Chapter 16

Using the survival-security-flourishing model to explain the emergence and shape of the medical profession

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Introduction

In this chapter, we will explore the value of Little's theory of 'modest foundationalism' as a means of shedding a fresh perspective on the medical profession. In particular, we seek to determine whether we can explain why the medical profession exists, and persists, in the form it does in Western societies, without resorting to the almost taken-for-granted assumptions about self-interested striving for power and status that prevail in much of the sociological literature. We first review the development of theories about the emergence and maintenance of the medical profession, drawing primarily from sociological traditions in the USA and UK. Next, we articulate our understanding of the main elements of Little's theory, in which he identifies three pre-normative values – survival, security and flourishing – that, he argues, exist and are expressed in any culture or society. We then propose that a shift in the level of analysis from that of society to that of the collective – in this case the medical profession – can offer new insights into the nature of the profession and its role in society. We conclude with observations about the relevance of this wider perspective for theory and for medical education and governance.

Threads of sociological thought about the medical profession

The medical profession has long been studied as the prototypical model of professionalisation, and its study has formed the basis of many general theories of the professions. A central goal for these theorists has been to explain the high levels of autonomy and prestige held by professionals in society, relative to other occupations.

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The functionalist approach

Early work tended to characterise professions as a distinct type of occupational group, by delineating special 'traits' that set professions apart from, and above, other occupations (Carr-Saunders and Wilson, 1933). For several decades thereafter, sociologists devoted much attention to articulating the distinguishing characteristics of professions, including an elevated ethical sensibility, an advanced body of knowledge and esoteric theoretical base, an altruistic orientation, and a sense of professional community, among other traits (e.g., Parsons, 1939; Goode, 1957; Greenwood, 1957; Millerson, 1964; Vollmer and Mills, 1966). These scholars maintained that such traits justified the autonomy, status and power held by professions.

Power-based explanations

An alternative line of thought emerged in the 1970s, dismissing functionalism as little more than a defender of the power and prestige of professionals that resulted from professionals' perceived invaluable role in society. Sociologists began to question the 'attribute approach' as little more than a 'mixture of unproven and often unexamined claims' for professional control and autonomy (Roth, 1974; Hafferty, 1988, p. 203). Instead, these scholars were determined to shift the focus from examining what functions professional groups served and why they differed from other occupational groups, to examining how the groups gained and maintained their power and prestige.

Freidson, one of the leaders of this new perspective, did not deny that professions and occupations were different, but his focus was on the unique ability of professionals to 'exercise control over their work and its outcome' and to be the 'arbiters of their own work performance, justified by the claim that they are the only ones who know enough to be able to evaluate it properly' (Freidson, 1973, p. 30). His goal was to explain how such claims to professional autonomy and control were achieved and maintained. His seminal study of the profession of medicine (Freidson, 1970a) laid out the stages through which the organised profession had historically engendered state support for barriers to entry, such as licensing, based on attainment of higher education and expertise. Larson described these efforts as 'professionalisation projects' (Larson, 1977), which revealed the interdependence between professional claims to expertise and institutional reinforcement through state-supported 'labor market shelters' of licensing and credentialing (Freidson, 1986). Abbott (1988) explored how professional groups established 'jurisdictional niches' to which they claimed exclusive rights to practice, which in turn furthered the power and prestige of such groups.

Balancing functionalist and power-based perspectives

The popularity of this approach to examining – and challenging – professional powers quickly overshadowed the earlier functionalist explanations, with their focus on the essential role of professionals in society. Nevertheless, in recent years, there have been signs of a blending of the two perspectives, recognising that professions can in fact be distinguished from other occupational groups and that their autonomy claims and concomitant power are not wholly unjustified. In his later writings, Freidson (1994, 2001) espoused a more balanced view of professionals and professional powers,

through what he labelled a 'third logic of professionalism' that has, at its core, a specialised knowledge that society values enough to want advanced and applied in socially useful ways. This specialised and valuable knowledge, he argued, largely justifies the jurisdictional protections and resulting professional power held by the medical profession.

Dingwall (Dingwall, 2004; Pilnick and Dingwall, 2011) struck a similar chord, highlighting the enduring asymmetrical relationship between patient and physician; others have also emphasised this asymmetry, which provokes an inevitable need for trust (Mechanic, 1998, 2004; Hall *et al.*, 2001; Broom, 2005). Dingwall drew from Adam Smith to illustrate the essence of trust in the medical profession and its relationship to prestige: 'We trust our health to the physician. . .Their reward must be such, therefore, as may give them that rank in society which so important a trust requires' (Smith, 1776 (1976), p. 118). Dingwall concluded that 'the place of professions in the modern world. . .uses more colours in its palette than the monochrome of occupational imperialism' (Dingwall, 2004, p. 10).

In this chapter, we pick up the threads of these more recent arguments – that the existence of the medical profession in its current form is better understood using both functional-based and power-based theories of professions. A linking mechanism, we will argue, can be found in Little's theory of foundational values and their expressions.

Foundational values and their expression

In Chapter 14, Little proposes an aetiological theory of foundationalism, in which he identifies three foundational values (F-values): survival, security and flourishing. We briefly summarise our understanding of his argument as follows.

The three F-values are pre-normative, descriptive, *a priori* necessities for a culture to continue and evolve. 'Survival' represents existence, without which a society and its people would disappear. 'Security' represents the need for stability, in order to facilitate survival. Security needs constitute the basis of our willingness to trust and to accept some forms of social control in exchange for predictability. 'Flourishing' represents the need for self-development and self-expression, beyond what is necessary for survival and security, that makes life worth living.

According to Little, these three F-values help to explain and justify our existence, as well as the specific patterns and institutions that give meaning to each society by enabling a sense of security and personal flourishing. While the three F-values exist in any context, their expression – that is, the beliefs, preferences, and practices that flow from the F-values – will differ over time and across cultures and societies. These are codified as axioms (A-values) and practices (P-values).

Axioms (A-values) are generalised principles or 'truths' that are espoused by a particular group in society. A-values often take the form of normative assertions of 'needs' that are derived from the three foundational F-values. They form the beginning of a normative ideology, or set of maxims, from which preferences and practices flow.

Practical values (P-values) are the practices that flow from the axiomatic principles, as a means for implementing the F-values. They are based on the preferences of a particular culture or society at a particular time. P-values thus represent translations of the A-values into actional 'shoulds'.

Explaining medicine using the survival-security-flourishing (SSF) framework

Little's model of survival-security-flourishing (SSF) focuses on the ways in which individuals come together to form societies that enable them to achieve survival, security and flourishing. Our goal is to explore the explanatory power of the SSF model within the health care context at three levels: the level of individuals in societies, the interactional level of patients and their physicians, and the collective level of the medical profession. It is through the combination of these three lenses that we believe a more nuanced understanding of the existence and shape of the medical profession can be advanced. We embrace Little's proposition that F-values are foundational and thus unvarying across societies and levels of analysis. We then propose that many, if not most, societies will espouse the following A-values related to the existence and shape of the medical profession.

- *An axiom that expresses the need for survival*: illness and disease threaten survival, so people need help to deal with illness and disease.
- *An axiom that expresses the need for security*: people who become sick need health services they can rely on and trust.
- *An axiom that expresses the need for flourishing*: people need expert health care so they can enhance their capabilities for self-development and self-expression.

We then propose that the above axioms can be turned into practical actions (P-values) at three levels of analysis: at the level of society, at the level of relationships among individuals, and at the level of collectives (Table 16.1). These three levels of analysis provide complementary explanations for the existence and shape of the medical profession in society.

The societal level of analysis

Survival

The key health care related axiom pertaining to survival (that people need help to deal with illness and disease) generates a societal-level P-value that 'a society should assure that sick people receive the help they need to survive'. More detailed societal-level P-values can be articulated beyond this general one, and their exact expression will depend on the health belief systems and the nature of medical knowledge available in a particular society at a particular time. For example, in one society, a P-value might be that 'people with fever should receive treatment with leeches'; in that same society at a more recent time, a P-value might be that 'people with fever should be treated with antibiotics'. Some societies might adhere to a P-value that 'people with breast cancer should be treated with herbal medicine', while in another society, at the same time, a P-value might be that 'people with breast cancer should be treated with radiation and surgery'.

Security

The key health care related axiom pertaining to security (that people who become sick need health services they can rely on and trust) might generate a societal level P-value that 'a society should assure that health services are appropriate, and that those

Table 16.1 F-values, A-values, and P-values representing relationships in health care at three levels

F-values	A-values	Societal level P-values	Interactional level P-values	Collective/professional level P-values
Survival	• **illness and disease threaten survival** • **people need help to deal with illness and disease**	• a society should assure that people receive the help they need to survive	• physicians should give priority to their patients' needs, as the *telos* of medicine	• a professional entity should exist to support a society's survival needs to manage illness and disease • a medical profession should establish jurisdictional boundaries and legal protections to assure its survival as a distinct entity
Security	• **people who become sick need health services they can rely on and trust**	• a society should assure that health services are appropriate for the needs of people in the society	• physicians should strive for the highest levels of competence, integrity and benevolence in caring for patients	• a medical profession should establish educational, licensing and credentialing requirements to practice medicine • a medical profession should create and enforce codes of conduct to assure ethical behaviour of its members
Flourishing	• **the expression of people's capabilities is restricted by illness** • **people need expert health care so they can enhance their capabilities for self-development and self-expression**	• a society should support research and advancement in medical knowledge, technology, and care provision	• physicians should respect the need for patients to restore their capabilities, and should apply their knowledge and expertise to facilitate that	• a medical profession should offer specialty training, and participate in biomedical and psychosocial research to enable its members to perform at the frontier of knowledge and care provision

allocating resources can be trusted to meet the needs of people in society'. While related somewhat to the discussion about survival needs, this P-value reveals the way in which societies can differ substantially in their system of health care services and providers, depending upon their view as to what is appropriate for the needs of people in their particular society. For example, one community's P-value might be that 'people should have open access to a 24-hour clinic', while in another, a P-value might be that 'people should be seen by specialist physicians through referral and appointment'. P-values relating to payment for health services can also be articulated and will distinguish among societies, such as, 'people should have access to health services regardless of ability to pay', in contrast to 'people should pay to have access to health services'.

Flourishing

The key health care related axiom pertaining to flourishing (that people need expert health care so they can enhance their capabilities for self-development and self-expression) generates a societal level P-value that a 'society should support research and advancement in medical knowledge, technology, and care provision'. This P-value explicitly addresses the evolutionary aspect of Little's model that goes beyond the instrumental P-values associated with mere survival and security; it focuses instead on an individual's or group's potential and capability for self-development and self-expression. It also acknowledges the potential that emergent diseases and epidemics are likely to require innovations in treatment. More specific societal level P-values might articulate an expectation that 'a society should devote a certain portion of GNP to investing in medical research', or that 'a society should foster private investments in technology and pharmaceuticals'. Such P-values are likely to shift over time even within the same society, depending on prevailing political and economic climates.

The interactional level of analysis

As noted earlier, while F-values and A-values might be stable across societal, interactional and collective levels of analysis, their expressions in P-values will be different for each level. We turn now to a more detailed discussion of the interactional level of analysis that involves patients and their physicians.

Survival

The key health care related survival axiom (that people need help to deal with illness and disease) might lead to an interaction-level P-value that 'physicians should give priority to their patients' needs'; this represents the *telos* or ultimate purpose of medicine. Implicit in this P-value is the belief that doctors should take the view that 'the health of (the) patient will be my first consideration' (Declaration of Geneva, 1948) and that 'physicians' self-interest should be secondary to the interest of patients'. Additional specific P-values might provide guidelines for the care of patients with serious disease or chronic illnesses in a way that, for example, incorporates tenets of patient-centred care, and have been shown to vary substantially across communities.

Security

The key health care related security axiom (that people who become sick need health services they can rely on and trust) might lead to an interaction-level P-value that 'physicians should strive for the highest levels of competence, integrity, and benevolence in caring for patients'. As studies of trust have shown (e.g., Hardin, 1996), these are characteristics of trustworthiness, which is considered essential for an optimal physician-patient relationship. Yet, interpretation and implementation of these characteristics can vary substantially between or within societies. A detailed P-value related to integrity might be that 'a physician should be completely honest and forthcoming in discussions with patients about their conditions'. In some societies, however, a different P-value might prevail, that 'a benevolent physician should protect patients by not telling them about a negative prognosis'.

Flourishing

The health-related flourishing axiom (that people need expert health care so they can enhance their capabilities for self-development and self-expression) might yield an interaction-level P-value that 'physicians should respect the need for patients to restore their capabilities, and should apply their knowledge and expertise to facilitate that'. This particular P-value aligns closely with the patient-centred care movement that emphasises respect for patients and patients' wishes. However, in some societies, a different P-value might be espoused that maintains a 'doctor-knows-best' approach to health care provision, with patients discouraged from expressing preferences or asking questions about their treatments.

The collective level of analysis

Thus far, we have detailed health-related P-values from the perspective of individuals in society (the societal level of analysis), and individuals interacting with their physicians (the interactional level of analysis). We turn now to the collective level of analysis to examine the explanatory power of Little's model in relation to the survival, security and flourishing of the medical profession itself. We suggest that this level of analysis both explains the existence of the medical profession as a collective, and reveals the indispensable connection that the survival, security and flourishing of the medical profession has to the survival, security and flourishing of individuals and societies.

Survival

The main health care related survival axiom (that people need help to deal with illness and disease) might generate a collective-level P-value that states that 'a professional entity should exist to support a society's need to survive by managing illness and disease'. This P-value is a likely practical expression of the need for society and individuals to receive the health care they need to survive, by identifying a group who can best serve that purpose.

A second collective-level P-value based on the survival axiom might state that 'a medical profession should establish jurisdictional boundaries and legal protections to assure its survival as a distinct entity'. This P-value shifts the focus from the survival needs of the community to the survival needs of the profession itself. As discussed earlier, there is a substantial body of literature devoted to the ways in which the medical profession has gained and maintained its exclusive legal jurisdiction to practice medicine (e.g., Freidson, 1970a, 1986; Larson, 1977; Abbott, 1988). Although non-physician health care providers, such as nurses and technicians, may have obtained a degree of legal authority also to offer health services, in most Western societies they have only limited authority to operate independently of the medical profession. Freidson (1970b) has referred to this arrangement as 'professional dominance', reflecting the asymmetry in the medical hierarchy where physicians remain legally in charge, overseeing the work of other health care workers. This ongoing dominance might be explained by a P-value (or set of P-values) that sustain such legal protections and help to assure the survival of the medical profession as an entity with distinct responsibilities.

Security

The main health care related security axiom (that people who become sick need health services they can rely on and trust) leads directly to collective/professional P-values that are designed to enhance the trust of individuals not only in their physicians but also in the medical profession as a collectivity. Notably, these P-values dictate the kind of standards that the profession should establish, such as 'a medical profession should establish educational, licensing, and credentialing requirements to practice medicine' and 'a medical profession should create and enforce codes of conduct to assure ethical behaviour of its members'.

The first of these P-values sets up barriers to entry, so that only appropriately educated and licensed practitioners can legally provide health care services. In so doing, this P-value (and more specific P-values that flow from this, outlining details of the nature of medical education, post-graduate training, licensing examinations, performance evaluations, and the like) signals to individuals in society and to patients that the medical practitioners caring for them have been vetted as having met the standards necessary to offer services.

At the same time that this P-value provides a signal of professional trustworthiness to individuals, it also serves the interests of the profession itself, by restricting the potential pool of practitioners and thus limiting competition. Such processes enable the profession to preserve its exclusivity, to heighten demand for its services, and thereby to enhance its power. All these factors strengthen the security for members of the profession as a lifelong career path, once they have successfully passed the barriers to entry.

A second collective-level P-value derived from the security axiom relates to the idea that 'members of the profession should conduct themselves ethically'. For individuals, this P-value is a valuable sign that their physicians can be trusted to exhibit the utmost ethical behaviour, because it is a widely espoused norm of the profession. For the profession itself, this P-value enables members to function with confidence in their own abilities and trust in their peers, and also serves as an important reinforcement of its claim to professional autonomy through practices of self-regulation. Similar to the profession's claim of autonomy and self-determination in setting educational, training and performance standards, the validity of the claim of self-regulation is demonstrated by endorsing and monitoring codes of conduct among members of the profession. Indeed, should a member of the profession engage in unethical conduct, the security of the entire profession may be threatened because of questions raised about the effectiveness of its self-regulation and, ultimately, justification for its claim to autonomy.

Flourishing

The key health care related flourishing axiom (that people need expert health care so they can enhance their capabilities for self-development and self-expression) might generate a P-value at the collective/professional level that states 'a medical profession should offer specialty training, and participate in biomedical and psychosocial research to enable its members to perform at the frontier of knowledge and care provision'. For individuals, this P-value helps to ensure that the profession will expand its knowledge base and expertise, thereby enabling individuals to continue to thrive in the face of emerging health issues that have the potential to threaten their capabilities.

For the profession itself, this P-value enables members of the profession also to expand their capabilities for self-development and self-expression through opportunities for specialisation and gaining advanced knowledge. In so doing, the profession enhances its value to individuals and societies, thus reinforcing the relationship between professional development and the survival and security of individuals and societies.

Discussion

Little has proposed that a set of three pre-normative foundational values underpins a set of axioms or 'truths' that a group or society may adhere to, and from which more specific preferences and practices become articulated and embraced. Although the foundational values are stable regardless of the context, the axioms may be different across societies and over time, and the practices will vary to an even greater extent. Little uses examples of individuals in societies to illustrate his argument.

We have drawn from the basics of Little's theory to explore the relevance of this framework at two other levels of analysis, namely, the interactional level and the collective level. We have identified the key survival, security and flourishing related axioms that pertain to health care; and, within that context, we have articulated several practical values that express these axioms. Our goal has been to use this approach to offer insights about the existence and shape of the medical profession that extend beyond purely functionalist or power-based theories.

Theoretical implications

We began by summarising two main strands of sociological thought about professions, one that justifies the long-standing power and prestige of the medical profession because of its value to society, and the other that challenges the power and prestige of the medical profession as having resulted from a self-interested process of negotiation with the state and other decision-making bodies to establish barriers to entry that has served to enhance professional powers in a variety of ways. We next identified some more recent writing to suggest there is merit in both perspectives, and set out to illustrate the validity of this more nuanced approach using Little's framework.

We have demonstrated how a society's need for survival, security and flourishing can be promoted when a group of experts – in this case a recognised medical profession – provides the health care that is needed for the survival of individuals in the society, serves as a reliable and trustworthy source for such care, and is well prepared to deal with emergent health challenges that may impinge on the flourishing of individuals. This interpretation aligns with the early understandings of a medical profession advanced by functionalist thought. Similarly, the medical profession fulfills a number of interpersonal roles whereby members of the profession help to promote survival, security and flourishing for their patients.

At the same time, when we employ Little's framework at the collective level and examine the relevant P-values, we can see how the medical profession's own survival, security and flourishing are enabled by the construction of professional boundaries, jurisdictional niches, barriers to entry, and opportunities for specialisation. These processes are all consistent with those identified by power-based theorists to explain professional power and its enduring autonomy and self-regulation.

Importantly, we show that these various views of the medical profession express the same health care related axioms which, in turn, are based on the same foundational needs for survival, security and flourishing. We also show that the survival, security and flourishing of a powerful medical collective can facilitate survival, security and flourishing at societal and interactional levels. Thus, our approach suggests that explanations of the existence and shape of the medical profession are richer when they engage in a complex, multi-level examination that neither rejects nor wholly embraces either of the two major

streams of thought that have prevailed in sociology for many decades. As with the best theories, we find that Little's framework provides greater clarity and nuance, and has broad applicability and explanatory power.

Practical implications

This nuanced view of the existence and shape of the medical profession also has implications for medical education and governance. From an educational perspective, it highlights the importance of encouraging students to feel proud of the many important functions that their profession fulfils, while reminding them not to take for granted the acceptability or ongoing existence of their professional power.

Further, this framework can help medical students better to understand, and manage, disagreements that may arise in the practice of medicine, by revealing that the same foundational values of survival, security and flourishing underpin beliefs and preferences, even when those beliefs and preferences may differ substantially across communities and over time. Recognising the convergence of F-values and, often, A-values, despite widely varying P-values, can be a powerful insight, especially for those working across cultures.

Efforts to improve the quality of medical practice should similarly focus not only on curtailing abuses of professional power, but also on promoting the medical profession's collective strength so that it can fulfil its many important roles.

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Chapter 17

Does medicine need a base? A critique of modest foundationalism

Ross E. G. Upshur

> But the scientific spirit requires a man to be at all times ready to dump his whole cartload of beliefs, the moment experience is against them. The desire to learn forbids him to be perfectly cocksure that he knows already. Besides, positive science can only rest on experience; and experience can never result in absolute certainty, exactitude, necessity or universality.
>
> *(C. S. Peirce, 1955, pp. 46–47)*

It is an honour and privilege to provide a commentary on Miles Little's thoughtful and provocative chapter (Chapter 14). In this chapter I will try to make amends for confusion created in some of my previous work that Little criticises. To that end I will clarify some of the terms that I have used in previous essays, particularly 'emergent'. I will, however, stand by my critique of foundationalism, rooted in either values or evidence. I will argue that it may be best to dispense with the concern for foundations entirely as unproductive and misleading. I will defend a version of fallibilism as most relevant to our understanding of evidence and values in medicine. After this, I will invert Little's FAP model and argue that what he has termed F-values are neither pre-normative nor foundational, but rather serve as regulative ideals. I will argue that there is nothing axiomatic about the A-values and that the P-values are where most of what is relevant to medicine transpires. In my chapter I will acknowledge sincere intellectual debts to Charles Taylor, Hilary Putnam and Peter Galison, though the animating spirit is largely Peircean.

Emergence and foundations

I would like to spend some time clarifying my position, apologising and, I hope, making amends for using the term 'emergence' in a confusing way and raising the issue of foundationalism in the first place. I will retrace my steps through a series of papers starting in the late 1990s to early 2000s where I sought to examine the conceptual bases of evidence-based medicine (EBM).

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