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Book review for Medical Law International

Medical Doctors in Health Reforms

Jean-Louis Denis, Sabrina Germain, Catherine Régis, & Gianluca Veronesi. (2022). *Medical Doctors in Health Reforms: A Comparative Study of England and Canada*. Policy Press.

£80

Health systems the world over are subject to almost perpetual cycles of reform. The authors of this volume recognise that if we are to benefit from this activity (and limit its harms), we must get better at it. To this end, they examine the impact of the interaction of political and institutional factors on attempts at reforming health systems, using case studies from Canada and England – where the crucial relation is the one between the medical profession and governments. Their aim is to arrive at an original model for understanding these interactions that is useful to policy makers and practitioners as they seek to improve both the process and the outcomes of reform.

The multinational, interdisciplinary team of authors bring to the task extensive experience in researching diverse but relevant areas and, as will emerge in the account below, a sharp understanding of effective collaboration. The authors make it clear that their work is built on the legacy of scholars such as Rudolph Klein[1] and Chris Ham[2] in the UK and Carolyn Tuohy[3] in Canada and provide a concise survey of the literature on medical doctors and health reform. Against this background, the book's unique contribution is a novel theoretical model for the interaction of medicine and government, underpinned by second order analysis of contemporaneous studies from multiple jurisdictions.

The book is the fourth in a research-based series published by Policy Press: *Sociology of Health Professions: Future International Developments*, edited by Mike Saks and Mike Dent. As well as having academic aims, the series aspires to making a practical impact. Due in no small measure to the economy and precision of their descriptions and analysis, as well as the accessibility of the model they developed, the authors have produced a work that is entirely consistent with these aims.

I met with one of the authors, Sabrina Germain, in November 2023 to discuss the book and the insights it has to offer.

Siun: I was struck by how cohesively the book is written. Given that there were four authors involved, multiple disciplines, and two continents, that is quite a feat. How did you decide to come together as a team to write, and why this particular book?

Sabrina: This project was born out of friendship and common interest in the field of healthcare law policy, management and organisational theory. Jean-Louis and Gianluca have worked on projects together over the years and have been meeting at conferences and in similar circles for some time. Catherine and I are both from Montreal and have known each other personally for many years and worked on projects together before. When Jean-Louis and Catherine, who are colleagues at University of Montreal, got the idea for this book they reached out to Gianluca and me respectively and we were both thrilled at the idea of writing a deeply interdisciplinary book. For us, that was the foundational idea.

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[1] Rudolph Klein, *The New Politics of the NHS: From Creation to Reinvention*(7th edn) (Routledge 2013).
[2] Christ Ham, *Health Policy in Britain* (Palgrave Macmillan 2009).
[3] Carolyn H Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the Unites States, Britain, and Canada* (OUP 1999).

We were lucky enough to be able to meet in person before and after the pandemic, which helped greatly. We developed the theoretical framework during these meetings and refined the core concepts which helped us generate heuristic devices to support the coding and interpretation of data. For this we worked in pairs, Jean-Louis and Gianluca on policy and organisational theory, and Catherine and I on the legal framing of the project.

We then regrouped according to country/jurisdiction to develop the narrative by country and second order analysis and came again together for the comparative analysis and conclusion. Regarding the unity of style – that was something we actively sought to achieve. Each of us contributed to every chapter. I'm glad to hear it had the desired effect.

Our hope was for a truly and deeply interdisciplinary study of this phenomenon. We thought that healthcare policy and law scholars would be interested in this unique comparative perspective, but also we wanted to appeal to policy makers, particularly in Canada, where the literature around healthcare reforms was more limited.

Siun: The research is concerned with how relations between government and organised medicine influence health reforms and policies in publicly funded health care systems (PFHS) – particularly with the push-and-pull that arises from government's desire to regulate medicine, and medicine's desire for self-regulation. In Chapter 1, you present the theoretical model underpinning the research, and situate it in a succinct summary of the literature on those aspects of the sociology of professions that are relevant to doctors' engagement in reform. You describe the theoretical model that emerges as 'a coproduction' in which doctors and governments are joined in responding to the need for change, but face 'symmetrical frustrations': government makes proposals and medicine pushes back, and medicine both shapes and reacts to proposals for reform. The 'real reform' emerges from these interactions. Ultimately, you say, this dynamic between medicine government means that health reforms are, in your words, in a 'constant state of becoming'. I feel I haven't conveyed the sense of 'movement' in the model. What might you add to my description of the model to make it come alive?

Sabrina: I think you are making a very good description of this phenomenon of push and pull that leads to the co-design of healthcare reforms. Often people imagine policy makers in a room writing down a vision in isolation.
However, what we tried to explain through our theoretical framework is that the product of a reform in health policy is a complex and more organic phenomenon. The phrase 'constant state of becoming' in my opinion translates that well, it is an ever-evolving negotiation and co-creation.

The 'real reform' really emerges from these interactions, particularly those in what we have conceptualised as 'the mediated space' – this space in which medical doctors and states/government agency come together and play out their own interest in producing change or sustaining a status quo. This in essence are the negotiations. But they are not done in an insulated manner. This means that each of the actors' positions or protagonists does not stay static. As a product of discussions and sometimes confrontation medical doctors and government representation will go back to their respective groups with slightly altered positions and the final compromise or bargain will come from this interaction in addition to other endogenous factors and some outer historical context. On a very abstract level it is about movement, space and temporality.

Siun: Context plays an important part in the model. I wonder if you could explain why law, especially the place of law in constraining or supporting the agency of both government and doctors, is so prominent in the model and analysis.

Sabrina: Yes, indeed, context matters a lot in healthcare policy. It may seem obvious but we became particularly interested in this element when defining the concept of reform. The legal act formalising the policy change is central but also the legal system within which this norm is created and evolves is crucial.

Also, going back to the mediated space, the interaction between the government and medical doctors happens in this negotiating space using different policy instrument and law is, of course, one of them. We therefore thought it would be helpful to conceptualise the element of context in terms of its distal and proximal nature, and law is both, in a sense.

We argue that distal and proximal context influence the manifestation of agency of reformers and the medical profession. Proximal context refers to the endogeneity of healthcare systems shaping relationship between different actors and the content of reforms. It interacts with and filters the influence of more distal context drivers.

We suggest that changes within healthcare systems promote greater alignment and interdependence between government and the medical profession. As a result, medical doctors may simultaneously participate in the development of reforms and resist transformative policies. This supports the logic of co-production in healthcare reforms.

Siun: The presentation of methodology and methods in Chapter 2 is remarkably lucid. The chapter provides methodological reasoning, referencing recent scholarship in medical politics and policy; justifies the cases selected; and explains the procedure for data analysis. Notably, it provides a strong rationale for focusing on organised medicine, rather than on individual doctors. In the case studies, however, the personalities and actions of individual *politicians* loom large. I wonder if you might be willing to offer a reflection on the implications (for our understanding of the phenomenon) of not attending equally to the effect of dominant (or dominating) individual doctors.

Sabrina: We have attended to dominant politicians and figures in narratives. However to your point – that was a decision early on in the project that considering our expertise we would not do a deep dive in political history or psychology of actors although it may be relevant for some studies. What mattered to us was the group dynamics. Or I should say – to determine whether there was such a group dynamic in the medical profession and whether it was different from country to country.

I can speak for the English case study and say that medical doctors in England have been very organised ever since the inception of the NHS. They may not always act in concert – we see differences in stances and opinion between the specialists (hospital) medical doctors and general practitioners. This was particularly prominent at the very start of the system. However, doctors are very much a unified group when it comes to preserving universality of care, which guarantees their status and their autonomy. Their workings and "lobbying" so to speak also happens behind the walls of Parliament and more indirectly, this may be why some prominent figures are not so obviously featured. Nonetheless we have, when pertinent, highlighted the role of important presidents of the BMA for example.

In Canada the situation is slightly different, politicians in healthcare policy are very much dominant and featured in the papers. Medical professionals, be it the generalist doctors or the specialists, really act as two distinct groups and units to defend their interests.

Siun: The book focuses on macro level reform, which – you explain – is inherently more political and likely to engage 'organised' doctors than reform at individual or practice level. It offers two cases from Canadian provinces and one from England, each spanning a period of almost 90 years. The English case describes waves of reform in the National Health Service from its inception, through a series of series of governments and (generally financial) crises, almost to the present day. Why was it important to look at reform over such a long period? And can you explain how the findings will be helpful to readers working on more temporally constrained projects?

Sabrina: The idea is that looking at such a long period we can first, better understand patterns of relationships and levels of engagement and strategies of doctors over time, beyond the details of each reform. Second, it also allows us to observe whether there have been shifts in the strategies of the main actors over time.

This has direct implications for those who are looking at one reform event only, as patterns of behaviours and relationship are likely to appear over and over again but also there needs to be an understanding that each reform has peculiarities that affect how actors will position themselves and act as a consequence.

It is very much about understanding path dependency elements and accounting for potential patterns rather than taking an anecdotal look at health reforms.

Siun: The two Canadian cases in Chapter 3 seem to centre (though not exclusively) on different priorities – healthcare access in the case of Quebec, and cost containment (with direct implications for doctors' remuneration) in the case of Ontario, while the English reform in Chapter 4 might be seen as part of a nation-building project. All, however, at various stages, had potential implications for doctors' hip-pockets. In Chapter 5, you note that the assimilation of the medical profession into the system was more thorough and enduring in England and attribute this to government strategy. How does the analysis take account of the differences in objectives of the different reforms? And more specifically, what did you find out about how severely doctors' concerns about their remuneration constrain reform?

Sabrina: Medical doctors' important concerns about remuneration have had the effect of strongly limiting the depth and nature of negotiations between the government and medical doctors. The participation of the medical profession in health reforms was also affected more broadly. Medical doctors remain weakly involved and interested in discussions when they do not directly touch on their financial interests. However, we have also noted that the government did not find the most potent means to substantially engage doctors the co-creation/co-design of health reforms. Also in spite of the different priorities that are unique to each country and each reform, we have observed consistent patterns of interaction between medical doctors and the government.

Of course I am generalising here for the sake of the argument, but we have noted a rejection of bureaucratic control, tensions around remuneration and resistance to agree to limit clinical and policy autonomy of the medical profession.

Siun: One of the things that interested me was the shift in dynamic when health ministers are medical doctors, for example Dr Gaétan Barrette in Quebec, whose influence you analyse under the heading *Devils and heroes: doctors in the drivers' seat* in Chapter 3. It would be interesting to know if the team was surprised by this – and what sort of conversations you had about it. What do you think is the importance of this for reform in the future?

Sabrina: Interestingly, the first impression was that the presence of a specialist (a radiologist) in the role of the health minister would somewhat favour the position of medical doctors, at least specialists, in health reforms. It turned out that the level of conflicts was particularly heightened during this period and the strategy used by the minister was based on an instrumental form of leadership.

Our Canadian colleagues were not surprised having experienced the reform first hand. They were, however, surprised when unpacking the scope of tactics used by the minister to push through the reform – highlighting even if the reforms were led by doctor, they remained closely aligned with the patterns of interaction observed in previous reforms.

Minister Barrette was coherent with the position of medical doctors as one key aspect of his reform was to reduce bureaucratic roles in the system. The difficulties Barrette encountered during the reforms process was a strong resistance from specialist doctors. This broke down the preconception that a specialist doctor would make for a better policy maker for the design and implementation of healthcare reforms.

Siun: You report that reforms usually ended up being diluted (if not abandoned), and you gave at least one instance where frustration of government's aim prevented patient and community harm. In the Conclusion, however, it appears that you consider joint policy-making to be desirable and are somewhat

discouraged by governments' relative lack of interest in embracing governance practices aimed at promoting collaboration. You are also critical of medicine's commitment to discursive practices aimed at shoring up the profession's historical influence and autonomy. Here, and in the narratives and analysis, the bureaucrats and managers seem to emerge as a common – if not enemy – bugbear. What insights does your research give into the prospect of a generative – possibly tripartite – relationship in the future?

Sabrina: Collaboration is of course desirable, because of the expertise that is held on both sides, and we've seen that a very centralised top down approach to policy making can drive the conflict and kind of the antagonistic nature of it.

It is difficult to say what the future holds, because a lot of this is intrinsically linked to politics and the governments in power. The medical profession is also a changing group and may evolve over time. They may change what their aims are in policy making.

In any case, as you point out, greater collaboration and co-design is likely, in our opinion, to lead to better policy. The disconnect between policy maker and people (the medical doctors) who are in charge of implementing the decisions and dealing with the population has had some negative effects.

What we have seen with the COVID-19 pandemic is that greater integration is better, and that is also what is strongly encouraged with the latest healthcare reform in the UK. The Health and Care Act 2022 embraces the idea of co-design and policy making even at a very local level. The idea being to have civil servants from the NHS, people from the care and community sector, the population and medical professionals work together to create better policy that truly responds to the population's needs.

Siun: Finally, may I ask what are your hopes for the book?

Sabrina: Building on the legacy and, in a sense, "standing on the shoulders" of Carolyn Tuohy's book *Accidental Logics* in which she had looked at dynamics and change in the American, Canadian and British healthcare systems, we wanted to lead a comparative analysis to understand the logics and dynamics between the medical profession and government in the crafting of healthcare reforms in two western welfare states with publicly funded healthcare system.

We wanted to contribute to knowledge but also to be a helpful tool/framework of analysis for graduate students in the field of health policy, law and organisation theory. Hopefully the book is well received in political circles and can lead us to do some empirical work with the key stakeholders that were involved in some of these reforms in Canada and England.

Ultimately, we want to provide a unique outlook on the role of medical doctors and we hope this can open the door to a different perspective on healthcare reform making/process that leads to a more collaborative approach.

The authors of *Medical Doctors in Health Reforms* have succeeded in their goal of presenting a convincing model for medical doctors' engagement in policy making that acknowledges the legal and political contexts in which it occurs, and they have made recommendations that are practical and sensitive to these contexts. The book will be a valuable resource for policy professionals, especially in jurisdictions where political change has created opportunities for new approaches – and readers in need of a coherent and accessible history of health reforms in England and Canada need look no further.