda hastaların hekimlere karşı tavırlarına yansımaktadır. Halkın mesleğin mensubu oldukları için bireylere atfettiği statü ve ayrıcalıklar, meslek grubuna güven ve saygı kayboldukça azalmaktadır. Halkın mesleğe dair algısı görüşmecilerin mesleğin daha ayrıcalıklı ve bağımsız oldukları geçmişine dair bir özlem duymalarına yol açmaktadır. Bu nostalji hissi, aynı zamanda toplumda kaybettikleri statü ve saygı için bir yasa dönüşmektedir.

Hekimliğe olan saygının azalması aynı zamanda hekim-hasta ilişkisinde güvenin aşınmasında rol oynamaktadır. Tedavinin başarılı olması için hastanın hekimin tavsiyesini yerine getirmesi, bunun için de hekime güvenmesi gerekmektedir. Dolayısıyla güvenin aşınması, hastanın alacağı bakımın niteliğini de olumsuz etkilemektedir. Konu üzerine mevcut araştırmaların aksine, bu çalışmada görüşmeciler en çok daha az eğitilmiş hastalar tarafından sorgulandıklarını ileri sürmektedirler. Bunu doğrudan AKP hükümetlerinin ve devlet görevlilerinin, görüşmecilere göre oy kazanmak için bir stratejinin parçası olan, hekimleri kötüleyen söylemlerine bağlamaktadırlar. Yalnızca kendi çıkarları için çalışan açgözlü seçkinler olarak sunulmaları, halkın şüpheciliğini ve güvensizliğini şiddetlendirmektedir. Bu durum, sağlık hizmetlerine daha kolay erişimle bir araya gelerek hekimlerin artık yalnızca kentsel seçkinlerin ve ayrıcalıklı kimselerin erişebildiği nadir varlıklar olarak görülmesine son vermektedir.

Bilgiye ve tıp teknolojilerine erişimin artması ve kolaylaşması, hekim-hasta ilişkisinde mesleki bağımsızlığı etkileyen önemli etkenlerdir. Görüşmecilere göre hastalar tıbbi işlemlerle, teknolojilerle ve tedavilerle ilgili daha çok bilgi edindikçe daha talepkar olmaktadır. Edindikleri bilgilerin doğruluğu sorgulanabilir olsa da bu bilgilere dayanan talepleri hekimlerin karar alma süreçlerine müdahaleyle sonuçlanabilir. Tıp teknolojilerine erişimin ve bu teknolojilerin kullanımının artmasının da mesleki bağımsızlık üzerinde etkisi bulunmaktadır. SDP'nin başından itibaren tıbbi görüntüleme cihazlarının ve tetkiklerin erişiminin ve yaygın kullanımının artması, bu cihazlar hakkında bilginin ve hastaların teşhis ve tedavilerinde bu cihazların kullanılması konusunda taleplerinin artmasına da yol açmıştır. Tıp teknolojilerinin artan kullanımı, hastalar arasında bu teknolojilerin tıbbi bakım için gerekli ve hatta vazgeçilmez olduğu inancının yerleşmesine neden olmuştur. Bu da hastaların teşhis ve tedavinin yönetimi hakkında profesyonel kararlarını kontrol altına alma çabalarına yol açmıştır. Görüşmecilere göre hekimlerin tıp teknolojilerini kullanıp kullanmama kararı, hastalar tarafından performanslarının ve yetkinliklerine dair değerlendirmelerine yansımaktadır. Daha çok teknoloji kullandıkça “iyi doktor” olarak görülmektedirler. Öte yandan teknoloji

kullanımının artmasıyla hastaların hekim algısı, bir makine kullanan teknisyeni, standardize edilmiş, mekanik bir süreç yürüten ve bireysel yorum ya da değerlendirmeye başvurmayan birini andırmaya başlamıştır. Bu durum hastaların, hekimlerin klinik akıl yürütme süreçlerini görmezden gelerek ve teşhis ve tedaviye dair kararlarına müdahale ederek mesleki bağımsızlıklarına meydan okumalarıyla sonuçlanmaktadır.

Son olarak, sağlık çalışanlarına karşı şiddet hekimlerin tıbbi kararlarını yönlendirerek mesleki bağımsızlıklarını azaltan bir başka etken haline gelmiştir. Tüketimciliğe yapılan vurgu ve hekime güvenin aşınması, hastaların hekimleri her taleplerini yerine getirmekle yükümlü olarak görmelerine yol açmıştır. Hekimler bunu kabul etmediğinde psikolojik, sözlü ve fiziksel bir tehdit olarak ortaya çıkmaktadır; dolayısıyla kendilerini saldırılardan korumak için hastaların taleplerini, kendi klinik değerlendirmelerine göre yanlış ya da gereksiz olduğunu düşünseler de, yerine getirmek zorunda hissedebilmektedirler.

Saha çalışmasına dayanan bu üç bölümün bulguları, özellikle devlet merkezli toplumlarda, kolektif ve bireysel bağımsızlığı birbirinden ayırmanın mümkün olmadığını ortaya koymaktadır. Tıp mesleğinin sağlık alanındaki diğer aktörlerle ilişkisi tarihsel olarak incelendiğinde, klinik bağımsızlığın ekonomik ve siyasi bağımsızlıkla doğrudan ilişkili olduğu görülmektedir. Kaynaklar üzerinde sağlanan otorite veya yasal düzenlemeler, teşhis ve tedavi için gerekli kaynakları veya mesleği icra etme kabiliyetini kontrol altına alarak tıbbi kararları şekillendirebilmektedir. Fakat Türkiye örneği iki zıt durum bir arada içermektedir. İlki, ekonomik ve siyasi bağımsızlığın yokluğunun klinik bağımsızlığı da olumsuz etkilediğidir. İkincisi ise, 1980'den önce Türkiye'de olduğu gibi, tıp mesleği toplumda etkili ve güçlü görüldüğü zaman, mutlak siyasi ve ekonomik bağımsızlığa sahip olmamasına rağmen mesleğin kendisini klinik bağımsızlıktan yoksun olarak algılamamasıdır. Buna rağmen, SDP içinde yeni düzenlemeler ve aktörler tıp mesleğinin ayrıcalıklarına meydan okumak için fırsat buldukça siyasi ve ekonomik bağımsızlığa algısında görülen düşüş, klinik bağımsızlığa da yansımaktadır. Türkiye'de tıp mesleği neredeyse hiç siyasi



bağımsızlığa sahip değildir, işlerinin neredeyse her boyutu hükümetin ve kamu kurumlarının kontrolü altındadır. Sağlık politikaları, finansmanı, sağlık hizmetlerinin yönetimi ya da sunumu ve hatta kendi mesleki meseleleri üzerinde etki sahibi olmalarına izin verilmemektedir. Bu, gelir etme biçimleri, kaynakların dağılımı, hizmetlerin ücretlendirilme edilme biçimi, nerede nasıl çalışabilecekleri gibi diğer çalışma koşullarını da etkilemektedir. SDP’de devlet politikaları hükümetin tıp mesleğine dair söylemi ve mesleğe karşı tavrıyla şekillenmektedir. Bu da siyasi alanın sağlık hizmetleri ve tıp mesleği üzerinde önemli ölçüde etkisi olmasına yol açmaktadır. Siyasi bağımsızlık hükümetin eylemleri, politikaları ve düzenlemeleriyle kısıtlanmakta, bu da doğrudan klinik ve ekonomik bağımsızlığı etkilemektedir. Bu çalışma, mesleki bağımsızlığın siyasi, ekonomik ve klinik boyutlarının iç içe geçmiş olduğunu ve birbirinden tümüyle ayrı olarak görülemeyeceğini ileri sürerken, aynı zamanda sağlık hizmetlerine ve tıp mesleğine dair merkezi karar alma organının devlet olması nedeniyle siyasi bağımsızlığın diğer iki boyut üzerinde belirleyici gücü olduğunu göstermektedir. Tıp mesleğinin siyasi bağımsızlığının çok az olması, işin finansal boyutu, kaynakların dağılımı veya çalışma bağlamı üzerinde kontrol sahibi olma gücünde kısıtlamaktadır. Her ne kadar gündelik yaşamda klinik kararlarına doğrudan bir müdahale olmasa da, bu kararların hükümetler ve kamu kurumları tarafından yapılan düzenlemelere dayanan ekonomik endişelerle ya da hekimlerin eylemlerine müdahale etmeyi hedefleyen yasal düzenlemelere dayanarak manipüle edilmeye çalışılması, siyasi bağımsızlığa sahip olmamanın klinik ve ekonomik bağımsızlığı da olumsuz etkilediğini göstermektedir. Anglo-Amerikan bağlamdan çıkan geleneksel profesyonel meslekler kuramları devlet-profesyonel meslek ilişkisini istikrarlı ve çatışmasız olarak nitelendirmekte, devleti mesleğin ve mesleki bağımsızlığın meşruiyetini ve kurumsallaşmasını destekleyen bir aktör olarak konumlandırmaktadır. Bu araştırmanın bulguları ise bu ilişkinin karmaşık, dinamik ve çatışmalı olduğu Türkiye’de durumun farklı olduğunu göstermektedir. Meslek kurumsallaşmasının ilk adımında devletle iç içe, hatta adeta devletin himayesi altındadır; karşılığında devlet sayesinde toplumda yüksek statüsü meşruiyet kazanmıştır. İç içe geçmiş, karmaşık ilişkileri çatışmadan azade olmamıştır. Bu çatışma mesleğin toplumsal statüsüne de

yansır; devlet ve mesleki bağımsızlığı kısıtlama çabaları, mesleğin statüsünü düşürmektedir.

Bu çalışma, tıp mesleğinin tam ve mutlak siyasi ve ekonomi sahibi olmadığı ve dolayısıyla klinik bağımsızlığının da kısıtlandığı koşullarda, mesleki bağımsızlığın meslek grubuna ait homojen bir değer olarak değil, bireysel bir değer olarak deneyimlendiğini ileri sürmektedir. Bulgular piyasa aktörleri, devlet ve halkın tıp mesleğinin sağlık alanındaki pozisyonuna karşı artan müdahale çabaları karşısında klinik ve ekonomik bağımsızlığın azaldığını göstermektedir. Hekimler bağımsızlıklarının öznel düzeyini, mesleklerinin içkin bir değeri veya işlerinin vazgeçilmez bir ögesi olarak değil, kendi şahsi çalışma koşullarına göre tanımlamaktadır. Bu, meslekin profesyonelliğinin kuruluşların örgütsel yapıların bürokratik mantığı karşısında tehdit altında olduğunu ileri süren Evetts'in (2004) ifadesiyle mesleki profesyonellikten örgütsel profesyonelliğe kayışı andırmaktadır. Bürokratik kuruluşlarda çalışan olmak Türkiye'de hekimler için yeni bir gerçeklik değildir; fakat azalan mesleki bağımsızlık hem kamu hem özel sağlık kuruluşlarının yapısının, kuruluşların idaresine hakim olan yönetsel ilkelerin ve tıp mesleğinin bu meselelerde sahip olduğu güç(süzlük) düzeyinin bir sonucudur. Sağlık hizmeti sunulan ortamların ve bu ortamlarda sunulan çalışma koşullarının çeşitliliği de mesleki bağımsızlık algısının çeşitli olmasına yol açmaktadır. İşin icra edilme ortamı, performansı ve profesyonel hedefleri etkilemektedir (Hafferty 1988, 208). SDP altında, işveren kuruluşun yapısının ve onun belirlediği koşulların mesleki bağımsızlığın tanımlanmasında etkisi vardır. Mesleki bağımsızlık, her ne kadar ideal olarak öyle görülmeye devam edilse de, artık tıp mesleğinin homojen, birleştirici, sabit bir değeri değildir. Farklı bağımsızlık algıları, bağımsızlığın bireysel ve örgütsel bir değer olarak deneyimlendiğini göstermektedir.

Bu araştırmanın bir diğer temel sonucu, tıp dışı kararların klinik kararlar üzerinde etkisinin artması nedeniyle mesleki bağımsızlığın azaldığıdır. Ekonomik ve lojistik meseleler üzerinde otorite sahibi olan aktörler, ki bunlar hemen hemen tümüyle tıp dışı aktörlerdir, hekimler üzerinde baskı uygulayarak

tıbbi kararların finansallaşmasına yol açmaktadır. Hekimlerin klinik bağımsızlığı istihdam edilmeye devam edebilmek, gelir sahibi olabilmek ve yönetim ve hastalarla çatışmayı engellemek için bu baskılara uyum sağlamak zorunda olmaları nedeniyle kısıtlanmaktadır. Gerekli kalifikasyonlara ve uzmanlığa sahip olmak artık hekimler için mutlaka yüksek maddi ve iş güvencesine sahip olunacağı anlamına gelmemektedir. Sağlık hizmetleri piyasasının yapısını ve kurallarını belirleyen tıp mesleği değil, piyasa ve bu alanda hekimlerin çalışma koşullarını belirleyen kamu kurumları, hükümetler, sağlık kuruluşları, yöneticiler gibi diğer aktörlerdir.

Bulgular, tüketimciliği ve müşterileşmeyi destekleyen politikaların, hastaların hekimlerin klinik bağımsızlığına müdahalede bulunmalarına olanak sağladığını göstermektedir. Kamuoyunda mesleğe dair değişen algının hekim ve hasta arasındaki gündelik etkileşimlerin niteliği üzerinde olumsuz sonuçları bulunmakta, bu da hekimlerin klinik kararlarını etkilemektedir.

SDP düzenlemeleri, sağlık kuruluşlarının kar amacı gütmemesi, yeni yönetsel teknikler, hekimlerin işini giderek daha çok dış değerlendirmeye ve kontrole açık hale getirmektedir. Tıbbi uygulamaları standartlaştıran ve rutinleştiren pratikler, gözetim ve değerlendirme araçları, tıbbi yöneticiler, kamu kurumları, sigorta şirketleri gibi tıpta uzmanlığı olmayan aktörler için daha erişilebilir hale getirmektedir. Tıbbi bilgiye erişimin kolaylaşması, profesyonel mesleğin uzun eğitim, kalifikasyonlar ve bilgisinin karmaşık doğasına dayalı olan toplumsal statüsünü de zora sokmaktadır. Hekimler giderek artan biçimde klinik akıl yürütme yerine klinik rehberlere, algoritmalara göre karar almak zorunda bırakıldıkça, müşteri memnuniyetine göre değerlendirildikçe ve hizmetleri niteliği yerine niceliğine göre ücretlendirildikçe, sıradan insanlar ve hekimler arasındaki güç ve bilgi uçurumuna dayanan statüleri de erimektedir. Hekim ve hasta arasındaki sosyal mesafe, güç asimetrisi, ayrıcalıklı pozisyonlarını sürdürebilmelerini sağlamaktadır. Hekimlere ve bilgilerine erişim artıkça tıbbi bilgi ve uygulama da gizemini kaybetmekte, bu sosyal statülerini hem kendi gözlerinde hem de halkın gözünde, aşındırmaktadır. Hekimin hasta gözünde

statüsünün aşınması, hekim kararlarına müdahale etmeye çalışma ve en aşırı düzeyinde şiddet olarak ifade bulmaktadır.

Çalışma, profesyonel meslekler literatürüne Türkiye’de tıp mesleğinin mesleki bağımsızlığını sosyolojik bir perspektiften inceleyerek katkıda bulunmaktadır. Türkiye örneği toplumdaki güç mücadelelerini, çatılmaları ve müzakereleri göz önünde bulundurmanın ve mesleki bağımsızlığı sabit ve mutlak değil dalgalı ve dinamik bir değer olarak görmenin önemini göstermektedir. Mesleki bağımsızlığın düzeyi ve bireysel olarak hekimlerin onu nasıl algıladığı, mesleklerini içinde icra ettikleri sosyal, ekonomik ve siyasi bağlama bağlıdır. En klinik kararlar bile kişisel, etik, siyasi, ekonomik ve yasal kısıtlamaların olduğu bir bağlamda alınmaktadır. Bu araştırma aynı zamanda bir profesyonel mesleğin devletle yakın ilişki içinde kurumsallaştığı, devletin desteğiyle toplumda güç ve etki sahibi olduğu, fakat yine devlet tarafından siyasi ve ekonomik bağımsızlığın esirgendiği, özgün bir vaka sunmaktadır. Devletin mesleki bağımsızlığı yalnızca gönüllü olarak kısıtlamadığı, aynı zamanda mesleğin meşruiyetini halkın gözünde sorgulanabilir hale getirmek için meslekten desteğini tümüyle çektiği için özgün bir vaka. Bu durum hükümetin mesleğe karşı tavrı ve mesleğe dair söylemiyle şiddetlenmiş, halkla ve hastalarla ilişkisini olumsuz etkilemiş, kamuoyu nezdinde mesleğin itibarını sarsmış ve hekim ve hasta arasındaki güveni aşındırmıştır. Mesleki bağımsızlık yalnızca, Batı literatüründe çok örneği görüldüğü gibi, teknolojik değişim, bilişsel temel veya ekonomik faaliyetlerde değişim, bürokratikleşme, yöneticilik, müşterileşme sonucu dönüşmemektedir. Aynı zamanda hükümet politikaları ve hedefleri sonucunda da dönüşmektedir. Devletin sağlık hizmetlerinde uyguladığı politikalar mesleğin piyasa ile ilişkisini doğrudan etkilemekte, hekimlerin ekonomik bağımsızlığını kısıtlayarak gündelik çalışma yaşamında klinik karar alma süreçlerini olumsuz etkilemektedir. Devletin tarihsel olarak mesleği neredeyse himayesine almış olması ve sağlık konusunda merkezi karar alıcı aktör olması nedeniyle Türkiye’de siyasi alanın mesleki bağımsızlık üzerinde büyük etkisi vardır. 2000’lere kadar devlet ve meslek arasında güç dengesi genellikle karşılıklı olsa da, neoliberal SDP politikaları ve AKP hükümetlerinin tıp mesleğine karşı düşmanca popülist

söylemleri, tıp mesleğinin mesleki bağımsızlığının kısıtlanmasıyla sonuçlanmıştır. Anglo-Amerikan profesyonel meslek kuramlarında devlet ve meslek arasındaki ilişkisi çatışmasız ve sorunsuz olarak görülse de, Türkiye örneği bize bu iki aktörün ekonomik veya ideolojik çatışma içinde olabileceğini göstermektedir. Teknik meseleler, ekonomik veya ideolojik meseleler haline gelebilir (Starr 1982). Ekonomik çıkarlar, çatışan ideolojiler ve statü endişeleri sağlık alanındaki diğer aktörleri tıp mesleğine karşı hareket etmek üzere motive edebilir. Mesleğin devlet, piyasa ve halkla ilişkisi, siyasi, ekonomik ve klinik bağımsızlıklarını azaltacak biçimde iç içe geçmiştir.

Bu çalışmanın profesyonel meslekler sosyolojisine ve Türkiye’de tıp mesleğine dair çalışmalara katkısı, mesleki bağımsızlığı toplumsal aktörlerin birbiriyle etkileşimi üzerinden ele alması ve hem meslek grup düzeyine hem de bireylerin öznel algılarına odaklanmasıdır. Mesleki değerlerin ve ayrıcalıkların anlamı, yalnızca meslek mensupları tarafından içselleştiriliyor ve tecrübe ediliyorsa vardır. Mesleki bağımsızlığın sosyal bilimler perspektifiyle incelenmesi, sağlık hizmetlerinin niteliğinin artırılmasına katkısı da bulunacaktır. Fakat sağlık sisteminin tüm boyutlarını ve mesleğin her kesimini içerebilmesi için benzer çalışmaların kentsel olduğu kadar kırsal alanlarda ve meslek hayatının farklı dönemlerindeki hekimleri de kapsayacak şekilde yapılması faydalı olacaktır. Çalışmanın da gösterdiği gibi, farklı sosyal ve ekonomik koşullarda çalışan ve devlet, piyasa ve halkla farklı ilişkiler kuram hekimlerin mesleki bağımsızlık algısı da farklılık gösterecektir.

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