Doctors on Status and Respect: A Qualitative Study
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Abstract
While doctors generally enjoy considerable status, some believe that this is increasingly threatened by consumerism, managerialism, and competition from other health professions. Research into doctors’ perceptions of the changes occurring in medicine has provided some insights into how they perceive and respond to these changes but has generally failed to distinguish clearly between concerns about “status,” related to the entitlements associated with one’s position in a social hierarchy, and concerns about “respect,” related to being held in high regard for one’s moral qualities. In this article we explore doctors’ perceptions of the degree to which they are respected and their explanations for, and responses to, instances of perceived lack of respect. We conclude that doctors’ concerns about loss of respect need to be clearly distinguished from concerns about loss of status and that medical students need to be prepared for a changing social field in which others’ respect cannot be taken for granted.

Keywords: Physicians Health occupations Ethics Social dominance

Background and Rationale
The Changing Status of the Medical Profession
While doctors as individuals and as a profession are generally considered to enjoy a privileged position in society, some believe that we are witnessing “the end of the golden age of doctoring” in many Western countries (McKinlay and Marceau 2002, 379). This loss of position has been attributed to both a reduction in the status of professions in general as well as specific forces in and around medicine (Hafferty and Light 1995; Mechanic 2003).

External threats to the status of physicians are numerous and include: the introduction of market forces, most notably third-party payers, which means that doctors can no longer decide for themselves whom to treat and at what price (see Menke 1971; Kurunmaki 1999; Kirschner and Lachicotte 2001; Kocher and Sahni 2010); the bureaucratisation, or “modernisation,” of health care delivery, with its ever-increasing regulation and scrutiny of doctors’ performance (see Lupton 1997; Nettleton, Burrows, and Watt 2008); the rise of evidence-based medicine, which arguably has undermined the legitimacy of clinical decision-making and experiential reasoning (see Timmermans and Oh 2010); the introduction of new medical technologies, which sometimes limit doctors’ domains of competence and make them increasingly dependent upon machines and laboratories in their everyday work (see Menke 1971; Rice 2010; Burri 2008); the rise of consumerism and the associated “proletarianisation” of medicine (see Timmermans and Oh 2010; Lupton 1997, 1998); and the continued transformation of other health professions, including nursing, allied health, and complementary medicine, so that they increasingly compete with medical practice (see Barrow, McKimm, and Gasquoine 2011; Voogdt-Pruis et al. 2011). At the same time, increasing specialisation within the medical profession means that some groups of doctors have come to enjoy far more...
political power, professional and public prestige, and remuneration than others (see Watt, Nettleton, and Burrows 2008; Hafferty and Light 1995). Each of these forces has the potential to undermine doctors’ actual or perceived position in society and, taken together, suggest that medicine is enjoying anything but a “golden age.”

These changes in position have been attributed to the “deprofessionalisation” of medicine, associated with loss of power or renegotiations of power (Lupton 1997). These changes have also been framed sociologically as stemming from changes in forms of social capital within the biomedical “field” (Kurunmaki 1999; Burri 2008), changes in the kinds of knowledge, or “doxa,” that are privileged (Nettleton, Burrows, and Watt 2008; Burri 2008), and changes in the dynamics of professional identity and boundary work associated with these shifts (Dukerich, Golden, and Shortell 2002; Burri 2008).

Many observers have applauded these changes, arguing that they have eroded medical hegemony, increased the accountability of the medical profession (see Dent 2006), led to a more equitable distribution of power in the clinical setting (see De Voe and Short 2003), and reduced the pressure on doctors to be sole clinical decision-makers (see Thistlethwaite 2005). At the same time, however, it has been acknowledged that doctors themselves might not view these changes as uniformly positive and might resist them in various ways.

In this context, a body of qualitative empirical research has emerged that examines doctors’ responses to threats to their professional position. These micro-level studies (e.g., Annandale 1989; Lupton 1997; Nettleton, Burrows, and Watt 2008; Hardey 1999; Allsop and Mulcahy 1998; Samson 1995; Berg et al. 2000)—as distinct from macro-level analyses of gender and power inequalities within and between professions (Snelgrove and Hughes 2000)—have been justified on the grounds that we need to know what individual doctors think about their changing social position (Lupton 1997; Watt, Nettleton, and Burrows 2008) and whether these perceptions and responses support or refute commonly held assumptions about the dynamics of control within, and between, professions (Armstrong 2002). The majority of these qualitative studies have focused on medical professionals’ attitudes toward consumerism, managerialism, and the incursion of other health professions into traditionally medical territory.

In general, these studies have demonstrated that doctors recognise the benefits of a more informed and autonomous public, and even the appropriateness of medicine having a diminished status in the eyes of its “consumers.” However, they also think that some groups of patients have become excessively critical and demanding, in part as a result of negative media coverage of medicine, and they feel hurt by patient complaints, which are seen as a challenge to their professional competence and expertise and even as attacks on individual identity (see Lupton 1997, 1998; Allsop and Mulcahy 1998; Watt, Nettleton, and Burrows 2008). In contrast to these mixed reactions about changing public perceptions of the medical profession, studies of responses to the “marketisation” and bureaucratisation of medicine demonstrate more or less uniform resentment on the part of practising doctors. While some doctors display a degree of loyalty to their organisations and to the health system, many express significant concern about the impact upon medicine of regulatory changes and organisational demands. These changes are seen to be particularly threatening to the tacit (or experiential) dimensions of clinical knowledge and to the practice of the “art” of medicine (see Nettleton, Burrows, and Watt 2008; Watt, Nettleton, and Burrows 2008). With respect to their position in relation to other health professionals, doctors seem to be largely supportive of other professional groups extending their roles, but express concerns about role confusion and lack of adequate skill on the part of these other practitioners (see Barrow, McKimm, and Gasquoine 2011; Voogdt-Pruis et al. 2011).
From “Status” to “Respect”

This literature makes it clear that doctors are very aware of the many changes to their professional position and are having some difficulty adjusting to these changes. For the most part, this has been interpreted as evidence of doctors’ desire to maintain their position of power in society and the political recognition associated with that power. In other words, doctors who express concern about changes to their position in society are generally assumed to be concerned about reductions in their social status (Cockerham and Scambler 2009; Peck and Conner 2011; Whitehead, Austin, and Hodges 2011; Zazzali et al. 2007; Maseide 1991). Less attention has been paid to the nuances of doctors’ responses and to whether doctors’ discomfort might stem from other concerns, such as a perceived lack of respect.

We think that this is a problem because status and respect, while related, are not synonymous. Status, as we define it, refers to an individual’s or group’s acknowledged position within a hierarchy. It is something that is possessed as a “right” that goes with a position in a hierarchy, and it is closely linked to power. It leads those who have it to expect to be treated in a certain way because of that right, no matter how they behave—“it’s the superior whose needs count and who gets recognition” (Sennett 2003, 53). Because it inheres in social positions, it can change—sometimes easily, sometimes only with considerable pressure—during times of social change.

Respect, on the other hand, is a positive assessment of the moral worth of one person or group by another person or group. Darwall (1992) usefully distinguishes between “recognition respect”—such as respect for persons simply because they are living beings—and “appraisal respect,” which is grounded in the belief that a person has manifested characteristics that make him or her deserving of positive appraisal. For the purposes of this article, we understand respect in the latter way: Someone (an individual or a group) earns respect by exemplary personal qualities and behaviours and can lose respect by irregular or “substandard” behaviour. Because it inheres in the person or group, rather than in a social position, respect might be more stable than status in times of social change, provided the person or group is able to demonstrate continued merit (Darwall 1977, 2004; Pettit 1989; Warren 1997; Bird 2004).

Status and respect are, of course, closely related in reality. Sennett (2003), for example, argues that inequality—i.e., lack of status, according to our definition—sets the scene for lack of respect by precluding the formation of the kind of character that is generally respected—i.e., the kind of character that develops itself, cares for the self, and gives back to others. Others have noted that status is one of the outcomes of appraisal respect: Those who are appraised positively are more likely to increase their hierarchical status and all that goes with it (Benditt 2008; van Quaquebeke, Zenker, and Eckloff 2009).

But the ease with which the terms status and respect are conflated tends to obscure significant differences between them, and we think that, despite—or indeed because of—this mutually reinforcing relationship, these concepts are best kept separate. A senior doctor might, for example, hold a senior position in a hierarchy and enjoy all of the rights accorded to people in that position, without being considered to be a morally worthy individual. Similarly, a junior doctor might lack power in the medical hierarchy but be highly respected as an individual. A doctor’s views about, and experience of, status might, therefore, be significantly different to his or her views about, and experiences of, respect. We acknowledge that status and respect have been defined in different ways, and we accept that our understanding of respect might be viewed, according to some definitions, as simply another variant of status. We suggest, however, that there is both theoretical and practical benefit in delineating the concepts of status and respect.

In this article we explore doctors’ perceptions of the degree to which, and ways in which, they are respected, as individuals and as a profession. Using data from qualitative interviews with 20 medical practitioners, we show that respect is most salient in three kinds of interactions—interactions with
patients, interactions with other doctors, and interactions with hospital managers—and we characterise the meaning of respect and disrespect in these contexts.

Methods

Medical practitioners associated with the Sydney Medical School (Australia) were invited to participate in interviews. Twenty-two people were approached, and 20 were able to participate. Sampling was purposive and aimed at achieving maximum variation in gender, age, and specialty. There were seven women and 13 men. Ages ranged from 28 to 76 (median age 49), and years since graduation from three to 52 (median years 26). Specialties included anaesthetics, general practice, internal medicine, surgery, ophthalmology, radiation oncology, psychiatry, emergency medicine, paediatrics, and public health. In some cases, participants were still affiliated with the medical school through full-time or part-time academic appointments, while others practised solely in hospital or community settings. Our goal in using this sampling strategy was not to examine these sub-groups in depth or to identify subtle differences between sub-groups, but rather to ensure that we were not missing any major issues that might be obscured by interviewing only one “type” of doctor. We continued sampling until thematic saturation had been reached—that is, until no new themes were emerging from the interviews.

Our principal research question was: “What values matter to doctors in their practices and in their educational experiences?” Interviews were semi-structured, with participants encouraged to reflect on episodes in their careers that had stayed in their minds because of their moral dimensions. They were also asked to talk about specific issues such as the cost of health care, the availability of health services, the appropriateness of the medical education program they had received or were teaching, the rise of evidence-based medicine and the place of evidence and research in medical education and practice, and the impact of role models and mentors. Participants were not asked specifically about status or respect, and there was no one question that elicited talk of status and respect; rather, these statements were infused throughout the interviews. We asked, for example, for participants to reflect on colleagues whom they admired and colleagues of whom they disapproved. Statements about respect emerged most frequently and consistently when participants were asked about such colleagues and about the most and least satisfying aspects of their training and current practice.

Interviews were conducted by a medical practitioner and a psychologist, either together or separately. All interviews were anonymised, with coded numbers used for each participant. Ethical clearances were obtained from the university. We have withheld detailed demographic details of each practitioner to protect anonymity.

Once it became evident from the data that status and respect were important emergent concepts, transcripts were thematically coded for statements relating to status and respect. Our methodology was underpinned by critical realism, which encompasses ontological realism (the idea that the objects of our studies are real, having independent existence and ontological status); epistemological relativism (the idea that our knowledge of reality changes diachronically because of changes in our understandings, our previous investigations, our experiences, and our values); social naturalism (the view that social facts and social reality are sufficiently similar to scientific facts and reality to treat their study as naturalistic); and judgemental rationalism (the belief that there are rational criteria that may help us to choose among competing theories) (Bhaskar et al. 1998). A process of dialectical empiricism (VanLear 1998) was used to categorise the emergent themes into more abstract concepts, using constant comparison (Charmaz 2006; Clarke 2003; Morse 1994) and reformulation of research questions and theories (Morse 1994). Dialectical empiricism is a research technique for analysing qualitative data. It consists of iteratively generating and modifying research questions in the light of increasingly abstracted analyses of the data, until a degree of generalisation is reached that is determined by the nature and context of the study. The technique we used, which
is modified from that described by VanLear (1998), is particularly useful because it encourages reformulation of research questions as emergent themes that are seen to be important, while at the same time maintaining contact with the original purpose of the study. An audit trail was maintained, and agreement about themes, codes, and categories was reached at regular meetings of the research group. A process of abduction (Reichertz 2007) was used to relate emerging themes, concepts, and categories to definitions of respect and status.

Results

Statements about both status and respect were evident in our data. We considered a statement to be about “status” if it referred to entitlements associated with a position occupied within the health system hierarchy and accorded to a person or group simply by virtue of holding this position in the hierarchy. We considered a statement to be about “respect” if participants were concerned about positive regard for their talents or virtues from another individual or group.

Status

To the extent that our participants were concerned about status, this related primarily to the interface between medical professionals and hospital managers and health system bureaucrats. There was an expectation that doctors, simply by virtue of their seniority in the medical hierarchy, should have some right to control medical resources.

I need to do a procedure on someone who is waiting for this procedure, and I can’t do it because the hospital hasn’t paid the company, who makes the valve I want to put in, for the last one I did. And I shake and I shake and I can’t make any money come out. … I catch myself saying, “Why the hell should someone in my position have to micromanage this?” (P3).

Concerns about status also manifested themselves in discussions of relationships between different groups of doctors. A few participants were concerned about the need to compete with other doctors in order to attain a position in the medical hierarchy and about their inability to attain their desired formal status within the competitive medical hierarchy.

It’s interesting because my wife’s done medicine and she’s never really enjoyed it, and felt that during medicine there was often a dog-eat-dog competition, people climbing the ladder and the hierarchical sort of thing (P10).

Under Professor B nobody could be a professor but him. … There was no other professor in any of the major hospitals or anything, he just wouldn’t allow it. He was the professor (P3).

Finally, concerns about status manifested themselves in talk about remuneration, with some participants expressing indignation about perceived inequities in payment. Payment was seen as a right, accorded to particular groups primarily by virtue of their relative position in the medical hierarchy. Concerns about relative remuneration were felt by general practitioners, who compared themselves to specialists; hospital doctors, who compared themselves to private practitioners; teaching academicians, who compared themselves to clinicians; and doctors of all kinds, who compared themselves to managers and policy-makers.

I think that general practice should be better funded and that GPs should be paid more. I think it’s scandalous that specialists earn so much relative to GPs (P8).
**From Status to Respect**
For the most part, however, our participants had more to say about respect than status. That is, they spoke less about their position in the health system hierarchy and their associated rights and more about the extent to which they—as individuals or groups—were positively assessed by others on the basis of their moral, or other personal, qualities.

**Respect From Patients and the General Public**
Many participants reflected on the pleasure that they experience as a result of being regarded positively (as individuals) by patients and (as a group) by the general public. It was important to our participants to be acknowledged for providing good care—and this could be manifested in patients choosing to return to see the same doctor on more than one occasion or thanking the doctor directly for what he or she has done, even when the doctor has been unable to save a patient.

> And clinically I always get a lot of the sort of personal satisfaction of looking after patients, and them coming back to see you time and time again, choosing to come back to you is again that external recognition that people are obviously happy with what you are doing, that feedback is good (P1).

> When I left [the hospital] there were so many patients with such fond, such warm thoughts, and it really ... there's not many professions that can give you such overwhelming gestures of support and appreciation. I think there’s boxes of cards and letters (P10).

> So we went down the pathway of keeping him comfortable ... and they were really thankful to me actually, and they even remembered my name, like they kept saying, “Thank you very much for everything you’ve done.” ... So I think it showed me that they appreciated [my efforts], and they actually thanked me (P16).

Our participants also wanted to be viewed by patients as trustworthy confidants, to whom patients could reveal intimate information.

> I think patients test you out, and you find that you get progressively deeper and deeper in a relationship with a patient, especially once they keep coming back. ... And there are things that people will tell you that they would not even tell their spouses about how they feel about things (P11).

In contrast, P3 described how he felt unable to continue caring for a patient who did not demonstrate the appropriate level of trust and respect. This patient had been admitted to a hospital not of her choosing and was threatening to leave. The doctor promised the patient that he would try to find a bed for her at her preferred hospital, if she would wait for him to do so. She did not comply with her promise to wait and discharged herself from the first hospital—an act that was seen as a deep display of disrespect.

> [S]he ... was admitted to [Hospital A] ... and was desperately keen to come to [Hospital B]. ... And I said, “I hear you, this is not always easy to do ... just promise that you’ll give me eight hours before you leave.” ... And I rang back six hours later with a bed [at Hospital B], and she’d gone. And I rang up and left a message, and I said, “[Patient Name], I’ve looked after you a long time, I cannot look after you anymore.” ... If [Patient Name] doesn’t have enough faith in me to wait six hours for me to get back to her, when I’m doing her a favour, then we have not got a bilateral relationship, [and] that’s not good for her, either (P3).

Patients in less affluent or more remote geographical areas were seen to be more willing to appreciate doctors’ efforts and personal sacrifices than those in wealthier urban areas.
I’ve worked in [Country Town]. You see a very different group of patients there, a lot of them from poorer socioeconomic backgrounds, a lot of poorer health coming in, like more advanced diseases. But at the same time a lot of the patients are a lot more grateful, because they’ve got less help out there, medical-wise (P15).

At [Hospital X] they’d always come half an hour [early], because they don’t want to be late (P10).

Lack of collective respect was also a concern.

There is little respect for politicians, the church leaders, and doctors. So much so that I think pharmacists were the most popular people last time they did a thing on professions. I think a lot of people would prefer to speak to their kind, friendly bus driver, than their rushed GP, who doesn’t seem to give a damn about them (P13).

Negative portrayals of medicine in the general media were seen as a particularly important manifestation of a lack of collective respect for doctors’ efforts to provide good care.

This is going to sound really a bit lame, but, um, I’d like to see better recognition for the good things in our system, instead of, you know, constantly whinging about some of the infections in the states, and the bad things that happen… The medical press are as guilty as anything as being negative about things. I think there should be some more good news stories about what we do (P1).

Respect From Other Doctors

All of the participants in this study spoke of the importance of being respected by other doctors. While junior doctors were aware of their low status in the medical hierarchy, they were concerned not so much with their status but with the way in which they were regarded and treated by more senior doctors. Consistently, the junior doctors in our study described how much they appreciated being acknowledged for their (developing) clinical competence.

So I actually feel that some of them don’t treat me like a registrar, but they treat me like a colleague, which is very nice to know that they’re looking out for me, and I’m not just a workhorse for them (P16).

So although my supervisor initially was quite harsh to me, I just kept doing the best I could. … And he actually was so impressed with me that he offered to be a referee for me to apply for surgical training at the end (P16).

Indeed, simply being deemed worthy of mentoring and conversation was a source of great pleasure for P8.

He was, certainly he was a mentor, and I think we clicked very strongly. … And he just loved to talk about things. He always had this conspiratorial thing of just beckoning you into his office and shutting the door, and you’d know he had a thousand other things he ought to be doing, but he would just want to talk about something or other (P8).

Even senior doctors greatly valued the respect they received from colleagues. Participants gave many examples of situations in which they had been acknowledged by their peers for their personal efforts and achievements by being asked to contribute to policy, by being given prestigious positions and prizes, and by having their work published and read. Importantly, these acts of acknowledgment did not seem to operate simply as status markers but rather as expressions of genuine positive regard from one’s peers.
Getting the job here at the university, and being asked to contribute to policy or practice or committees ... shows that I suppose people must value what you do in some way. So that kind of external recognition is really, really nice (P1).

I was the youngest professor of [this specialty] in Australia. I was proud to set up the tertiary referral centre. ... I am proud of what I have done. I am really proud this year because I got the College Medal for [this specialty], giving the ... Oration of the College conference ... in May. So I’m proud of those things (P18).

It’s nice to get recognition from your peers for the work that you do ... and when you publish things and people read your work and “oh really, that’s great, how exciting” (P1).

Our participants also wanted to be respected for having unique kinds of knowledge and expertise and for having leadership and mentoring capabilities.

The other amazing scientist, [Professor H.] ... He’s very scientific in the sense of [being] published in Science, The New England Journal of Medicine, thinking all the time about mechanisms and what might be going on, but asking me each time, valuing what I might bring at the same time because I had a different knowledge base as a clinician (P4).

And actually I’ve had people come to me quite specifically and say, “I’ve decided that I’d like you to be my mentor.” ... And I hope that’s been valuable to them (P8).

Failure of doctors to respect their peers—no matter how junior—was viewed as bullying or harassment.

And there was a culture at [Hospital X]. ... It was a harassment sort of culture: intimidation, yelling, and real stripping down. And you’d give a talk, I remember [Dr. B.] gave a talk, but spent hours and days preparing, and [a senior doctor] walked out after five minutes, saying, “This is rubbish,” and just walked out (P10).

There was one surgeon in particular who ... because he wasn’t a particularly good surgeon, he’d be snapping at the person who was assisting him, and mumbling under his breath and not giving clear instructions, and just saying, “No, no, no,” but not saying what the person was doing wrong (P17).

At the collective level, some participants worried about the ways in which their departments or specialties were viewed by their peers or by more junior doctors. As with individual respect, our participants did not demand recognition by virtue of their collective status, but rather wanted to be acknowledged collectively for the quality of the work they were actually doing or the efforts they were making under difficult circumstances.

We’re a bit understaffed because of various things, and I think our department has hit a very low point, and it’s seen as dysfunctional by, I think, a lot of other people in the hospital (P16).

My criticism of the College [of General Practitioners] exam is: I don’t think it’s hard enough. ... Now that may change as there are more graduates, and as the College derives more power, because at the moment we’re like the cousin that’s trying hard to get a job, so to speak. Once there are people queuing up to do general practice, then I think that will actually improve the quality of general practice (P11).
Respect From Managers and Bureaucrats

While few of our participants made positive statements about their relationships with managers, rare demonstrations of respect in this context appeared to be particularly meaningful. P19 recalled his pleasure at being “listened to” when he was a junior medical officer (JMO), and P4 felt that her professional identity was enhanced when the system began to respond to her advocacy efforts on behalf of an under-served patient group.

[W]e developed these guidelines for JMO handover, and I did a health study ... and lo and behold, NSW Health actually listened and took it all on as policy. I was really excited, because they actually listened to what junior doctors said (P19).

I actually feel proud of the fact that [this disease] is actually something that’s far better recognised and resourced now than it was 10 years ago, and I think I’ve been very involved at a number of levels in making it, certainly in New South Wales, part of basic [speciality] recognition (P4).

In contrast, concerns about lack of respect from hospital administrators featured heavily in our participants’ accounts. Indeed, almost all of our participants had something to say about the disrespect that they or their colleagues had experienced from hospital managers or university bureaucrats. Here their concern was not so much about the rights of doctors by virtue of their status, but rather a lack of regard for doctors’ perspectives, expertise, and efforts.

Every year we used to lobby to change the hospital policy to call residents to do blood cross-matching after hours. (... This was before any overtime was being paid.) ... So I used to have to make representations to the hospital CEO about this, and he said to me 1 day, “You know, every year you elect a new representative, and by the time they work out what needs to be done, they’ve moved on” (P8).

And the problem is that a lot of people who could provide that one-on-one type of mentorship feel disengaged by the university, undervalued and disengaged (P3).

This manifested itself particularly strongly in our participants’ attitudes toward clinical governance. Our participants were not opposed to governance per se, but strongly resented the fact that their own efforts and expertise to improve the quality of care were not being acknowledged.

I’m really, really sceptical about governance. But I think my concern is mostly about the way it’s delivered, in that it tends to be delivered in quite a patronising way, and doctors are presented with ideas like morbidity and mortality meetings, which were there to begin with as though it’s some sort of a bureaucratic idea that the doctors weren’t already doing spontaneously (P17).

I don’t have a great optimism that the things that I do, or we all do, make a great deal of difference. We write, we complain, we bring it to the notice of the relevant administrators; it’s a perennial problem. So I do feel a certain amount of powerlessness about changing that, and we’re all trying, individually (P5).

Discussion

The results of this study suggest that doctors are more concerned with respect than with status and that respect is most salient in three kinds of interactions: interactions with patients, interactions with other doctors, and interactions with hospital managers. Our findings are consistent with other empirical research, which has demonstrated that respect is a highly valued aspect of organisational and professional life (van Quaquebeke, Zenker, and Eckloff 2009).
**Limitations and Future Research**

As tends to be the case with qualitative studies, our sample was small and we cannot be certain of the extent to which these findings are generalisable. Because our aim was to achieve maximum variation, we also could not draw out fine distinctions between sub-groups of doctors based on gender, age, and specialty. Given that these could all impact upon perceptions of status and respect, further research focusing on these distinctions would be enlightening. We were also unable to determine why our participants spoke more of respect than of status. It is possible, for example, that it is currently unfashionable to complain about lack of status, but acceptable to be concerned about lack of respect. More directed in-depth qualitative analysis would help to draw out these underlying motivations. Interestingly, only two participants mentioned the issue of medical negligence, and in both cases they were discussing the experiences of other doctors. Future research could explore this finding. Other specific research questions that emerged from our findings are identified below.

**The Effects of Perceived Disrespect**

This salience to our participants of perceived (dis)respect is significant because perceptions of the degree to which one is respected can have important psychological and social consequences. Psychologically, receiving respect can enhance the security of people’s judgements about their own self-worth (Benditt 2008; Smith et al. 1998; Tyler and Blader 2000). Of more interest to sociologists is the fact that individuals and groups who are respected (or perceive themselves to be so) tend to behave in particular ways. Social psychological and social justice research has shown that interpersonal respect can generate pro-social behaviour such as fulfilling one’s roles as a member of a group (van Quaquebeke et al. 2009; Simon and Sturmer 2003; Tyler and Blader 2000). Organisational research has shown that respectful leadership can enhance motivation, job satisfaction, and performance (Judge et al. 2004). In contrast, individuals and groups who perceive themselves to be unfairly disrespected tend to feel anger and a sense of injustice (Miller 2001). As Miller has argued:

> Individuals are committed to the “ought forces” of their moral community ... and people believe that these forces deserve respect from all members of the community. The violation of these forces represents an insult to the integrity of the community and provokes both moralistic anger and the urge to punish the offender in its members (Miller 2001, 535).

As sociologist Émile Durkheim observed in 1858, the perceived disrespect can come from within, as well as outside, the group (Durkheim 1964).

People who feel that they have been disrespected often respond in socially disruptive, and even aggressive, ways as they attempt to restore their self-esteem and/or educate the “offender” (Miller 2001). People who feel that they have been slighted might withdraw or attack. Withdrawal can be voluntary or involuntary and can take the form of refusal to comply with authority (Huo et al. 1996); lack of identification with the group and unwillingness to compromise one’s personal goals and concerns for the good of the group (Jeremier, Knights, and Nord 1994; Simon and Sturmer 2003); and reduction in work performance (Lind, Kanfer, and Earley 1990). These responses are somewhat different to the ways in which people respond to loss of status. Benditt (2008) notes that people who lose status often respond by trying to lower other people’s positions in the hierarchy or by projecting themselves as equal or superior to higher-ranking people.

Our results demonstrate that doctors feel that they are disrespected from both within their professional group (i.e., from other doctors) and outside it (i.e., from managers, patients, and the general public). While little was said directly by our participants about how they respond to such perceived disrespect, there is no reason to think that their reactions, when slighted, should differ
from those of other groups. This might, in turn, help to explain some otherwise frustrating attitudes and behaviours on the part of clinicians.

First, doctors have been observed at times to be unwilling to work in teams—not only with non-medical professionals but also with colleagues from other specialties. This has been understood as a function of increasing specialisation, with each specialty group competing for resources and status (Hafferty and Light 1995; Watt, Nettleton, and Burrows 2008) and being immersed in its own knowledge and culture (Hall 2005). An alternative or additional explanation for doctors’ apparent unwillingness to collaborate with their medical and non-medical peers might be that they perceive themselves as being disrespected by these peers, leading them to be less willing to compromise their own goals and concerns for the good of the team.

Shekelle (2002) has suggested that there might be four reasons for physicians’ resistance to clinical governance: that physicians may not agree with the criteria by which quality is being measured; that physicians are concerned about being blamed for harm to patients; that clinicians resent the extra work associated with clinical improvement activities; and that clinicians have not been shown models of successful quality improvement programs. We would add to this the possibility that clinicians resist clinical governance efforts because of perceived disrespect from managers and bureaucrats.

Perceived disrespect from managers could also explain the observation that clinicians are sometimes sceptical of humanistic movements such as “patient-centred care.” This apparent resistance has been understood as stemming from “old-fashioned,” paternalistic, clinical values (Gillespie, Florin, and Gillam 2004); from concerns about the resources required to, for example, spend more time talking to patients (Tufano, Ralston, and Martin 2008); from the perception that adopting a patient-centred ideology can threaten clinicians’ sense of status in relation to patients and colleagues (O’Flynn and Britten 2006); and even from “cynical disengagement” on the part of students and doctors (Coulehan and Williams 2003; White et al. 2009). We would argue that doctors’ apparent resistance to patient-centred care, and other similar humanistic medical movements, might stem in part from a the perception that such movements are already consistent with current medical values and practice and that their formalisation into social movements, with the associated bureaucratic criticisms and demands, are yet another sign of managerial disrespect. In other words, we suggest that doctors are not actually opposed to the values underpinning movements such as patient-centred care but resent the way they are formulated and delivered.

**Practical Implications**

The implications of these findings are three-fold. First, it is important to remember that doctors’ resentment of changes in their social position might be due to perceived disrespect rather than (or in addition to) perceived loss of status. In other words, doctors are likely to be just as concerned that their genuine skills and efforts are not being recognised as they are about losing their hierarchical power. This means that apparent resistance to social change should not be automatically assumed to be due to the unwillingness of “status-hungry doctors” to give up their power and privilege. Future research could be used to more carefully tease out those instances (if any) where the issue for doctors is truly loss of status as opposed to loss of respect.

Second, more care could be taken to distinguish between those social changes with which doctors genuinely disagree and those that doctors would embrace more wholeheartedly if they were delivered with the appropriate degree of respect. Our participants were not, for example, at all opposed to patient-centred care or evidence-based medicine (their embracing of these two epistemic paradigms and their efforts to navigate across them will be described elsewhere). Nor were our participants against the idea of working in teams or making health systems safer or more economically efficient. But they were resentful of the ways in which these apparently new
“initiatives” were imposed upon them. They suspected, for example, that cost-cutting, rather than safety and quality, is a significant driver of change. With this in mind, efforts should be made by those wishing to change clinical practice to recognise the good that is already done by clinicians, listen to their voices and opinions, provide reasonable facilities for their work, acknowledge the legitimacy of their requests, and in general implement Drucker’s (1988) suggestions about the role of administration in fields that depend for their existence on knowledge workers. Rather than viewing this as simply “giving in” to an already powerful profession, it could be viewed as a way of motivating more cooperative behaviour in the face of the considerable social and psychological threats posed by changes to medicine and the world it inhabits (Drucker 1988). Future research could help us to distinguish more clearly between those social changes that doctors genuinely resent and those that they would embrace more wholeheartedly were it not for the perception that they are imposed by, or on behalf of, people who are not appropriately respectful.

Third, medical education could focus more on the issue of respect, in order to prepare young doctors for the changing social world they will inhabit. Medical students and doctors could be encouraged to accept the inevitable instances of undeserved disrespect that they will encounter, to ensure that their own practice is genuinely respect-worthy, and to articulate real concerns about perceived threats to quality of care. They could also learn to recognise and acknowledge that they are sometimes overly concerned about status and that they need to accept the realities of a more egalitarian medical field in which demands for status are less likely to be accommodated. Future research could help to identify relevant educational deficits and perceived educational needs in relation to becoming more reflective practitioners.

**Conclusion**

Changes in medicine understandably provoke unease amongst doctors—an unease that is commonly ascribed in significant part to loss of status. Our empirical study confirms the tensions that doctors experience between themselves and colleagues, patients, administrators, and the general public, but suggests that this tension is experienced at least as much as a lack of respect as a loss of status. If we want doctors to work in teams, cooperate with managers, and take the best possible care of their patients, then doctors’ concerns about loss of respect need to be clearly distinguished from concerns about loss of status, and medical students need to be prepared for a changing social field in which others’ respect cannot be taken for granted.

**Competing Interests**

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