UNIVERSITY OF TAMPERE

THE IMPACT OF PATIENTS' INTERNET USE ON MEDICAL PROFESSION:

The Challenges of Online Patients and .com Health

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Master's thesis
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The purpose of this study is to evaluate how the availability of health information available through the internet is affecting the medical profession Finland. The availability of medical information via the internet is one of the factors explaining the changes in the position and construction of the medical profession. Patients' use of the internet for health information is challenging a core feature of the medical profession: the monopoly over medical knowledge. Rather than evaluating the changes from 'outside', the patients' point of view, the study evaluates the changes in the social position of the medical profession from 'inside', as the doctors themselves perceive it.

The research material was collected from semi-structured interviews conducted between November 2006 and January 2007. The material consists of 11 interviews with doctors from both the public and private sectors employed in Pirkanmaa region. The theoretical framework of the study is based on social constructionism, which puts an emphasis on the knowledge being socially constructed. The interviews were analysed as representations of the social reality of the study participants using the content analysis method. The approach to the data was inductive and therefore the analysis moves from the specific to the more general.

The study examines how the patients' internet use has impacted the medical profession. On one hand the doctors perceived the patients' internet use as something that offers new possibilities for both the patient and the doctor with regard to the relationship they have with their patients. The doctors experienced the patients' internet use as a beneficial factor in terms of the patients' increased knowledge of, and interest in, their own health. This in turn can improve the communication between the doctor and patient, resulting in a more equal relationship. The patients' internet use has also impacted positively on the management of care and the maintenance of the doctors' own expertise.

On the other hand, doctors experienced the quality and quantity of information, patients' lack of skills, and the anxiety such information can cause in patients being reflected negatively in their tasks and the content of their work. The patients' internet use has also had an impact on the core characteristics of profession, autonomy and authority. The patients' internet use has affected the ability of the medical profession to function independently. The doctors' authority, which is based on their claims of knowledge, skills and expertise over medical tasks, is also being challenged by patients' internet use.

However, the medical profession is responding to these challenges by forming new forms of expertise. It is possible that the changes initiated by the patients' internet use have changed the medical profession's own understanding of profession and also had an impact on the way the general public conceptualise the medical profession. Nevertheless, patients' internet use is not invalidating the need for the expertise held by the medical profession and the services provided by doctors.

Key words: medical profession, profession, doctor, patient, internet, health, information society, informatisation, doctor-patient relationship, qualitative research, social constructionism, content analysis.

Tables

1 INTRODUCTION

Participating in the MA programme in the Information Society and Russia strengthened my existing interest in evaluating the role of the internet in society. This, combined with my employment history as a web content producer, led me to develop the ideas for the MA thesis that would draw on both my employment experience and the academic insights from my studies. As a web content producer my role was to write, edit and produce information related to health and illness. It was equally satisfying to follow the number of people who used the information I produced and to evaluate its usability. It was clear from the number of people using the website I was producing content for, as well as from academic research and official figures, that using the internet for accessing health information is commonplace.

It was from this notion that I developed the idea of researching the effects of increased internet use in relation to health information in Finland. As I was evaluating my own authority as a producer of information (sometimes specific medical and drug-related information) I became interested in how the medical profession regards health-related information produced by sources from outside the profession.

Whether or not it is acknowledged that we in live in the so-called information society, the fact that there is more information around and readily available to a greater number of people than ever before cannot be denied. (Webster, 2002, 2) The number of internet users in Finland and globally continues to increase. In Finland, health information is among the most searched topics.

It is possible for people to access thousands and thousands of health and illness-related web pages in a very short space of time, any time of day, often free of charge and, depending on the technology they use, from a variety of locations. This convenience is driving more and more people to use the internet as a source of medical information.

The World Health Organization (WHO), the European Union (EU) and the Finnish Government all have aims to provide citizens with electronic channels for maintaining their health and accessing

healthcare services. It is hoped that these electronic services will help health providers to offer improved services and better fulfil the growing demands for such services. (Drake, 2009, 16)

The majority of the research related to internet usage in relation to health is focused or conducted in the Anglo-Saxon countries. This field of research is relatively new, as is the internet as a medium. Plenty of research has focused on the users and the user demographics of internet health information. The researchers have also been interested in the advantages and disadvantages of internet health information, as well as the reliability of such information. Some of the research has concentrated on the doctor-patient relationship and the effects of the internet health information on this relationship.

At the beginning of the research process I was also drawn into researching the outcomes of internet health information from the patients' perspective, but rather quickly changed to approach the topic from the point of view of the medical profession. After conducting the research interviews in the winter of 2006/2007, I felt that I had bitten off more than I could chew. Employing the approach of evaluating how the availability of health information through the internet affects the medical profession from 'inside', the doctors' standpoint, rather than from 'outside', the patients' perspective, felt overwhelming.

Whilst tackling my feelings of despair I came across an inspirational doctoral thesis by Hanna Toiviainen (2007) entitled '*Consumerism, patients' and consumers active behaviour and, in particular, physicians' experiences and views of patients as consumers*'. As Toiviainen stresses, there has not been a great deal of research focusing on the doctors' perceptions of the different aspects of consumerism, such as the commercialisation of health services, the development of patient status and the choices patients make, even though many changes have taken place in this area. (2007,13)

Treatment decisions taking place in the consulting room have been studied in terms of speech and interaction, as well as from the point of view of patients in Finland. (Ruusuvuori, 2000; Drake, 2009).However, no research has been conducted into the outlook of doctors regarding shared treatment decision-making, patient participation in the decision-making, or choice of treatment. (Toiviainen, 2007, 34) This reassured me that I was on the right track with my thesis and that the chosen subject was

worth pursuing. In addition to the topical nature of the subject, I also feel that my research may make a contribution to the field of research on the medical profession in Finland.

The expansion in the use of information and communication technologies (ICTs) and especially the internet is, amongst other things, said to be responsible for changing and challenging the foundation of doctors' autonomy and professional status. (Hardey, 1999; 2000) The presence and availability of such a wide range of health-related information is challenging the exclusive access of the medical profession to expert knowledge, which is the foundation of their profession and professional autonomy.

The medical profession has been and continues to be a valued profession in Finland. (Kokko, 2007; Lappalainen, 2007) The general public trusts and values the knowledge and skills doctors hold and maintain. Until recently, patients have had limited possibilities to access specialist medical information and the medical profession has dominated the production of, access to and usage of medical knowledge. The ease of access to understandable medical knowledge through online sources of health information is challenging the knowledge that characterises the profession. At the same time, this ease of access to knowledge produces increasingly aware and informed patients who are transforming the tasks that define the medical profession.

This thesis is organised so that the first chapter explains the informatisation of society and the internet use in Finland. The second chapter outlines theories on profession that are considered relevant in relation to the research topic. The importance of outlining these theories lies in the 'holy grail' of the sociology of professions as the debate on whether or not professions exist as professions or merely as types of occupations. In addition to the scarcity of the sociology of professions, there is no set or agreed definition of a profession, thus what constitutes a profession is clarified. The fourth chapter concentrates on the specific theories of medical profession. In the fifth chapter, the study examines the development and current state of medical profession in Finland as well as outlines the organisation of Finnish health care sector. Then the study moves on to examining the effects of internet use and informatisation. Prior to moving on to the chapter on the analysis and findings, the methodology of the study is explored. The study is completed by chapter that includes discussion on findings and the conclusion.

2 INFORMATISATION OF SOCIETY

Today, there is more information readily available to a greater number of people than ever before. The interpretations of the information society are vastly diverse, but it is commonly agreed among the theorists that, “there is something special about information” (Webster, 2002, 2). For some, the growth of information is the basic reason for all the societal changes currently taking place. (Blom, Melin & Robert in Karvonen, 2001, 110) Others see informatisation as significant as the invention of steam-powered machinery and electricity for the development of the society. (Karvonen, 2001)

Conversely, there are people who claim that no ‘information revolution’ has taken place, as the changes that have occurred simply have not been significant enough to signal the start of a new epoch in the development of society. Also, some reject the ‘informatisation of society’ entirely, as for them there is a lack of sufficient evidence that the changes in society are the result of the increased role of information or the development of information technologies. Consequently, the growth of the role of information can be perceived as a new dimension of an old acquaintance: the informatisation of society is a by-product of the dominant economic order, capitalism.

In the context of this study, the informatisation of society is viewed not as a modern phenomenon in its own right but a result of the continuous historical development of society. (Webster, 2002, 265) As the growth of the role of information in society is understood as a process, an ongoing development using the ‘informatisation of society’ over information society seems more appropriate. The commonly used term ‘information society’ implies that a conclusive stage in the development of society has already been reached or that an exhaustive definition for the term exists. Therefore, it is felt that the informatisation of society is a better-suited term for describing and illustrating the processes and changes that are taking place in society in relation to the role that increased information plays.

The informatisation of society is often explained in terms of quantitative changes such as the number of people that use information technologies or proportion of so-called knowledge workers in the labour market. The results of the quantitative measurements of change are then used to authoritatively indicate the informatisation of a given society. However, the characteristics that are evaluated by qualitative measures, by their very nature, predefine the informatisation of society. Consequently, such

information provides us with no real understanding of the effects of the increased role of information on society and its different segments.

According to Frank Webster, the key to understanding the changes in relation to the informatisation of society is to deploy an approach that prioritises ‘theoretical knowledge’ over the measurement of quantitative characteristics of the role of information in society. (Webster, 2002, 26) The ‘theoretical knowledge’ as such is an abstract idea, but is used by Webster to describe the role of information in people’s lives. As innovations are often born out of need, in a similar way we have changed the ways in which we use information to our benefit, for example by using the information known to us in helping us in making decisions or assessing risks.

Therefore, only by examining the ways people use information and information technologies to organise their life is it possible to theorise about the effects of the informatisation of society. “Nonetheless, theoretical knowledge could be taken to be the distinguishing feature of an information society as it is axiomatic to how life is conducted and in that it contrasts with the ways in which our forebears-limited by their being fixed in place, relatively ignorant, and the forces of nature-existed.”.(Webster, 2002, 28.)

This thesis aims to evaluate the effects that the increased role of information in society has on the medical profession. As the informatisation of society can be evaluated in terms of how people are using information, the utilisation of online health information by patients indicates changes in the position of the medical profession in society. The position of professions in sociology is fascinating, as changes in society are reflected in the way in which professions are viewed and understood.

Therefore, the changes, in this case the informatisation of society as evidenced by the patients’ use of the internet for health information, can be observed by evaluating the changes in the position of the medical profession. In this case the informatisation of society manifests itself as, for example, the diminishing role of the medical profession as the sole keepers and holders of medical information.

2.1 Internet use in Finland

The usage of the internet is for many a daily activity, and for some the internet has replaced traditional sources as the main media tool. As the diversity of devices that enable online access and the reach of wireless networks grow, more and more people are using the internet for a wide range of activities, one of which is information searching. Whether or not the internet has become the most important channel for information is open to discussion; it is difficult to say, as statistically accurate and therefore comparable studies on different information channels and their use do not currently exist. The majority of the large-scale studies of internet usage focus on the frequency and rate of recurrence of use but fail to inform us about the motivation for, or meaning of, internet use. (Savolainen, 2003)

Finland is often flagged as one of the leading countries in the development of the information society and informational economy and it has one of the highest percentages of internet usage among its population in the world. (Castells & Himanen, 2002) Statistics Finland estimated that around 86% of Finns aged 15 to 74, or over four million people, used the internet in the summer of 2010. Moreover, the Finns are active users of the internet, with 72% of the population estimated to have used the internet at least once a day. (Statistics Finland, 2010)

The demographics of internet use in Finland are interesting, as nearly all under 45-year-olds have used the internet for something. Those aged 55-64 years were also active internet users, with 75% of this age group estimated to have used the internet in the past three months in 2010. However, the share of internet users drops in the older age group (65-74 years-olds), with less than 43% of this group having used the internet for something in 2010. (Statistics Finland, 2010)

A survey conducted in 2010 found that about 74% of American adults use the internet. The majority of these internet users (80%) have used it to search for information about a specific disease or treatment. This translates to 59% of all adult Americans. (Fox, 2011) European countries also report a lower overall rate for regular internet use (65%) than the United States in 2010. (Eurostat, 2011b) The majority of European citizens reportedly still obtain their health information from elsewhere than the internet, as only 34% of citizens aged 16-74 across 27 European countries reported that they used the internet to search for health-related information in 2010. (Eurostat, 2011)

In Finland use of the internet for 'seeking health information' was the sixth most popular purpose in 2010 after sending or receiving email, finding information about goods or services, online banking, browsing travel and accommodation services and reading online magazines. (SVT, 2010)

Table 1. Purposes of use of the internet in the past three months, 2010, % of internet users

Purpose of use	**%**
Sending or receiving e-mail	77
Internet banking	76
Finding information about goods or services	74
Reading online magazines or TV channel internet pages	74
Browsing travel and accommodation websites	59
Seeking health-related information	**57**
Obtaining information from public authorities' websites	49
Listening to music online or downloading music to a computer or other device	42
Looking for information about education, training or course offers	37
Consulting the internet with the purpose of learning or increasing one's knowledge about something	37

Source: Suomen virallinen tilasto (SVT) (2010) Tieto- ja viestintätekniikan käyttö', Tilastokeskus
See appendix 4 for the complete listing of purposes of use.

In 2010, 57% of Finns reported using the internet to search for health information, with Finnish women being more active health seekers (64%) than men (51%). Of all citizens aged 16-54, over 65% stated that they have used the internet to search for information relating to health. (SVT, 2010b) In Scandinavia, the rate of internet usage for health information is the highest in Europe, with Finland having the highest percentage of internet usage in relation to health.

Table 2. Individuals using the Internet for seeking health-related information in selected European Union countries, 2005-2010

Country/Year	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Finland	39%	44%	47%	51%	56%	57%
Sweden	23%	28%	25%	32%	36%	40%
Germany	-	34%	41%	41%	48%	48%
United Kingdom	25%	18%	20%	26%	34%	32%
Poland	7%	11%	13%	19%	22%	25%

Table conducted by the author from Eurostats figures, Individuals using the Internet for seeking health-related information', 2011

One of the objectives of the Finnish Government's Information Society Programme 2007-2015 was to improve social welfare and health services by making them more widely available, but also by improving their quality and cost-effectiveness. As part of the programme, the Ministry of Social Affairs and Health conducted a health information project to provide citizens with reliable and quality-assured information via the internet. (Information Society Programme, 2006)

The national health portal, Terveyskirjasto (Health Library) went live at the beginning of 2007, supported by Sitra, the Finnish Innovation Fund and the Finnish Medical Society Duodecim. (Finnish Medical Society Duodecim, 2011) In its first year, Terveyskirjasto had about 800,000 visits and 60,000-70,000 articles were accessed daily. A user survey from 2007 found that the majority (95%) felt that using the Terveyskirjasto was easy or very easy. Interestingly, 22% of the respondents reported that information from Terveyskirjasto had reduced their need to contact a health centre while 3.4% felt an increased need to contact a health professional. (Sitra, 2007)

These findings go hand in hand with the main rationale behind Terveyskirjasto: to offer people reliable health information quickly, easily and at the point of need, when people need support in order to assess their own situation and need for healthcare services. Terveyskirjasto continues to build on its success and by January 2011 had reached one million visitors per month.

On average, a visitor accesses three articles, the most popular being those on high blood pressure, norovirus, chlamydia, bronchitis and haemorrhoids. However, the article searches and accesses in Terveyskirjasto are affected by the seasons (for example, in the summer one of the top searches is for borreolosis) and by health issues that appear in the media in Finland and worldwide (for example, in 2011 these included narcolepsy and EHEC bacteria). (Finnish Medical Society Duodecim, 2011b)

3 PROFESSIONS

The study of occupations is a long-standing and familiar topic in sociology. The earliest sociological observations of profession can be found in the literature that analysed the nature of employment and organisation of labour during the development of industrial capitalism. Classical sociologists such as Durkheim and Weber concentrated on the study of occupations rather than professions. Nevertheless, it can be argued that the functionalist approach presumes that the existence of professions above the normative occupational groups is central to the functioning of a modern society whereas the Weberian school acknowledges that professions are results of specific socio-political processes. (Parkin, 1974 in Nettleton, 1995, 197)

Marxists theorists associate the professional ranking as a method for certain individuals to maximise their personal financial returns in a particular social order: capitalism. Due to the fact that professional groups enjoy the protection of the state, the Marxists writers argue that professionals contribute and legitimise the capitalist social order. The professions have been given market control over specialised knowledge, which they use to exercise control over the working class and improve their own market position.

The factors of power and societal control are also central in the analysis of the profession by feminist theorists. For instance, according to some feminist writers the medical profession represents a legalised channel for reinforcing patriarchal authority and control over women in society, for example through the division of labour in medical services. This is clearly illustrated by the division of female employment (nursing and midwifery) and male employment (clinicians) in medicine.

Social scientists around the world have been fascinated with the concept and structure of professions. However, the traditional epicentre for the study of professions has been the United States and the United Kingdom, from where the majority of the sociological theories of professions have emerged. Among the reasons why professions have been strongly present in Anglo-American writings are the traditionally theoretical nature of social sciences and the strong presence, visibility and position of professions in society. (Konttinen, 1989, 1-3; Crompton, 1990,149-150)

Medical sociologist Sarah Nettleton (1995) has produced a contemporary summary of the core characteristics of a profession which combines aspects from both past and present definitions. Firstly,

she notes that for an occupation to be ranked as a profession it must have specialist knowledge at its core. In most cases the specialist knowledge central to the profession has been achieved through a long period of training, and only those belonging to the particular profession have access to this information. The profession therefore has authority over the information related to their profession and the field of expertise in question. Secondly, a profession is characterised by an understanding of altruism. It is believed that a professional's motivation is based on the usage of their skills in the best interests of the customer or patient rather than the professional's own interests.

Thirdly, the profession has a monopoly over the practice of tasks that have been defined professionally and "it is deemed illegal for a non-professional to carry out [these] defined tasks" (Nettleton, 1995, 196). Finally, the profession must be free from external interference. As the profession has monopoly over the practicing of tasks, the professional must also be free to employ his or her specialist skills in order to treat the patient or serve the customer. Subsequently, "the profession as a body must be largely self-regulating: patients need to be protected from charlatans and incompetent practitioners" (Harrison & Pollitt, 1994, 2). Only a fellow professional can evaluate who is suitable to practise and who is not.

Although over the years a great deal of attention has been paid to defining the concept of profession, no authoritative or broadly accepted definition has been agreed. Various social scientists have been compiling lists, definitions and characteristics that they believe best describe the definition of a profession. These lists have, for example, included such attributes as the marks of a profession being specialised skills and knowledge requiring long study and training, success measured by the quality of service rendered rather than by any financial standard, freedom from influences and opinions outside the profession, monopoly over the practising of tasks that have been defined professionally, the organisation of a professional association for the maintenance and improvement service and also the enforcement of a code of ethics. (Blauch in Becker, 1970, 89; Nettleton, 1995)

In spite of this, while such lists describe the criteria for a profession they fail to explain why an occupation has become a profession and what functions professions fulfil in society. In order to achieve a more objective and comprehensive understanding of the profession in society, it has been suggested, for example by E.C. Hughes (1958), that social scientists need to move away from adopting a traditional composition of

professions that assumes and accepts the image of the profession as presented by the profession itself. (Turner, 1987, 131)

Similarly, Howard Becker, in his piece of writing '*The Nature of Profession'* (1970), stressed that it is fairly easy to develop scientific and abstract concepts of profession that fulfil the requirements of social scientists. Hence, the concepts developed by social scientists often fail to match the ideas of profession held by the general public. Nevertheless, the contribution of classical theorists of sociology to the study of professions is reviewed in brief before moving on to a more in-depth evaluation of the theories of the medical profession.

3.1 The classical sociological approaches to professions

Émile Durkheim, one of the founders of what is known as the discipline of sociology, claimed that the division of labour in society is natural and is central to the functioning of society. The functionalists believe that the way society operates can be compared to the functioning of a biological organism. (Giddens, 1979, 76) Durkheim explained the function of society in terms of 'mechanical' and 'organic' solidarity. Mechanical solidarity exists in smaller, close-knit societies and is based on the homogeneity of the individuals of that society, as they feel connected through shared and similar activities. These collective beliefs and the shared solidarity guide the individual's actions in society. (Durkheim, 1990, 85-86 and 110-111)

Social change, such as the shift from agricultural to industrial society, occurs when it is functionally necessary for a society to change. As the society develops, mechanical solidarity is replaced by organic solidarity, which is created by the requirements of the more advanced society. As the more advanced society is more complex, the social order of such a society requires its parts to differentiate and function interdependently. Organic solidarity arises from the need for division of labour, as the specialisation of work is a requirement for the survival of the society. Organic solidarity stems from this cohesion, the dependence that the individuals have on each other to perform the required tasks in order to ensure that the society functions.

As organic solidarity is based on the division of labour, the development of professions in society is therefore seen as a natural and inevitable process. (Thompson, 2002, 85) The development of modern professions is a result of the society which in order to function requires a specialised and differentiated workforce. At the same time, the society legitimises the position of such professions. (Durkheim, 1990, 126-128 and 176-178)

The Marxist theories of professions are based on the analysis of social classes and the economic relations of production. The Marxist theorists argue that two classes based on ownership of economic means, the bourgeoisie and the proletariat, exist in capitalist societies. The bourgeoisie class own and control the means of production while the proletariat have nothing but their labour to offer. This type of social structure, which depends on relations of production, creates inequalities and social stratification between the two classes as the bourgeoisie exploit the proletariat and alienate them from the products of their labour, because they not only benefit from the labour activity but also further gain profit from the products of proletariat labour. This contradiction is the principal basis for understanding the Marxist theories of society and societal change. (Wright, 1997, 29-31)

For Marx, professions were not significant players in the class conflicts of capitalist societies and it has been argued Marx's stance on professions leaves some room for interpretation. On the one hand Marx supposed the members of professions would align themselves with the bourgeoisie, but on the other hand he believed it was possible that the professions may be placed with the proletariat or that members of professions were bystanders who may side each way. (Burrage, 1990, 1)

Of the classical sociologists, the theories of Max Weber have been the ones most often used as the basis of analysis in the study of professions (MacDonald, 1995, 21) The Weberian theory of social stratification comprises three elements: class, status and party. The Weberian approach to class and therefore also to professions "on the other hand conceptualises class as having a number of components which derive from the market and from status honour, both which involve the notion of social actors in the first instance as competitors and in the second as participants in mutual evaluation." (MacDonald, 1995, 44) To Weber, class represents economic category, a group of people who share a similar position in society in relation to the market. Weber believed that class position is determined according to an individual's skills and abilities

to perform in the market. (Collins, 1991, 24) In relation to professions, the key in Weber's theory is not that of class but the concept of status group.

The notion of a status group can be understood as a collection of people who are rewarded similarly in status honour and share a similar lifestyle, identity and even profession. (MacDonald, 1995, 42-43; Collins, 1991, 24-25) The individual's market value, what he or she deserves and acquires, in the society is dependent on both economic matters and on the status honour. Both classes and status groups can engage in the collective pursuit of their interest and therefore, according to Weber, enter into to the third dimension of the stratification: the political order. (Weber, 1978, 926-938 in MacDonald, 1995, 43) Through these collective political actions, the classes and status groups are able to promote their own interests. Collins (1991, 24-25) argues that for the study of professions, an important extension of Weber's ideas is the way in which the status groups become part of the market structures and attempt to control the conditions in which the market operates. We have come to know those who are particularly successful in this as professions.

Even thought the classical theorists of sociology, Durkheim and Weber, did not have that much to say specifically about professions and Marx did not count professions as significant players in the class conflict, their theories cannot be overlooked when evaluating and studying professions. From Weberian theory, it is good to keep in mind the idea that the position of a profession in society is based on their skills and knowledge, which for Weber represent an equal virtue to economic assets. The most significant heritage of Durkheim's theories for the study of professions may be the notion of a natural shift of society based on mechanical solidarity to a society of organic solidarity in which the professions emerge and develop according to the needs of the society. In the study of professions, Marx's most significant ideas can be said to be the concepts of class-based social inequality and its consequences for society.

3.2 The sociology of professions

The first clear definitions of profession can be found from the texts of Brandeis (1912) and Flexner (1915).[1] Nevertheless, the history of modern studies of professions can be said to have begun in the 1930s by Talcott Parsons and Everett Hughes. In his writings, Parsons put an emphasis on the ethical character of

[1] Brandeis L. D. (1912) 'Business- a Profession' and Flexner A. (1915) 'Is social work a profession'

the profession, its service to people and its basis of technical knowledge, whereas Hughes criticised this conventional approach and highlighted the material and symbolic benefits that are gained from the occupational monopoly. (Turner, 1987, 131)

Often the theories of profession have been categorised into two kinds: those of functionalist theories and those that fit under the label of neo-Weberian theories. (Konttinen, 1989; Crompton, 1990; Palukka, 2003, 21-22; Turner, 1987, 131) Others such as Brante (1991, 75) have emphasised the two lines of research tradition: philosophical/conceptual or historical. The first of these is taxonomic as it aims to define, describe and classify the profession theoretically based on empirical findings and historical facts, and the latter examines and outlines the histories of single professions in order to identify the true nature of profession.

Eliot Freidson stressed that as professions are characterised by the society they develop in, it is questionable if these theories of profession are applicable for the study or evaluation of profession in another society. In addition, Rosemary Crompton (1990, 150) goes as far as stressing that the concept of profession is not a universal or generic concept in sociology, but is specific to Anglo-American sociology.

Konttinen (1989, 4), however, argues that what comes to the definition of profession and its applicability in profession in another society has a great deal to do with how strictly the definition of a profession is applied and how much emphasis is placed on the special characteristics of professions in a society. Moreover, Konttinen is aware of the scarcity of research in the field of the study of professions and stresses that there are so many descriptions that constitute a profession and their purpose in society, and even definitions that are the total opposite of each other. Therefore the various theories of profession may appear complex and contrary.

3.2.1 The theories of profession

Finnish sociologist Ilkka Pirttilä (2002) has analysed the theories of profession and organised them under two categories, each of which has four sub-groups. I have used Pirttilä's grouping of the theories as the framework for the table below to illustrate and highlight the various theoretical approaches to profession. In addition, I have complemented Pirttilä's groupings with information from other sources.

Table 3. The theories of profession

Theory	Definition of profession	The purpose of professions
Sociology of professions		
The classics of sociology of profession (Carr-Saunders & Wilson, Hughes and Parsons)	Institutionalised group of experts who objectively and universally solve societal disparities & altruistically work towards common good	Professions are essential for the functioning of modern society (Pirttilä, 2002, 13)
Weberian and Neo-Weberian (Weber, Berlant and Larson) theories	Closed social group who have state-granted monopoly over certain services in society	Through the social closure professions are an essential part of the rationalisation process of society. (Collins, 1991, 24)
Traditional interactionist approaches (Hughes, Strauss and with certain reservations also Freidson)	Through an interaction an occupation defines its content and status. A profession has a high status which is socially constructed	A profession is an occupational group that defines a problem so that it can only be solved by its expertise. (Riska, 2004, 145)
Feminist theory (Crompton, Harding and Witz)	The occupations which are defined as professions maintain the tradition of division of labour in a household based on patriarchy	The continuity and reinforcement of gendered structures in society through the dominance of males as members of these occupational groups. (Riska, 2004, 149-150)
New and open expertise		
Modern Interactionist theories (Silverman, Heritage and Perelman)	Socially distinct groups who share their own reality and models of behaviour which is are reinforced through defined discourses	Professions have skills and knowledge over matters and their actions are authorised thorough rhetoric reassurance. (Pirttilä, 2002, 14)
Organisational and occupational sociology (Argyris, Nonaka, Sveiby and Schön)	The expert job or profession is a type of employment that is challenging, socially constructed and mentally demanding	Differentiation between types of jobs: 'occupational-centred', 'profession-centred' or 'organisation centred' (Argyris, 1964, 17)
Sociological-anthropological approach to new expertise (Douglas and Strathern)	In late modernity, members who are able to successfully legitimise their position by identifying dilemmas and predicting the course of things in the future. (Nowotny H., Scott P. and Gibbons M., 2001, 229)	The experts and professions aim to interpret risks, uncertainty and knowledge in a global realm and hence gain the trust of the general public as well as their clients. (Pirttilä, 2002, 15)
Contemporary theories of late modernity (Bauman, Castells, Beck, Giddens and Foucalt)	Experts or professions are not a clearly distinguished layer in society but they are essential in the modernity as it is a culture based on risk. Therefore experts are at the core of assessing risks and problem solving. The modern forms of expertise are open to everyone. (Giddens, 1991, 31-32)	To answer the demands of late modern society, the expertise of a professional is more narrowly focused and specialised but this itself produces new expertise. (Giddens, 1991, 31-32)

Table conducted by the author from various sources as cited above.

Carr-Saunders and Wilson pioneered the field of profession with their comprehensive study, The Professions (1933) by defining the essential sociological characteristics of professions and their importance for the modern society. (Burrage, 1990, 6) In their view the "possession of a specialised intellectual technique acquired as a result of a prolonged period of training is the essence of profession" (Freidson, 1970, 161). Carr-Saunders & Wilson's complimentary view of professions of society also contains a belief of professionalisation as a stabilising and equalising force in society. They believe that due to the specialisation of technology, many occupations will become professions. At the same time, the professionalisation of the business sector is shifting the focus of employment from profit making to professional pride. Carr-Saunders & Wilson also stress that the professionalisation of society implies that the suitability for a profession is measured according to skills and capabilities. (Konttinen, 1989, 18-19)

Harold Wilensky's detailed analysis of the development of profession, *The Professionalization of Everyone* (1964) is also somewhat evolutionary in its approach to professions. He stressed that professions are born out of a need and the development of professions is periodical. At first an occupational group "starts doing full time the thing that needs doing" (142). The next natural step, according to Wilensky, is that training for an occupation will become relevant for some reason or another. Then suitable training becomes requisite for entering the occupation and those who already possess the training form associations to protect their interests. Eventually the professional association acquires the support of law to protect the occupation and its standards. (ibid. 144-145)

The difficulty in both Wilensky's as well as in Carr-Saunders & Wilson's analyses are that they are describing the ideal conditions for or an ideal type of profession which is not specific but universal. This makes it difficult to apply to various types of professions across societies. Secondly, not all occupations will become professions, as the need for occupation to evolve into profession often arises from a defined need in society. (Collins, 1990, 13)

Talcott Parsons utilised a comparative framework in his article '*Professions and Social Structure'* (1939) in stressing the importance of professions to the functioning of the modern society but also to distinguish different domains of work from each other. (Parsons, 1939, in Hafferty & Castellani, 2010, 203) In his structural-functionalist approach, Parsons regarded professions as institutions whose purpose was to ensure that their members used their skills and knowledge to the greatest social benefit.

For Parsons, professional specialisation represents the search for the best and most efficient, and therefore 'rational' mode of achieving given ends. (Crompton, 1990, 151) The medical profession represented a prototype of occupations based on expertise and trust, and whose actions were based on altruistic motives. Contrary to this is the 'businessman', whose interests and actions are guided by profit-making and self-interest. (Riska, 2004, 145)

This consensual and positive view of profession and society dominated the study of professions until the mid-1960s, reinforcing the largely positive benefits of professions to society such as strict ethics, integrity, universalistic and functionally specific relation to their clients, and employing skills based on scientific knowledge. (Brante, 1990, 75-76)

During the 1970s the theories of profession in sociology moved away from the descriptive kind towards more analytical models that largely criticised the earlier theories of professions for affirming the elite position of professions in society. (Hafferty & Castellani, 2010, 204) For example, Eliot Freidson (1970) used the medical profession as a representative of all professions, arguing that a profession is a particular type of occupation with some special characteristics and, therefore, that it competes with other occupations for economic, social and political rewards. (Swick 2000, 613) Many of these later theories of profession have focused on the profession of medicine, and will thus be reviewed in the next chapter in the context of medical professions.

Andrew Abbott introduced one significant general theory of profession towards the end of the 1980s. In '*The System of Professions'* (1988) he argues that experts are continuously engaged in making claims and counterclaims for jurisdiction over existing, emerging and vacant areas of expertise. The significance of Abbott's theory in relation to others is shifting the focus away from the autonomy of professions as such and concentrating on the process through which professions constitute and reproduce themselves, also in relation to other professions. (Johnson, 1995, 17) Abbott claims that past theorists have not taken into account the interdependency of professions from each other and the way in which this competitive system of professions generates the raison d'être for them.

The purpose of the system approach is to analyse and conceptualise the changes that take place in the arena in which professions operate (external) and the way in which the professions respond to these changes (internal), for example by occupational closure or reinforcement of expertise. (MacDonald, 1995, 14-16) System analysis, however, has been more widely used in studies of service occupations than to analyse the medical profession, as the latter tends to be well organised and striving for professional status and recognition. (Benoit, 1994, in Riska, 2004, 149)

3.2.2 Howard Becker's approach to professions

Howard Becker (1970) challenged the customary way the term profession was defined and understood. Becker argued that on the one hand the term 'profession' is used as a scientific and abstract concept, but on the other hand it is often used in a morally evaluative sense. The term profession is a scientific and abstract notion because it can be used as "a verbal tool with which the social scientists isolate a particular kind of occupational organization for further analysis and investigation, just as physical and biological scientists use such terms as carbon or mammal to isolate a particular phenomena for study" (90).

In contrast, the term profession is quite freely used to describe certain type of occupations, such as those in sciences, as well as to exclude other types of occupations. This dual usage of the term illustrates that it is more often than not used to portray "a morally desirable kind of work" rather than a form of occupational organisation (ibid. 90). Becker stressed that the use of the term in morally evaluative sense has, in fact, pushed certain occupations, such as law and medicine, to achieve a morally desirable status in society.

For this reason, Becker argued, the concept of profession is never static. The moral criteria held by people, which is also used to evaluate the constitution of profession, changes over time. Furthermore, Becker noted that many occupations seek the label of a profession, for example by advocating and promoting their occupation tasks, which in turn reinforces the non-static nature of the concept. Therefore, by examining the idea and definition of profession, it may be possible to contrast the changes in the concept of a profession to the wider social transformations taking place in a society.

Becker advised approaching a profession “as an honorific symbol in use in our society” and “that we should analyze the characteristics of that symbol” (ibid. 93). He suggested a move away from the common approach of analysing the concentration of the characteristics and tasks of employment that fulfil the criteria of the core features of a profession as generally perceived by people**.** People may have different views on what characteristics constitute a profession and which do not, yet Becker was certain that “substantial agreement on a set of interconnected characteristics which symbolize a morally praiseworthy kind of occupational organization” (ibid. 93) can be found.

Becker believed that people construct their ideal of the profession from a set of ideas about the type of work done by ‘real’ professions, from its internal (colleagues) and external relations (other professions and the general public) and from the way an occupation takes care of social needs and the needs of the members of the occupational group. Nevertheless, Becker did not suggest that these sets of ideas of profession offer an exhaustive classification for a profession, but that “both members of professions and laymen believe that they must be made to hold true if the occupation is to be made a real profession… ” (ibid. 93). Therefore, the ideal of profession is best understood as a standard that an individual uses to evaluate and compare occupations in order to decide the moral worthiness of such occupations.

Becker also had a place for the popular definitions and conceptions of profession in his analysis. He noted that the popular concepts cannot be completely ignored in the examination of professions. Popular definitions and concepts of profession are useful, too, because they can offer a sufficient basis for the analysis of the characteristics that are used by people to construct the ideal or a symbol of profession.

According to Becker, the features of profession, similar to those mentioned by other theorists, such as lengthy training, strict professional control, monopoly over knowledge and the position in society are central to the ideal of the profession should be questioned in order to gain a more comprehensive understanding of professions. These features of professions also have a central place in the analysis of professions because if an occupation fulfils such criteria, then it may be argued that such occupation enjoys autonomy over its work. If an occupation has autonomy over the tasks of employment, people may consider it as a profession.

Conversely, it can be argued that “his image of the professional justifies his demand for complete autonomy and his demand that the client give up of his own judgement and responsibility, leaving everything in the hands of the professional” (ibid. 97). The symbol and ‘imagined’ ideology linked to profession legitimises the autonomy and authority of the profession over the defined tasks. However, the availability of information in the Internet is shifting the medical profession’s autonomy by providing the patients with information (even knowledge) that enables them to judge and claim responsibility over their own health. Nevertheless, it should be remembered that the Internet information is merely challenging ‘the image of the medical professional’ rather than the (professional) knowledge of the medical profession.

According to Becker, an individual evaluates the features of an occupation (knowledge, skills, motivation, control) and then decides whether an occupation is a profession and to what degree he or she should and can put his or her trust in the occupation. Therefore, we must aim to evaluate if the physicians themselves are aware of situations in which they have felt that their ‘image’ or role as a doctor was challenged or compromised by a patient. Such situations could in theory indicate that the ‘criteria’ individuals use in deciding the ‘moral worth’ of the medical profession is changing. It will be difficult, however, to evaluate to what extent the criteria are changing due to the availability of information on the internet. In spite of this, the assessment of the image and changes to it by the profession itself may prove fruitful. As noted by Becker, profession is “part of the apparatus of the society, to be studied by noting how it is used and what roles it plays in the operations of that society” (ibid. 97).

4 THE PROFESSION OF MEDICINE

The ways in which the medical profession is understood and conceptualised depends on which perspective it is viewed from. Laymen, patients, members of the medical profession, the state, academics and members of other occupations and professions perceive and comprehend the medical profession in a variety of ways.

Medicine can be said to have two essential meanings to the medical profession. First, it can be seen as a body of knowledge and a set of skills, as well as technology, that are used to understand health and illness and to identify, diagnose and treat illnesses. Secondly, medicine is an organised profession[2] that has common attributes such as common initial training, codes of conduct and a self-regulatory professional body. (Illsley, 1980, 59)

For the wider audience the medical profession often represents an occupation that is characterised by the sense of vocation or calling, a set of ethical codes, selflessness, trust and lengthy training. It is also generally believed that by its nature the medical profession protects the interests of their patients as well as the standards of their own service, even when it is not in their own interest to do so. Therefore, the words used to describe the medical profession are often words such as objective, altruistic, autonomous and professional. (Illsley, 1980; Konttinen, 1991)

The position of the medical profession in society is based on the complexity of the knowledge and the set of skills that are required for doctors to perform their work, as well as the legitimacy that the public affords them. (Lowrey &Anderson, 2002, 1) The medical profession has monopoly over medical knowledge and the practice of medical tasks. It also has the monopoly over controlling the profession internally in terms of who can enter the profession, who is allowed to practice and how the work should be carried out.

[2] Illsley (1980) notes that medicine can be identified as a single profession for everyday purposes. We should not overlook the diversity of skills, knowledge, ways of working, types of treatments and relationship with patients that doctors from a variety of different expertise areas have inside the medical profession. The medical profession is not a unified group, rather it is a diverse one with a variety of characteristics. However, in the context of this study the term ‘medical profession’ is used in its wider sense and common characteristics are used to describe the medical profession as a whole.

The autonomy that the medical profession enjoys originates from the nature of the tasks that it performs. The profession's autonomy is also based on its claims of status on the basis of scientific discipline. (Illsley, 1980, 65) The authority of the medical profession is defined as the patient's grant of legitimacy to the doctor's exercise of power based on the assumption that it is benevolent. (Haug & Lavin, 1981, 212) The medical profession's autonomy can also be understood in terms of professional authority as "the legitimised control that an occupation exercises over the organisation and terms of its work," (Elston, 1991, 61) or as "the authority over others, often referred to as medical dominance" (ibid. 61).

Mary Ann Elston (1991) has also identified three different forms of autonomy that the medical profession is able to exercise: economic, political and clinical/technical autonomy. Elston stresses that the professional autonomy of a doctor is the legitimised control that he or she exercises over the organisation and the terms of work. She also makes a clear distinction between the profession's autonomy in relation to its dominance: the medical profession's authority over other professions. Economic autonomy refers to the factor that doctors, at least in some countries, are able to decide how much they want to charge for their services. Doctors are practical experts in their subject matter. This allows them to step into the political arena as legal experts in health issues and also in policy making. Clinical autonomy applies to the right of the profession to set its own standards and control clinical performance. (Elston, 1991, 61-62)

In Finland, the position of doctors is also based on an unwritten contract with Finnish society: the profession is committed to an ethically high level of service and therefore society guarantees and reinforces the position of the profession. (Finnish Medical Association, 2005, 136) Understanding the medical profession and its position in society in this way is functionalist in its approach. Functionalists believe that expert knowledge is essential for the functioning of developed society, and the development and existence of the medical profession is seen as a response to the system's need to control illness.

Hence, the medical profession is rightly awarded exclusive control over matters of health and illness as it works in the interests of patients. By the nature of its work the medical profession is then committed to the maintenance of public health, and consequently these efforts are counted as valued achievements

for the common good. In return for such actions, the medical profession are awarded status and economic rewards. (Morgan, Calnan & Manning, 1985, 108)

As mentioned in the previous chapter, the idea of professions evolving through historical development and natural division of labour, and somewhat 'earning' their position and status in society has been firmly rejected by many theorists over the past forty years. By the 1960s the sociologists had started to examine the processes by which some occupations become professions. The focus therefore shifted to the political practices of professions and especially to examining the ways in which professional status had been achieved.

During the 1970s American and British social scientists in particular adopted a thoroughly critical stance on professions, their status and autonomy, and their exercising of power over other occupations. (Harrison & McDonald, 2008, 28-29) These theorists do not theorise about the medical profession alone, but many use the medical profession as their key example. Therefore, such theorists are reviewed in this chapter as they focus on, and evaluate the autonomy of, the medical profession and the monopolistic position of doctors over matters of health and illness.

In 1970 Eliot Freidson published a pioneering study of professions, '*Profession of Medicine'*, which was seen as a response to the normative model of the medical profession developed by Parsons. Freidson delivered a fresh interpretation of an old topic and sparkled a debate on health professions over that lasted over two decades. (Riska, 2004, 146-147) Freidson claimed that the distinction between a profession and an occupation is found in the legitimised and organised autonomy that a profession is given in the right to control its own work. The right to professional autonomy is normally granted by the state or controlling elite.

According to Freidson, here lays the key to understanding professions. Protection from the state or the elite enables certain occupations to pursue professional status in society instead of their status being based on the quality of work or skills that make a particular occupation superior to others. Nevertheless, Freidson does also acknowledge that the medical profession uses its expert knowledge and other attributes as grounds for attaining and maintaining its position, but the position would not be

achieved without the support of the state and the elite in the first place. (Morgan , Calnan & Manning, 1985, 108-109)

In his next examination of professions, '*Professional Dominance*' (1970) Freidson extended the themes from his earlier book in arguing that medicine is able to gain social closure through complex occupational strategies such as professional ethics and corresponding professionalism, and in its most extreme form this social closure may emerge as almost total occupational control: professional dominance. (Castellani & Hafferty, 2010, 205)

In *'Professions and Power'* (1972) Terence Johnson argues that the professionalisation of certain occupations is not due to these occupations' inherent qualities but in fact a type of occupational control brought upon by certain historical conditions. For Johnson the medical profession's control and autonomy are something that originates from the ability of the profession to define and cater for the needs of the 'client' as well as from a special type of relationship with the state.

Occupational control is reinforced by the difference in the level of expert knowledge and specialist skills between the profession and the consumer. Johnson stresses that the wider the knowledge and skills gap between the profession and the client, the more likely it is that the relationship is based on uncertainty. Therefore, the relationship is characterised by the dependence of the consumer and the dominance of the profession in which the consumer is not able to control any aspect of the relationship and thereby benefit from it. (Morgan, Calnan & Manning, 1985, 110; Turner, 1987, 135-136; Konttinen, 1989, 98-100; MacDonald, 1995, 5)

Magali Sarfatti Larson (1977) argues in his book, '*The Rise of Professionalism: a Sociological Analysis*' that medicine as a scientific discipline and as a profession is based on the vital and universal need for its serves, which is often used as the basis for jurisdiction of its position in society. According to Larson the general ideological climate of Western societies has favoured the functions medicine claims to serve, such as the value of individual life and individualism in general. (ibid. 19)

Medicine's vital importance to public health was reinforced by the occurrence of epidemics, and hence the medical profession was able to earn government backing for its monopolistic position. (ibid. 23)

Larson is mostly fascinated by the formation of state-protected monopoly and the ways in which the medical profession gains and maintains its authority. (Larson, 1977; Konttinen, 1989, 134-135)

Larson stresses that medicine is an exceptional profession in the sense that it deals with matters of life and death, and puts the patient in the position of relying on the judgement of the professional and trusting his or her expertise. In turn, the public belief in the medical professions profession's superior skills further enforces the ideological basis of trust. Of all professions, it appears to have the strongest claim to being an ideal service and demonstrating devotion to human welfare. (Larson, 1977)

In addition, the private nature of the doctor-patient relationship, which limits direct external control, further reinforces the profession's dominance in matters of health and illness. The position that the medical profession has gained in society is due to its successful claims of superior knowledge and skills, and tying itself to science that has given it cognitive base and hence credibility in the eyes of the consumer. (Morgan, Calnan & Manning, 1985, 115-116)

Other theorists who have specifically focused on the medical profession include Jamous and Peloille (1970), who examined the French university hospital system, from which they draw their observations on the medical profession and its knowledge. From these observations Jamous and Peloille developed the concept of the 'indetermination/ technicality' [I/T] ratio as a means for classifying occupations. The higher the I/T ratio or level of specialist knowledge held by an occupation, the wider the gap is between the professional and the client. (Harrison & McDonald, 2008, 29)

The specialist knowledge that the medical profession claims to hold has a "distinctive mystique which suggests that there is certain professional attitude and competence which cannot be reduced merely to systematic and routinized knowledge" (Turner, 1987, 136). Jamous and Peloille also noted that a systematic body of knowledge such as medicine provides the grounds for external regulation and control by the profession itself. (ibid. 133)

Jeffrey Berlant (1975) conducted an empirical study of the medical profession in the UK and the USA by employing the Weberian concept of monopolisation to emphasise how the medical profession has used administrative structures of the state to further its collective interests. (Larkin, 1983, 11)

Furthermore, Noel Parry and José Parry (1976) examined the power conflicts in society and the part played by professions in these conflicts. As a result of such conflicts, the professions have achieved a superior and therefore powerful position in society. This position can be then best understood and reviewed in the context of general theories of class in society. (MacDonald, 1995, 5)

Randall Collins (1979) again sees professions as being based on a combination of market closure and high occupation status honour, but also puts an emphasis on the professional culture and professional identity which reinforce the profession organisation and therefore the success of medicine as a profession. (Collins, 1990; Saks, 1995, 72; Konttinen, 1989, 146)

Paul Starr (1982) highlighted the social context in which the medical profession in the USA was transformed from an occupation lacking status to a valued profession due to the expansion in the market for medical services resulting from economic growth, urbanisation and the development of public transport systems. (Turner, 1987, 191)

Gerald Larkin (1983) introduced the notion of 'occupational imperialism', meaning that the medical profession can mould the division of labour to their own advantage by excluding other occupational groups and delegating tasks in order to gain wealth and maintain status and control. (Larkin, 1983, 15) This leads to a conflict between the medical profession and other healthcare workers, and the relationship is shaped by differentiated access to exterior sources of power. (ibid. 17)

A few theorists such as Haug (1973, 1981 & 1988), Oppenheimer (1973), McKinlay and Arches (1985), and McKinlay and Stoeckle (1988) approached the medical profession and its dominance, autonomy and control from a different point of view by raising questions about the possible decline of professional dominance. These theorists suggested, on the basis of observations in the USA, that doctors are increasingly being subjected to external forms of regulation and are in fact losing control over the content of their work. (Nettleton, 2006, 214)

The proletarianisation theory (Oppenheimer, 1973) relies on the general theory of social change and presumes that the changes in society that have had an effect on other occupations are now also having a considerable effect on the profession of medicine. In Marxist tradition, the theory of proletarianisation

argues that the logic of the capitalist development is subordinating the activities of the medical profession and transforming its labour processes to the needs of the capital. The causes of proletarianisation are related to a number of trends in the organisation of work under capitalism. (Oppenheimer, 1973 in Jones, 2003, 242)

The proletarianisation of healthcare can be seen in practice by observing the changes in the position of the formerly privileged profession of medicine. Doctors are facing a decrease in their level of control over decision making due to the complex organisation of modern healthcare and the increased level of leadership over the tasks and content of their employment by non-clinician managers. The proletarianisation theory notes that the increased specialisation of information, rationalisation of activities and technologisation of medicine are deskilling the medical profession. These processes together also challenge the cultural and social authority of doctors in the eyes of the general public. (Elston, 1991, 62-63; Jones, 2003, 242)

The deprofessionalisation theory (Haug, 1973, 1988; Haug & Lavin, 1983) concentrates on the changing relationship between doctors and their patients. The rationalisation of medical practice and knowledge has led to a decline in the cultural authority of medicine and a reduction in the extent of its monopoly over health-related knowledge and a decline in paternalistic position in society. More specifically, Haug called for the 'revolt of the client' by arguing that professional authority is being undermined by the emergence of an increasingly educated and critical populace. (Annandale, 1998, 228) The deprofessionalisation thesis also mirrors the wider trend of critically viewing expert knowledge and the rationalisation and codification of it. (Elston, 1991, 65)

The growth of bureaucracy has led to the medical profession working in hierarchical and bureaucratic settings that undermine its professional autonomy. The development of knowledge and volume of information available may cause divisions inside the medical profession, separating it into distinctive groups as the members are forced to specialise.

Hence doctors are driven to maintain their monopoly through specialisation. The increasing complexity of medical care increases the professional uncertainty about diagnosis and treatment, which undermines patient trust and confidence, and affects the doctors' credibility with patients. The medical profession's

position is also challenged by the ‘para-professionals’ offering their services to their clientele. (Turner, 1987, 137; Haug & Lavin, 1983 in Lowrey & Anderson, 2002, 2; Annandale, 1998, 228)

Haug had already made a sharp observation in 1977 on the computerisation of specific occupational knowledge and its consequences. She believed that greater access to occupational knowledge is likely lower the level of public legitimacy afforded to the occupation. In turn, the degree to which the occupation is able to control its work is threatened. (Haug, 1977 in Lowrey & Anderson, 2002, 4)

The theories of deprofessionalisation and proletarianisation are very much centred around the American healthcare system and its professionals. Many of the challenges highlighted by the theorists are not necessarily issues in Finland, or even in Europe as a whole. It is, however, good to bear in mind that even if they are theories developed in the USA in order to explain the state of matters in that country, there may be some aspects that are valid in explaining similar developments elsewhere.

Both the deprofessionalisation and proletarianisation theories can be said to be lacking specificity and their value is reduced to mere descriptive accounts of the developments in American healthcare. Also, in order to have faith in the proletarianisation thesis, one must accept the Marxist view of societal development as accurate.

In regards to the proletarianisation theory, it is hard to consider doctors as wage-labourers, or even proletarian for that matter. Doctors still maintain the power to supervise other health professionals, hold a range of specialist skills and the authority to diagnose and treat patients, and hold some control over the means and organisation of production. (Jones, 2003, 242-243; Annandale, 1998, 226) On a general level, the acceptance of the proletarianisation theory presupposes the validity of proletarianisation of the entire labour force in advanced capitalist society. (Elston, 1991, 63) Freidson reduced the notion of proletarianisation to a mere slogan instead of an analytical concept and therefore inapplicable to the medical profession. (Freidson, 1986, 15, 21 in Elston, 1991, 64)

The deprofessionalisation thesis can be criticised for similar flaws, as the lack of specificity makes it hard to test in practice. As Elston (1991) points out, it is not clear what the end of the deprofessionalisation process would be: radical democratisation of knowledge and skills, reduction in

collegiate control, greater involvement of third parties and the consumer, or the elimination of medicine's privileged position. The deprofessionalisation theory also puts significant emphasis on the use of technology as part of medical procedures and the effects this has on the medical profession. (Elston, 1991, 64-65)

Haug's thesis was developed to explain the situation in American healthcare in the 1970s and 1980s, and she was in many ways ahead of her time in hypothesising consumerism in healthcare and the challenges to medical knowledge. (Annandale, 1998, 228-229) In fact, the deprofessionalisation thesis with its notion of computerisation of knowledge (Haug, 1977) is still somewhat relevant today in relation to the use of the internet by patients and the challenges this brings for the medical profession.

As Jones (2003) puts it, a modern example of the deprofessionalisation of doctors in the modern age is the drive towards client-centred care, and better-informed patients, including those who use the internet, are examples of challenges to the cultural legitimacy of medicine. On the other hand, Dingwall (1996) states that the proliferation of free information on the internet is not threatening the professional powers of medicine, but the diffusion of information on risk and health makes additional demands on the profession and act as arbitrators of uncertainty (in Jones, 2003, 243). If you examine the changes that both the proletarianisation and deprofessionalisation theories highlight from the viewpoint of patients, these changes can be said to be democratising the doctor-patient relationship.

5 MEDICAL PROFESSION IN FINLAND AND FINNISH HEALTH CARE SECTOR

In order to understand the development of professions and changes in professions, it is essential to understand and review the societal conditions in which the professions came to exist. Professions develop, adapt and change in relation to the society they are embedded in. Therefore the development of professions in a given society is unique, but similarities to other societies may exist. The development of professions in continental Europe was guided by strong bureaucratic states that legitimised and controlled the professions as well as organised the institutions providing training leading to professions. Hence this has also affected the theories about professions in general, as the Anglo-Saxon theories are merely based on the societal context in which they developed.

In order to understand the development of professions in continental countries such as France and Germany, the central role of the state and the relationship between the state and the professions must be taken into account in the evaluation of professions in such countries. (Konttinen, 1991, 17; Konttinen, 1998, 35) In the United Kingdom and the United States, the development of professions was tightly linked to the principles of the market economy. It was left for the market to decide which professions or professional groups survived, as there was little interference from the state. (Konttinen, 1991, 10)

5.1 The history of professions in Finland

The development of professions in Finland is distinctively characterised by both the strong role of the state and the class structure of the society. Despite the strong role of the state, the civil society also had a significant effect on the way the Finnish field of professions developed and moulded. Sociologist Esa Konttinen, responsible for extensive research into the history and development of professions in Finland, has stressed that it is only possible to fully understand the position, success and failure of professions by reflecting the professions against the development of the society in which the professions developed. (Konttinen, 1991, 11) As the study examines the changes in the Finnish medical profession, it is therefore necessary to review the historical features of Finnish society that have had an effect on the development of professions in Finland.

To understand the system of professions in Finland we must look back to the 17th century, as the class structure began to develop during this period. Finland, then part of the kingdom of Sweden, experienced an intensive building of the state, forming of an army and unification of areas in an attempt to subject Finland to be governed as an entity. During this time the nobility began to develop in connection with the judiciary and the army. Achievement of such social positions was significant as the feudal system in Scandinavia was weak and therefore no landed gentry really existed. Frequent war activities together with the lack of landed gentry meant that the significance of the army as the provider of noble statuses grew. Notably, most holders of noble positions in the society were either army officers or priests and access to noble status was almost solely through these two channels. (Konttinen, 1991.)

During the 17th century, the members of the clergy acted as an apparatus to unify the people under a common government and hence the clergy grew both in size and importance. The influence of the clergy extended across the whole society, leading the clergy to hold a historically significant position as the most valued profession at the time. (Koskinen and Mykkänen, 1998, 9) The Lutheran church also had a strong hold over the field of education, as the Turku Academy, established in 1640, was governed by the church and was primarily used to train priests. (Konttinen, 1991, 20-21)

It may be difficult to envision the importance of these social developments that took place hundreds of years ago in relation to the professions of today. However, the significance of this lays in the way the Finnish social groups tightly attached themselves to these two professions: the nobility to army officers and the clergy to priesthood and university and schoolteachers. The attachment of leading social classes to these professions further increased the importance of such professions. Occupations without class connections were perceived to be devalued. For example, the status of the university-educated medical profession continued to be weak in Finland until the 19th century, as the profession held little or no value in the eyes of the higher social classes. This is contrary to the situation in, for example, the United Kingdom, where the medical occupation had strong links with the aristocracy and through this gained high status in society. (Konttinen, 1991, 21.)

In 1809 Finland became an autonomous Grand Duchy within the Russian Empire, and the same year the army was dissolved by the order of Tsar Alexander I. (Konttinen, 1991, 23-24) This period in

history is significant for the development of professional structures in Finland as the position of the senate and the central administration, both backed by Russia, was extremely strong. The central government of the empire monitored life in society as a whole and indirectly controlled the development of society and its different segments, including professions. (Konttinen, 1998, 33)

The dissolution of the army left many members of the nobility troubled, as a significant proportion of the noble class were positioned in the army. The bureaucratisation of society is important in the development of professions in Finland for two reasons. Firstly, the administrative posts were sought after, especially after the nobility had been displaced from the army. Secondly, the bureaucratisation of society had a significant effect on the ways in which the professions organised themselves to respond the needs of the novel central administration. (Konttinen, 1991, 23-24.)

The ineffectiveness of the bureaucratic regime led to structural changes, which began in 1814 when the training of public servants was rationalised by introducing the requirement of vocational qualifications for administrative posts in the central administration. The rationalisation of the training of public servants also indicated to the leading classes that their privileged access to senior administrative positions ceased to exist. This, together with the dissolution of the army, which had altered the position of nobility in society, pushed the leading social classes into the universities in order to guarantee their status. As the leading classes of society tightly attached themselves to university education, especially the study of law, such education further increased the divisions between social classes. (Konttinen, 1991, 25; Stenvall, 1998, 67-68.)

The introduction of qualifications or degrees as a requirement for certain posts symbolises a distinctive feature of a modern profession. (Konttinen, 1998, 34)
This was the beginning of the modernisation of professions, as the occupations that required university education became steeply differentiated from the other occupations. (Konttinen, 1991, 28-29) As the access to university education and therefore to professions was predetermined by social class, this, together with the underdeveloped social structures, meant that the Finnish field of professions appeared both modern (university-focused) and traditional (the dominant role of traditionally strong classes in the field of professions) at the same time. (Konttinen, 1991, 31-32)

In the latter part of the 19th century, Russia lost the Crimean War and Tsar Nicholas II died, events that were reflected in Finnish society as liberal reforms by the new Tsar, Alexander II, owing to pressure from the Western states. The liberalisation of the society altered the traditional power relations and as a result the noble class experienced devaluation in their social position. Conversely, this liberalisation further rationalised the bureaucratic state administration which benefited the educated segments of the society, merely the public servants. (Konttinen, 1991, 33.)

The latter part of the century also gave birth to the political movement of the Fennomans[3], which instigated a shift towards a new social order. The Fennomans were in favour of a strong state, as their own elite position was dependent on it, hence the role of the state remained strong. However, the strong state did not act as an obstacle in the process, in which the somewhat traditional class-structured society began to break down and the liberal bourgeoisie society started to develop. Thus, the strong position of the state can be observed in the internally homogenous nature of professions. (Konttinen, 1998, 35-36.)

The development of bourgeoisie society, industrialisation and liberalisation of the economy brought about possibilities that enabled professions to establish private practices and new occupational groups to come into being. The monopoly held by the leading social classes over access to universities together with the language and gender restrictions were removed, hence making entry to education leading to a profession more widely available. The structurally more liberal society prompted the development of a civil society in which professional associations began to be founded and the different occupational groups grew more independent of each other. (Konttinen, 1998, 36; Mykkänen & Koskinen, 1998, 12-16)

The establishment of professional associations further facilitated the modernisation of the field of professions as the professions further estranged themselves from the upper hierarchy of social classes. The withdrawal of profession from the leading social classes and the wider access to university education meant that the class gap between occupations and professions never became large in Finland. Since the establishment of professional associations in Finland, such associations have enjoyed high

[3] The Fennomans were a significant political movement in 19th century Finland. The main focus of the Fennomans was to transfer the minority position of the Finnish language and culture to that of national the language and dominant culture.

levels of membership and they have therefore been successful in gaining benefits and guarding the rights of their members (Konttinen, 1996, 18; Mykkänen & Koskinen, 1998, 19)

The status structure of the professions continued to exist similarly: connected to the state, to certain classes and to the central administration until the 1906 parliamentary reform of the unicameral parliament. (Office of Parliament, 2008) As the governing of the state became more egalitarian, social class as a factor in the field of professions further lost its importance. The first educational institution that was independent from the state, the Helsinki School of Economics, was established in 1911, followed by institutions such as the Åbo Academy in 1917, the University of Turku in 1920 and the University of Social Sciences in 1925. (Elovainio, 1972, 242 in Mykkänen & Koskinen, 1998, 18) Such institutions opened doors for new types of training and education, and hence to the development of novel occupations and occupational groups. (Konttinen, 1991)

Finland gained independence from Russia in 1917 but the building of the Finnish welfare state only began after the Second World War, in order to stabilise and reorganise the society. (Haatanen, 1992, 48) The shift from an agricultural society to an industrial capitalist society was slower in Finland than in other Nordic countries, but the development of the Finnish economy followed a somewhat similar path to its Western neighbours. (Torstendahl, 1991 in Koskinen & Mykkänen, 1998, 10-11) The beginning of the industrialisation of Finnish society did not have a major effect on the structure of professions as the industrial style of production required little or no involvement of professions and consequently the dominant position of the somewhat traditional professions remained unchanged. (Koskinen & Mykkänen, 1998, 11-12)

However, as the economic order of capitalism became more organised, the effects of such economic order together with the maintenance of welfare society came to be felt in the structure of professions. The organisation of capitalism had a two-way effect on the professions. On one hand, as production began to be more technology based, wider scale and specific, it required new types of expertise. On the other hand, the enlarged scales of production required effective management and administration from the enterprises, which increased the need for such specialists. (Chandler, 1962, in Koskinen & Mykkänen, 1998, 13)

The maintenance of the welfare society required an effective public administration and a mixture of new occupations to support its functioning. As this service class grew in size, the demands for preparatory education and training for such occupations also increased. (Konttinen, 1996, 20; Koskinen & Mykkänen, 1998, 14) A network of vocational educational institutions was built by the state and the individual municipalities to support the needs of the rapidly industrialising economy and society. (Kettunen, 2001, 80-81) The industrialisation of society redistributed the population from rural to urban areas. This generated new markets for goods and services that required both a specialised and a non-specialised workforce. (Koskinen & Mykkänen, 1998, 16) This period witnessed both the striving of new occupations to create a professional identity and areas of expertise and the struggle of the older, established professions to maintain their authority and monopoly over expertise. (Konttinen, 1996, 20-21)

Finland faced economic recessions in both the 1970s and 1990s. The latter had deep and long-lasting effects on Finnish society, politics and the economy, as Finnish GDP was reduced by 10%, many businesses went bankrupt, the national currency was devalued, major banks had to be supported by the state, unemployment levels soared, and public expenditure was cut, not to mention the psychological cost of the recession. (Keskimäki, 2003, 1518; Kiander & Vartia, 1996, 72-86; Kavonius, 2001, 6-9)

The central government and the municipalities cut their consumption and expenditure significantly and in order to support the large public sector and its services, new taxes and tariffs were introduced. (Kiander &Vartia, 1996, 72-86) For example, overall health expenditure decreased by about 12% (Linna & Häkkinen, 1996 in Keskimäki, 2003, 1518) and other parts of the public sector were forced to function with extremely scarce resources. For example, for the first time in history, members of medical profession found themselves unable to obtain employment after graduation or out of work. Hence, in 1993 the number of entry places to study medicine was cut by 200 to 350 students per year. (Vänskä J. et al., 2005, 16)

As the level of unemployment was high, for many studying for longer was an attractive option and the level of education in society increased during the recession years. (Työministeriö, 2003, 79) Between 1994 and 2003 the numbers of students participating in education leading to a degree increased 13% from 105,000 in 1994 to almost 120,000 in 2003, making Finland one of the most educated nations in

the world. (Tuononen, 2005) As the Finnish population in general became more and more educated in the aftermath of the recession, the society was rapidly changing in a novel way. The government established the first National Information Society in 1994 (Tietoyhteiskuntaohjelma, 2006, 11), and throughout the 1990s Finland was hailed as a model of the development of information society and informational economy. (See for example Castells & Himanen, 2002) The development of information society and informational economy affects the framework of what defines a profession, but also the tasks of their employment.

Together with education, possessing such skills as language and IT skills has become compulsory for the members of professions, too. As the general population has become more educated and knowledgeable, possessing special skills, the professions have been forced to discover new ways to remain differentiated from other occupations. In many cases this has meant that members of professions are becoming specialists in a defined area of expertise that defines their profession. New occupations that claim the status of a profession are continually coming into existence.

The internationalisation of Finland (and the process of globalisation in general) has altered the field of professions, as the members of professions are expected to have competent language and social skills as well as strong expertise over specialist subjects in order to operate in the international field. (Mykkänen & Koskinen, 1998, 21-22; Stenvall, 1995, 241-243; Temmes, 1995, in Stenvall, 1998, 77) It remains to be seen how the change in the age structure of the Finnish working population may affect the field of professions in the future. It is also likely that the non-native members of professions will be altering the way in which the Finnish field of professions functions. (Tietoyhteiskuntaohjelma, 2006, 17)

In order to understand the development of professions in Finland, we must understand the ways which the social classes developed and the strong role of the state in relation to professions. Historically the leading classes had tightly attached themselves to university education, which enabled the members of such classes to become members of professions. The strong role of the state is manifested in the development of professions, as the field of professions itself is structurally homogenous. The homogeneity of the field is a result of state-led institutions providing the education leading to professions and the inability of the professions to organise themselves internally and centrally in the

early 19th century. (Konttinen, 1991, 28-29) The homogeneity of the field can still be observed today as, for most occupations which are defined as professions, there only exists a single educational track: the state-led universities. Also, the connection of the leading classes to university education may explain the respect for and status of occupations and professions which require university education. (Konttinen, 1996, 16)

As explained in this chapter in detail, to understand history is to understand the role of professions in modern Finnish society. As the dynamics of society have changed, the position of professions in society has also changed. However, as stressed by Koskinen and Mykkänen (1998, 21), the development of professions in Finland is a sum of many factors, and there is no unambiguous explanation for the position of professions in Finland at the present time.

One can point out various historical or social developments that can be used to explain the development of professions in Finland. For example, Henriksson and Wrede (2004, 9) have highlighted the importance of the welfare state as a unique environment. The fact that Finland is a welfare state has had an effect on the development of occupations and professions, and the way in which they function. Others may emphasise that the subject matter has not fully been researched and examined in order to provide a comprehensive or explanatory account of the position of professions in Finland (Mykkänen & Koskinen, 1998, 19). For others it is important to pay attention to the regulatory structures of the society and to those opportunities that such structures have enabled the professions to have in terms of development and institutionalisation. (Jauho, 2004, 104)

5.2 The characteristics of the Finnish healthcare sector

The Finnish medical profession work in an environment that is regulated by the government and guided by legislation from the Ministry of Social Affairs and Health. (Ministry of Social Affairs and Health, 2004) Finnish health policy places the emphasis on lengthening the active and healthy lifetime of citizens, improving quality of life, reducing the rate of premature death and reducing differences in health between population groups. The aims of the health policy have an effect on the line of work that the medical profession carries out. Healthcare in Finland is delivered through both ‘public’ and ‘private’ sectors.

The Finnish municipalities (336 municipalities in 2011) are responsible for organising healthcare for residents, and the public health services are mainly financed by tax revenues from the municipalities (35%), the state (25%) and health insurance (15%). (Association of Finnish Local and Regional Authorities, 2011)

Under the Primary Health Care Act, the health centres are responsible for providing guidance on health matters, prevention of diseases, provision of medical treatment, organisation of medical examinations and screenings, running of maternity clinics and child health clinics, arrangement of school, student and occupational health services, organisation of dental care, rehabilitation services and nursing services, as well as the provision of local ambulance services and certain mental health services. In addition to the 278 health centres in Finland there are also 20 hospital districts, which are responsible for organising and providing special care and consultation for the population of a set district. (Ministry of Social Affairs and Health, 2011; Association of Finnish and Regional Authorities, 2011)

Until the 1980s Finnish healthcare services were predominantly organised and provided by the public sector. Nowadays public health provision is increasingly being supplemented by private sector healthcare services. According to the Ministry of Social Affairs and Health, private healthcare costs amounted to approximately 14% of the total healthcare expenditure in 2002. The most used private healthcare sector services are physiotherapy, occupational healthcare, laboratory services, doctor's surgeries and rehabilitation services, which are mainly purchased by employers, households and the Social Insurance Institution. The use of private sector services is encouraged by the Social Insurance Institution reimbursing the patient for some of the cost in order to supplement the public healthcare system.

Finland was the first country in Europe to enact legislation regarding the status and rights of patients, in 1992. (Finnish Medical Association, 2007) All permanent residents of Finland are entitled to health and medical care that his or her state of health requires within the limits of the resources available under the

Act on the Status and Rights of Patients. In primary healthcare, the Act states that a treatment that has been assessed as necessary must be accessible within three months of the assessment.[4]

In addition, the Act provides a strong framework in support of patient rights, such as giving the patient the right to view and correct the information in their medical records or providing the patient with information on their state of health and the extent of the proposed treatment. It is likely that the strong rights of patients have had some implications for the role of the medical profession. What these implications are may be hard to separate from other factors affecting the role and status of doctors, but it is a factor worth bearing in mind when examining the medical profession in Finland.

5.3 The medical profession in current context

At the beginning of 2011 there were 22,821 doctors in Finland, of which 19,353 were of working age (under 63 years old). (Finnish Medical Association, 2011) The same year over 600 new students began their studies, lasting about six-and-a-half years, to become licentiates of medicine in five Finnish universities (Helsinki, Turku, Tampere, Kuopio and Oulu). In 2011, there was one working-age doctor per 278 inhabitants, which makes the density of doctors in Finland high by international comparison. (Finnish Medical Association, 2011 and European Commission of Health & Consumer Protection Directorate General, 2007) The demographics of the Finnish medical profession are changing as the medical workforce grows older (3,468 doctors over 65 years). In 2008 56% of working-age doctors were female, and the numbers of doctors of non-Finnish origin has been steadily growing in recent years, reaching over 800 in 2011. (Finnish Medical Association, 2011; Vänskä et al., 2009, 17-18)

[4] Nevertheless, this timeframe can be exceeded by three months in oral care and specialised healthcare provided in a primary care setting if there are reasonable grounds for the delay and the delay does not endanger the life of the patient.

Table 4. Development of the numbers of doctors in Finland, 1900-2011

Year	Number of doctors	% of female doctors	Inhabitants per doctor
1900	373	1	7,143
1920	657	6	4,756
1940	1,394	13	2,680
1960	2,915	22	1,573
1980	9,517	33	530
1990	14,325	42	359
2000	18,925	48	274
2003	20,285	49	259
2011	24,502	53	278

Table from 'Lääkäri 2009', by Vänskä J. et al. (2009, 19) and the Finnish Medical Association (2011) 'Lääkäri 2011'

Half of all doctors in Finland work in hospitals on a full-time basis. On average, a doctor working in a health centre earns around 5,604 euros a month according to the statistics released in 2009 by the Finnish Medical Association (FMA). (Vänskä, 2009, 1048) About one third of Finnish doctors run a private clinic in addition to working in a hospital or health centre, but only about 10% are solely employed by the private sector. About 64% of Finnish doctors of working age hold special competence in at least one field of specialised medicine. (FMA website; Finnish Medical Association, 2011, 3)

Finnish doctors are highly organised, with 94% of them belonging to the FMA. (Finnish Medical Association, 2001, 3) The FMA promotes values (medical expertise, humanity, ethics and collegiality), represents common interests (professional, social and economic) and advances medical expertise on the basis of professional knowledge on behalf of its members.

The FMA is actively involved in research of the medical profession in Finland. The FMA published a study in 2007 that examined the employment conditions of doctors in Finland. The study reported that more than half of the doctors working in health centres had thought about changing their place of employment due to factors such as the presence of time restrictions when seeing and diagnosing patients, and possessing little control over the contents of their employment. (Elovainio et al., 2007, 2071-2076) This is a worrying trend, especially when there are health centres and hospitals in many municipalities that are suffering from a chronic shortage of doctors. (Parmanne, 2010) In turn, the

increasing shortage of doctors in the public sector may highlight and further strengthen the role of medical professionals in Finnish society.

A survey study, *'Doctor 2008'* by the Ministry of Social Affairs and Health is useful in painting a picture of the medical profession in Finland at present. The study, which was published in 2009 and included doctors who qualified between 1997 and 2006, noted that there have been major changes in the education and training of doctors in the past few years which have had an effect on the activities of doctors. These changes include a reduction in the number of areas of specialities, an increase in the intake of students, and reorganisation of the basic medical training. For example, during the economic recession in 1993 the intake of medical students was reduced to 350 students per year, then increased to 480 students per year in 1997 and further increased to 602 students in 2002. In 1999, the fields of speciality in Finnish medicine were reduced by almost half, from 92 to 49. The basic medical education was also reformed. This reform was carried out so that the training would better prepare the students for work in the primary healthcare sector as well as to make it more adaptable to the rapid changes in the field of medicine.

The study explored such factors as the values, professional identity and job satisfaction of doctors. According to the study, the main reasons why the participants had chosen medicine as the field of their study were as follows: interest in human beings (82%), valued profession (59%), diverse employment possibilities (45%), success at school (40%), well-paid occupation (40%) and vocation (42%). Not surprisingly, 90% of the doctors taking part in the study said that they themselves value the work they do fairly or very much. More than half of the participants also felt that patients, nursing staff, managers and colleagues from the same field of medicine value the work the doctors do fairly or very much. Hospital-based doctors feel their work is more valued by the general public, media and colleagues from other fields of medicine than by doctors working in health centres. Many of the respondents based in health centres felt that that their work is valued little or very little by national and local decision-makers and the media.

The study found that female and male doctors view their professional identity differently. Female doctors considered themselves as doctors of calling, health educators, helpers, listeners, comforters,

social workers, and providers of prescriptions and sick notes, whereas male doctors identified themselves as technicians, healers, entrepreneurs, researchers and leaders.

Unfortunately, as many survey-based studies often do, the *'Doctor 2008'* study describes occurrences of dissimilarities among the study population but fails to explain why such disparities exist. Hence, it is anticipated that by approaching the topic of the professional status and identity of doctors through qualitative analysis, the examination of the changes in the Finnish medical profession will go beyond statistical generalisations and will provide a more in-depth interpretation of the phenomenon under study.

6 SOCIAL CHANGE & MEDICAL PROFESSION

6.1 Why do patients use the internet for finding health-related information

Patients' searching for health information is not a new phenomenon as such. In many cases the information searching is driven by a feeling of uncertainty in relation to one's health. (Wilson, 1977 in Drake, 2009, 151) Prior to the 'age of the internet' it was not uncommon for people to look for information in medical publications and lay media such as health magazines or medical handbooks. (Ende et al., 1989; Cassileth et al., 1980; Basch et al., 2004, in Bylund et al., 2007, 346)

The internet offers a major new source of health information with the potential to increase the patient's say in healthcare provision. (Malone, Harris, Hooker, Tucker, Tanna & Honnor, 2004, 189-191) The main difference with the potential of the internet as a source of information compared to before is that searching and finding information by using the internet is often quick, efficient, cost-effective and convenient. (Åkesson, Saveman & Nilsson, 2007) Searching information on the internet is private since it can be done from home, and it does not have the space and time barriers of traditional information-seeking methods. It is also relatively effortless. There are hundreds of thousands articles just a few clicks away that are easily obtainable, widely available and which can be tailored to the user's needs.

The internet is able to offer versatile health information ranging from scientific, academic articles to personal stories in higher volumes than ever before. (Williams, Nicholas & Huntington, 2003) Therefore it is not surprising that health information is one of the most frequently searched topics on the internet. (Fox & Rainie, 2000; Eysenbach, 2003) But what other motivations or reasons exist for patients' internet use beyond the ease of accessibility?

There are three primary ways in which people access online health information: by searching directly, by participating in support groups and by consulting health providers. (Cline & Haynes, 2001, 673) They have various motives, including personal, social and financial, for using the internet to search for health-related information. The patient characteristics and the context of the situation may also be factors which explain some patients' preference for internet-based information. (Lemire, Paré, Sicotte & Harvey, 2008)

Nevertheless, the populace that uses the internet for health-related information is not a homogenous group, but a crowd that varies in socioeconomic and health status, gender, age, racial background, patterns of search (how often, duration, on whose behalf they are searching for the information) and also in how they use and act on the information they find. However, less is known about the content and regularity of searches, the effects of the information obtained on patients' health decisions and outcomes, or the frequency with which patients present their doctors with such information and, therefore, what kind of impact this has on the doctor-patient relationship. (Malone et al, 2004, 189)

An American study focusing on who uses the internet to obtain information about health and illness discovered three groups of people. The first group consisted of healthy people obtaining health information; the second group was made up of chronically ill people and their informal caregivers; and the third group consisted of people who were newly diagnosed and searching for information on their diagnosis. (Cain, Mittman, Sarajohn-Kahman & Wayne, 2000)

A recent doctoral thesis (2009) by Merja Drake concentrated on the producers and seekers of health information on the internet in Finland. Amongst other things, her research identified some reasons behind patients' information searches. Often the reason for internet-based information searching is that patients are faced with a health-related dilemma that they wish to solve. The internet is also often used by patients in non-urgent cases where the patient feels that the matter is not serious enough to warrant a consultation with a healthcare professional. The patient may want to independently assess the situation or avoid an unnecessary visit to the doctors. The patients also reported that the urge to search for health information on the internet can be motivated by feelings of fear, uncertainty, confusion and distress in regards to a health matter. Hence the internet can offer an immediate source of information to ease such concerns. (Drake, 2009, 110-111.)

On the basis of her analysis, Drake (2009) conducted a detailed classification of the types of information seekers. Each class is also an explanation of the type of health information searching online.

Table 5. Types of information seekers

1) Seekers and absorbers of all types of health information
2) People searching for information for peace of mind
3) People searching for sensitive information and those who seek information prior to consulting a doctor
4) People searching for information on a specific symptom or problem
5) Diagnosed patients searching for further information in relation to treatment and treatment options. Patients using the internet for a 'second opinion'.
6) Patients searching for information in order to have a dialogue with their doctor or to better manage their illness and prevent further progression of the condition.
7) Patients with a rare or incurable condition searching for information on treatments and cures. Patients who belong to support groups.
8) Helpers and supporters – those searching for information on someone else's behalf

Table conducted by the author from Drake , 2009, 122-123

Large-scale studies suggest that very few patients are surfing the internet aimlessly looking for health information. Most users are looking for information on specific condition. (Fox & Rainie, 2000; Nicholas, Huntington, Gunter, Withey and Russell, 2003) Patients carry out searches to manage their healthcare independently and/or to decide themselves whether or not they need professional help. (McMullan, 2006)

People also use the internet in relation to health to obtain the contact details of doctors, and some are interested in the recommendations and experiences of other patients regarding individual clinicians or health services. (Green, 1996; Anonymous, 1997, in Cline and Haynes, 2001) Studies also suggest that there are internet users that search for health information on behalf of someone else. (Fox and Rainie, 2002)

Faith McLellan (2004) has highlighted some of the rationale behind the usage of the internet for health-related information. Patients often use the internet before and after a doctor's appointment. Patients use

the internet as a preparatory tool prior to the appointment with the doctor in order to maximise the limited consultation time and to ask accurate questions. Some patients aim to find answers to questions that they may be too hesitant or embarrassed to bring up with their doctor.

The internet is particularly appealing to patients who search for information about sensitive and stigmatised illness. (Berger, Wagner & Baker, 2005; Klein & Wilson, 2003, in Sillence, Briggs, Harris & Fishwick, 2007, 1854) Patients may feel more comfortable searching for such information discreetly in the privacy of their own homes without barriers of time or space. Another possible advantage of internet-based health information is that patients have the opportunity to reflect on and reconsider preferences prior to discussions with their doctor. (Gerber & Eiser, 2001) The internet also has the potential to widen access to health information in remote areas, for disadvantaged segments of the population and to otherwise hard-to-reach audiences.

More often than not the internet is the first destination for a person recently diagnosed with a serious or chronic health condition. (Goldsmith, 2000, 152) Patients do this to confirm the information given by their healthcare provider and also to gather additional information. (Nicholas et al., 2003) The patients may not be able to absorb all the information given to them during the consultation and hence they turn to the internet for additional support. (Drake, 2009, 107)

Another study reported that patients ‘go online’ when they become dissatisfied with the information provided to them by their healthcare providers. (Fogel, Albert, Schnabel, Ditkoff & Neugut, 2002) This dissatisfaction could be caused by factors, identified by James Anderson (2004) in his US-based study, such as constraints on consultation time, unrealistic expectations of the patient, an impersonal and distant care assessment by the doctor, and when the patient has the impression that the doctor has inadequate information technology skills.

People with a pre-existing condition or diagnosis frequently use the internet as a tool for obtaining information about ongoing clinical trials, new drugs and treatments, experimental options, or to create and find support groups or mailing lists. Some patients also ‘consult the internet’ in order to obtain alternative points of view from outside of mainstream medicine. (Lemire et al., 2008) People with chronic diseases are likely to use the internet in the event of a new symptom occurring. (Drake, 2009,

110) Furthermore, the internet offers a novel channel for communication that brings together patients with rare diseases and experts on such diseases worldwide. (Potts & Wyatt, 2002)

It may be easily assumed that people who suffer from poor health are the most active in terms of using the internet for health information, but the 'healthy users' who want to stay well should not be dismissed. For example, an American study from 2002 reported that people with poor health were more frequent users than those who rated themselves healthy. Interestingly, the majority of the participants (80%) found the information through search engines and 52% of the internet health information users participating in the study reported that they could believe most of the information on the internet. Also, the number of participants who reported that they learnt something new last time they went online was high, at 81%, and did not seem to vary according to health status either. Nevertheless, the sicker the patients, the more likely they were to discuss the information they found online with their doctor. (Houston & Allison, 2002)

6.2 The effects of information on the patient

For most people, the reason they use the internet in relation to health is that they want to be better informed. (Houston & Ehrenberger, 2001, 43) The motivations and reasons for doing so, however, vary. The most likely reason for someone turning to the internet for health-related information is that they have a dilemma which they wish to solve. (Drake, 2009, 110) The information that patients find online can help them to better understand their medical condition or diagnosis, leading to increased feelings of empowerment and self-efficacy.

A study focusing on cancer patients and their family members suggests that the participants found study the information on internet useful, and the majority of them felt empowered by the knowledge they obtained from the internet. The other benefits of internet-based information searching as reported by the subjects were decreasing confusion, achieving a greater sense of personal control over the disease, and being more focused and able to formulate questions for the doctor. (Edgar, Greenberg & Remmer, 2002) The internet also offers the possibility for those who have knowledge or personal experience of a condition to produce content themselves for others to read. (Hardey, 2001, 389)

A study focusing on the effects of internet-based information on women deciding whether or not to undergo hormone replacement therapy (HRT) also confirms that participants who used the internet for information felt that they were better equipped to go to their doctor, ask questions and find further information. The study also suggests that the internet played an important role in the early stages of decision-making and that further along the information from the internet simply reinforced the decision already made. (Hart, Henwood & Wyatt, 2004.)

An Åkesson, Saveman and Nilsson (2007, 641) literature review outlines that technical interventions provide patients help, support and knowledge. For many patients the access to information means increased independence (independent searches of information), confidence (less fear due to increased knowledge) and empowerment (to challenge their earlier behaviour). “Empowerment by retrieving information from the web is a process that encourages active participation and may foster autonomy and lead to more satisfaction with the medical system.” (Edgar, Greenberg & Remmer, 2002 in Åkesson et al., 2007) The positive impacts of using the internet for health information have also been recorded as the promotion of self-care, sense of personal control and increased interaction with their doctor. (Åkesson et al., 2007; Ferguson, 1997, 253)

Online support groups are also said to empower their members by providing them with support, information and shared experiences. The advantages of electronic support groups such as discussion forums or mailing lists are the removal of geographical and transportation barriers, anonymity and the chance to find peers online who share the same rare condition or diagnosis. (Eysenbach, 2003) These support groups are often able to offer in-depth and convenient information with the capacity for immediate reactions, an unlimited volume of participants and exposure to an increased number of opinions, expertise and experience. (Grandinetti, 2000; Sharf, 1997; Haythornwaite et al., 1998; King & Moreggi, 1998, in Cline & Haynes, 2001, 673) Often, the understanding and sense of empathy that the other members of a support group have in relation to an illness or condition is the key strength and something many feel their doctor cannot offer. (Cotton & Gupta, 2004, 1797)

For some patients, the internet and email are simply new channels to communicate with their healthcare provider. Evidently many patients are interested in communicating with their doctors by using email, as this would mean easier access to their healthcare providers in terms of patient-doctor dialogue.

(Biermann, Golladay & Peterson, 2006) However, the rate at which email is being used as a tool for communication in healthcare remains very low (in the USA, 6-9%) due to confidentiality and increased workload issues. (Sittig, King & Hazlehurst, 2001; Baker, Wagner, Singer & Bundorf, 2003) The focus of this study is on the use of the health information on the internet that is available to all. Although analysing the effects of doctor-patient email use are not in the scope of this study, the importance of email as a new facilitating tool in doctor-patient relationship is recognised.

Various studies report that women are more likely than men to look for health information online. The association between gender and the likelihood of internet use in relation to health is explained by women's traditional role as caregivers and in general their more active interest in personal health. (Lemire et al., 2008, 730) A person's perceived health status can have an effect on the information searches as some studies suggest that people who perceive themselves to be in poor health will use the internet more for health-related information. (Houston & Allison, 2002; Goldner, 2006)

Other studies have proposed the opposite: people that actively search for health-related information on the internet perceive themselves to be in good health. The explanations for this could be that those who have poorer health status are physically less able to use the internet or that the health information from the internet is helping the users to stay healthy. (Cotton & Gupta, 2004)

Interestingly, a US study found that a high rate of internet usage was characterised by low socioeconomic status and a low education level rather than chronic health status of the patients. (Lizska, Steyer and Hueston, 2006) Some studies argue that in actual fact the internet is having a de-democratising effect, as those in greatest need of the information are least likely to have access to health information online. Societal inequalities have an effect on the level which the internet is utilised for health purposes. (Cotton & Gupta, 2004, 1803) Only the most active patients (who are primarily concerned with their health) use the Internet, while the passive ones – those who it could really benefit – do not.

Access to health information is not only a case of the economic matter of not owning a computer; other barriers include such factors as lack of computer skills, low levels of literacy, physical issues (such a as eyesight) and lack of English language skills, as a great deal of health content is written in English.

(Wald, Dube & Anthoy, 2007, 221) There are many more factors (for example age and racial background) that affect and explain the individual differences in people's motivation and levels of internet health information searching. (Dutta-Bergman, 2005) However, this study concentrates on the experiences of doctors regarding patients internet use in general and therefore the factors that affect individual patients' use of the internet for health information are not key factors, and therefore not in the scope of this study.

The internet has the potential to shift a patient from being a passive recipient towards being an active consumer, a partner in healthcare, and help to create a more equal relationship between the patient and doctor. The internet also has the potential to create greater equity not only in access to information, but also in the provision of health for people in remote areas, for example. Nonetheless, it also has its drawbacks. The reported disadvantages of using the internet for health information by the users are the lack of physical contact and the non-clinically proven information. Sometimes the patients can find that the health information on the internet is confusing, overwhelming and conflicting. (Eysenbach, 2003.)

For a user's point of view, the credibility of the information on the internet is also an issue. Assessing the credibility and validity of the information may be time-consuming and frustrating, and incorrect, uncritical, misleading or out-of date information may have serious health outcomes. (Sillence, Briggs, Harris & Fishwick, 2006; Eysenbach & Köhler, 2002) The amount of health information available on the internet is enormous and at times the patient must possess evaluative skills in order to assess the importance and correctness of the information. (Kivits, 2004) A recent study from 2007 found that the average time the respondents spent sifting a portal containing health information and evaluating its usefulness was half a minute. (Sillence et al., 2007, 1856) The patients evaluate the reliability of the information by checking who has produced the information, by comparing information from other sources and in some cases presenting it to their healthcare providers. (Drake, 2009, 149)

Merja Drake's research revealed that half of the participants searched for health information weekly and the most popular tool for health information searching was the search engine, Google. The reasons why Finnish patients turn to the internet for health information were reported as its convenience, speed and availability. The most enthusiastic users of the internet for health information were pregnant women, and women overall seem to be more eager to obtain information from sources other than their

doctor, and especially from online services. All participants stated that they mainly look for information from Finnish sites, as they were interested in information that is valid locally. Also, verifying the trustworthiness and validity of Finnish sites is according to the respondents easier than evaluating foreign pages. (Drake, 2009, 103-107.)

According to a questionnaire conducted among users of the Finnish national health portal, Terveyskirjasto, 47% of male and 33% of female respondents reported that finding reliable and accurate information on the internet is difficult. One in five Terveyskirjasto users felt that using the portal has reduced the need to contact their healthcare provider. Nonetheless, 3% of the respondents said that the information obtained from the portal resulted in them contacting their healthcare provider. (Sitra, 2007)

Patients are searching for health information on the internet, but a variety of studies suggest that 28-85% of those who researched the internet for health information also brought it with them to discuss it with their healthcare provider. (Diaz, Griffith, Ng, Reinert, Friedmann & Moulton, 2002; Fox & Rainie, 2002; Murray, Lo, Pollack, Donelan, Catania, Lee, Zapert & Turner, 2003; Lizska, Steyer & Hueston, 2006) Studies suggest that doctors are still viewed as the single most important source of advice on health issues but they are not necessary the first port of call. However, it should be acknowledged that in spite of disclosing their internet use or bringing the information to the consultation in many cases patients are somehow influenced by information they have come across on the internet. Therefore, more often than not, the information has an effect on the process of consultation as well as on the doctor-patient relationship. (Sillence et al., 2007, 1854)

6.3 The effects of informatisation of patients on doctors

A large-scale American study of 1,050 doctors reported that 75% of the respondents thought that the increase of health information on the internet was a good or very good thing, and 77% of the doctors had encouraged their patients to search for information on the internet. (Murray et al., 2003) A UK study conducted in 2000-2001 reported that 74% of healthcare providers had been presented with internet-based information during an appointment. (Malone et al., 2004, 190) A more recent US study of patients found that 73% of participants had used information from the internet to make a health-

related decision but only 50% shared such information with their doctor. (Lizska et al., 2006) The doctors participating in the large-scale American study, however, felt that the majority of patients brought the information with them because they wanted the doctor's opinion on it. Most doctors also felt that this was beneficial for the doctor-patient relationship. (Murray et al., 2003)

The Finnish Medical Journal conducted a brief email questionnaire about patients' internet use in 2002 among occupational doctors employed in the private sector. The doctors were asked about how often they come across patients that use the internet to search for health information, and of the 47 respondents, 11 said that they meet such patients on daily basis, 17 identified this happening weekly, 13 reported meeting such patients on a monthly basis, while 6 respondents had not encountered such patients. (Suomen Lääkärilehti, 2002.)

The main concern many doctors share in regards to patients' use of the internet is the quality of the information. (Silberg, Lundberg & Musacchio, 1997, 1244-1245; McLeod, 1998, 1663-1665) As the amount of information in the internet is expanding rapidly, doctors are worried that patients are coming across information that is disorganised or infrequently updated and, therefore, not only out of date but in some cases also misleading. There are no editing or publishing guidelines, quality criteria or peer review processes for health information outside of official sites such as academic journals or websites maintained by government or other authoritative organisations. False or misleading information may be circulated from one site to another and may therefore appear valid as it can be found on multiple sites.

Doctors also fear that patients can have difficulties in assessing the quality of information and locating sources from which quality information can be found. Some patients' internet searches are jeopardised by technical difficulties and insufficient computer skills. (Cline & Haynes, 2001, 677-680.)

Studies suggest that doctors believe that even though patients have access to the same information as their doctors, they do not possess the skills to assess the reliability of the information. This type of medical information can contain specialist terminology or be targeted at healthcare professionals. Doctors also worry that even if the patients come across reliable and good-quality information, they do not have the ability to understand and interpret it. (Murero, D'Ancona & Karamanoukian, 2001.)

Studies have shown that patients who use the internet to self-diagnose or to find suitable treatments prior to an appointment are said to be disapproved of by their healthcare provider as it is seen as time-consuming and potentially misleading. Yet, patients with an existing diagnosis who have used internet for gathering information in order to improve the management of their condition and symptoms are regarded much more positively by their doctors, as this is seen as complementary to the professionally led and managed care. (Malone et al., 2004, 189-191.)

A British survey of doctors' experiences of patients using the internet found that the doctors feel that when patients put too much faith in the information they find on the internet it undermines the faith they have in their doctor. (Potts & Wyatt, 2002) The concerns doctors have about the quality of the information can be considered as sincere concerns for the well-being of patients, but some studies suggest that patients have reported being disapproved of by their doctor when they have shared information found online. (Broom, 2005) Many doctors believe that only qualified health professionals are able to assess and interpret medical information. (Gerber & Eiser, 2001) As Broom (2005, 332) summarises: "It is [also] clear that some medical specialists view Internet-informed patients as a challenge to their power within medical encounters and, as a result, employ disciplinary strategies that reinforce traditional patient roles and alienate patients who use the Internet."

A recent study concentrated on the factors that limit patients from discussing internet-based health information with their healthcare providers found that patients are not bringing such information with them, as they are concerned about treading on the doctor's turf or anxious what the doctor may think of them or the information they bring. This has resulted in some patients discussing and sharing information with their doctors without disclosing its internet origins. (Imes, Bylund, Sabee, Routsong & Sanford, 2008) It is also quite common for patients to feel that the doctors are refusing their requests based on information found on the internet in order to control wider healthcare costs. (Gallagher et al., 2001 in Murray et al., 2003)

In order to systematically review the effects of the informatisation of patients on doctors, the assessment of the effects is divided into two categories: 1) the effects on practical tasks, 2) the effects on the doctor-patient relationship. However, in some cases the effects that the patients' internet use is having on doctors may fit to both categories, resulting in some overlapping.

6.4 The effects of the informatisation of patients on doctors' practical tasks

The benefits of patients' internet use reported by doctors are that some doctors see the internet as a useful clinical partner in patient management as it can relieve them from providing lengthy education and ongoing emotional support. (McLellan, 2004, 373) Doctors may feel that they can use the appointment time more efficiently with informed patients who obtain information from the internet and elsewhere, as they may not have to explain the diagnosis or condition in such detail. Informed patients may also be more likely and more able to ask the doctor questions relating to their condition and to discuss the diagnosis or treatment options. (Gerber & Eiser, 2001)

Instead of saving time, the idea of a patient as a shared partner or informed decision-maker can have the opposite effect. Previous studies have reported that internet-based health information can have negative effect on the practical tasks of the doctor. Some patients may be unwilling to accept treatments offered to them, while some patients are making incorrect and inappropriate self-diagnoses based on information obtained from the internet. (Ziebland, Chapple, Dumelow, Evans, Prinjha & Rozmovits, 2004) Some patients may ask for unsuitable or as yet unavailable treatments, or they may demand unnecessary examinations. The doctor may feel the time constraints of the short appointment time or have to use the appointment time correcting misleading information or debunking myths that the patient has come across on the internet.

Even high-quality information that is used well can challenge doctors, leading to increased demands by the patients for the doctor's time and services. (Potts & Wyatt, 2002) This may lead to an additional appointment, which then leads to an increased workload. Viewing what the patients may be viewing is also time-consuming. (Hart, Henwood & Wyatt, 2004; Houston & Ehrenberger, 2001; Crigger & Callahan, 2000) Internet-based health information can also be the cause of unnecessary visits to doctors, as patients may want to be 'sure' and confirm their treatment or diagnosis. (Murray et al., 2003) As patients can easily obtain second opinions and in-depth information from the internet, and hence become self-taught specialists on a specific condition, this may leave some doctors feeling vulnerable. The fact that the internet allows the patients to obtain information from the same source as their healthcare providers puts pressure on healthcare providers to stay abreast of the information and deliver high-quality care. (ibid.)

The internet also offers doctors immediate access to current information. Most doctors nowadays frequently use a computer for obtaining information such as guidelines and articles, for emailing colleagues and to obtain laboratory and other test results. (Murray et al., 2003) Also, the internet is having a levelling effect inside the medical profession, as primary care doctors now have easy access to many guidelines that were previously limited to specialists, and such access may ultimately moderate the boundaries between general and specialist doctors. (Hartzband & Groopman, 2010)

A 2002 article in the Finnish Medical Journal (Suomen Lääkärilehti) highlights the effects of patients' internet use on doctors. As the patients become more knowledgeable the role of the doctor shifts towards the role of a consultant or partner in the management of health. Health matters are increasingly discussed and negotiated together with the patient, changing the traditional flow of information from doctor to patient. The article also emphasises the effect that the vast quantity and wide availability of information has on the medical profession itself. Doctors are faced with the impossible task of staying abreast of new research and findings, and constantly updating their own knowledge base and expertise. (Suomen Lääkärilehti, 2002.)

However, if effectively used by the doctor, the internet could offer an inexpensive and easy channel for health information and patient education materials approved by the doctors themselves. (Richards et al., 1998 in Cline & Haynes, 2001) Also, in years to come electronic patient records will become more widely available. At least by then most doctors will need to feel comfortable using information technology as a central tool in the relationship with their patients. In the future, the attitude of the doctor towards information technology may be a characteristic that the patients evaluate when choosing their healthcare provider.

The concept of an active and autonomous patient who seeks additional information and is engaged in the decision-making process is said to be at the centre of the 'consumerism' movement in medicine and health. (Booske, Sainfort & Hundt, 1999 in Dutta-Bergman, 2005, 1) Easily obtainable health information has changed the position of the patient in the decision-making process and altered the traditional doctor-patient relationship. It is more likely than not that a patient will challenge in some way the knowledge on which the doctor's authority is based.

6.5 The outcomes of patient internet use on doctors and the doctor-patient relationship

The public responses of doctors regarding public access to health information through the internet have ranged from caution to hostility. (Hardey, 2001, 389) Defensive attitudes by doctors may arise from the internet having a 'levelling' effect on access to information, as it is contrary to the sole possession of medical knowledge that has been the norm in the past. (Gerber & Eiser, 2001) Until recently, the doctor had the sole responsibility for medical knowledge and the patient was only accountable for his or her own preferences. Some studies suggest that the dominant position of doctors in the doctor-patient relationship is disintegrating, as the doctor is no longer the sole custodian of medical information. (Hardey, 1999)

Doctors are increasingly encountering patients who come to the appointment with internet-based information. The patients may expect the doctor to interpret the information for them or discuss it with them. Often the patients also seek acceptance from the doctor for the information they have found themselves, and when the information obtained is contradictory somehow patients are more likely to consult their doctors. (Imes et al., 2008; Drake, 2009, 114) The way that the doctor takes this information into account can influence the course of the doctor-patient relationship and may even have an effect on the clinical outcomes.

It seems that it will take some time for doctors to adjust to their new position in relation to information-seeking patients. The study focusing on Finnish information seekers and producers confirms this, as only one patient reported being encouraged by their doctor to obtain information online. Also, none of the healthcare professionals participating in the study reported recommending the internet as a source of additional information for their patients. However, the patients reported positive attitudes by the healthcare professionals towards online healthcare information brought to the consultation. (Drake, 2009, 116.)

Furthermore, the healthcare professionals felt that patients searching information independently online may indicate a general interest in their health matters and that it can help them to better manage their condition. On the other hand, the same professionals felt that online information can increase tension

between the patient and the doctor in cases where the information is incorrect or conflicts with the doctor's view. This can further complicate communication between patient and provider. (ibid. 117)

Therefore, internet-based health information has the potential to enhance the communication in general between the patient and doctor, and it also offers a tool for improving responsibility by sharing the burden of responsibility for knowledge. (Gerber & Eiser, 2001) As Bylund et al. (2007, 347) have summed up from their study of provider-patient dialogue findings: "The internet has profoundly changed the way patients seek health information and, consequently, the dialogue between providers and patients about health".

Misinformation can cause unnecessary anxiety, while the sheer volume of information can leave patients feeling overwhelmed. (Potts & Wyatt, 2002) The information may also take the central role during the appointment and leave the actual matter, condition or treatment as secondary. (Anderson, 2001) Also, when patients request inappropriate clinical intervention or treatment, the doctors often feel pressured to grant these requests, as refusing may lead to dissatisfaction by the patients. In societies where healthcare is funded by the state, the patients may be left feeling that the doctor is refusing their requests in order to save costs rather than on a clinical basis. (Murray et al., 2003)

Optimistically, the increased participation by patients through internet-based health information in the management of health could in theory lead to better-informed health and treatment decisions, increased patient compliance and satisfaction, and a stronger doctor-patient relationship resulting in better medical outcomes and more efficient service. (Cline &Haynes, 2001, 675) Control over their illness or condition may empower patients to make informed decision themselves and even sometimes take actions they may have not otherwise taken. Some have even suggested that such empowerment makes patients more vigilant in terms of noticing symptoms, and hence seeking care, earlier. (Wald et al., 2007, 220)

Some doctors view interactive health communication as a threat to their traditional relationship with patients, as patients are potential specialists who are making healthcare providers feel disempowered and professionally insecure. (Houston & Ehrenberger 2001, 43; Malone et al., 2004, 191) The providers may be unable to deal with the volume of information available and patients may sometimes

possess greater knowledge on a detailed subject than their doctor. (Cline & Haynes, 2001, 675) The reluctance of some doctors to use reference materials in front of their patients, even though it may be vital in a given situation, may further alienate patients from their healthcare providers. (McLellan, 2004, 374)

Miriam McMullan (2006) has identified three ways in which healthcare providers are responding to the 'internet-informed patient'. The healthcare provider may feel threatened by the information brought to the consultation by the patient and hence react defensively, reinforcing their expert opinion. Contrary to this, some providers collaborate with their patients in order to obtain and analyse the information together. Thirdly, the provider may guide the patient towards reliable health information. Another study seems to confirm this, as it found that doctors who are aware of the internet use of their patients may serve as better partners, at least for patients with a chronic condition, by initiating discussion on where to access information. (Lizska et al., 2006)

Gerber and Eiser (2001) suggest a participatory model for decision-making in health matters in which the patient takes responsibility by disclosing preferences, obtaining information and weighting treatment options. The doctor's role is then to ensure that the information on which the patient is basing his or her preferences is correct and the treatment options are feasible. In this participatory model, the doctor has to make changes to the traditional role of the sole keeper and authority of medical knowledge in order to adjust to this new type of relationship with patients.

Even if the patient is not interested in becoming an 'informed partner' in decision-making, after the appointment the internet-based information can help them feel more at ease or satisfied with the treatment decision. (Gerber & Eiser, 2001)

Some studies suggest that patients' interest in finding information does not necessary go hand in hand with the interest in participating in the medical decision-making. (Levinson, Kao, Kuby &Thisted, 2005; Gerber & Eiser, 2001) It is also good to bear in mind that when evaluating the importance of external information, doctors and patients do not always agree about what is good quality or useful information. Even if the doctor guides patients to internet-based sources he values, the patient may think otherwise about such sources. In some situations the patient may ignore the recommended

evidence-based medical information and find information based on other patients experiences and narratives the most useful and supportive. (Potts & Wyatt, 2002.)

Some doctors may also prefer seeing informed patients, as studies have shown that such patients are more interested in maintaining their health and taking responsibility for their health outcomes. A large-scale American study found that factors associated with internet-based health information searching were socioeconomic, as those most likely to be seeking health information on the internet were young, well-educated and had higher incomes. (Murray et al., 2003) In such situations, the internet may in fact worsen inequalities rather than acting as an alleviator in diminishing social inequalities.

Finnish researcher Helena Tuorila (2004) notes that correcting the patient's inaccurate information or expectations itself reinforces the holistic nature of the medical profession. The profession itself has argued that a more significant risk to their profession than internet itself is the incorrect information that exists on the internet and the harmful effect it can have on people's health. The information itself is not enough, argues Tuorila; the person also needs to know how to apply and act on the information, in which case the health professionals are still very much needed. Doctors' expertise is also needed in understanding health as an entity and in correcting misleading information that the patient may have come across. (558-559.)

7 METHODOLOGY

7.1 Qualitative research

The purpose of my research was to examine the perceptions and experiences of medical professionals in relation to the availability of health and medical information on the internet, more specifically the availability and use of such information by patients as a challenge to the foundation of their profession. As my interests lay in the observation and evaluation of alterations in the social position of the medical profession, it was decided that the study would focus on examining the possible changes from 'inside' the profession, as perceived by the doctors themselves. Hence, the intention was to employ a research approach that allowed me to understand and investigate the changes in the position of the profession as experienced by the professionals themselves.

In general, the aim of qualitative research is to understand and describe the phenomenon that is being investigated in-depth. Often, qualitative researchers are interested in bringing up the personal experiences and viewpoints of their study subjects. (Berg, 1989, 2) Qualitative research techniques provide means of accessing unquantifiable facts about the subject under study. In the case of my research the purpose is to examine how doctors make sense of their own profession, professional attributes, status and authority over medical knowledge.

According to Patton (2002, 244) there are no set of rules for sample size in qualitative inquiry, and the sample size is often dependent on what the researcher wants to know, what is the purpose of the study, what is useful, what will have credibility and what can be done with the available time and resources. Kvale's advice (1996, 101) is to "interview as many subjects as necessary to find out what you need to know."

When conducting a qualitative study, rather than recruiting a large number of study participants, the number of research subjects can be small and carefully selected. A large amount of data or large number of respondents can lead to a superficial and shallow analysis of the phenomenon under study. (Eskola & Suoranta, 1998, 61) The aim of qualitative research is not to provide statistical generalisations or measurements, but to understand activities, describe processes or provide a theoretical interpretation of a phenomenon.

7.1.1 Recruitment of respondents

For the purpose of this study, 45 doctors were contacted by email, telephone and post in November and December 2006. Both public and private sector doctors were included, the only criteria for participation in the study being that the respondents must actively carry out clinical work with patients. The names and contact details were acquired from municipal health service websites, private healthcare service websites and from a database that holds details of over a thousand doctors in Finland.[5] The phone book and 'yellow pages' were also used to obtain names and contact details of doctors in the Pirkanmaa region.[6]

As Eskola and Vastamäki (2001, 37) advise, researchers should consider how the first interview request is received by the respondents as this may affect the acceptance of the request and the success of the actual interview. Contact was, therefore, initially made by email because of its convenience for both the researcher and the potential respondents. [7] The letter of correspondence can be found in the appendix. In the first round 24 doctors (12 from the public sector and 12 from the private sector) were randomly selected from the sources mentioned above. The first round of correspondence resulted in four interviews, seven refusals, and six returned requests due to invalid email addresses, with seven potential respondents giving no reply.

The second round of interview requests was sent by email three weeks later. The seven potential respondents from the first round who had not replied to the first email were again sent an interview request. The contact details of the six doctors to whom the email had not been delivered were checked and, where possible, a second request for an interview was sent. In addition, doctors whose names or contact details had been acquired from various acquaintances who were aware of the research were also contacted. Altogether, seventeen potential respondents were contacted, including six doctors whose contact details were acquired from the internet sources mentioned above. This round of requests resulted in four interviews.

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[5] www.etsilaakari.fi is a database that holds contact details of 1,020 doctors (March 19th 2007) who take on private sector work. Doctors can be searched by geographical area, area of specialty, name, sex or practice location.

[6] As geographical location was not considered a significant factor in the scope of the study, the recruitment of respondents concentrated on the Pirkanmaa region.

[7] As many doctors can only be reached by phone via a central reception in a health centre or clinic, it was thought that email would be a more personal and direct way to make contact. Unlike a short phonecall, it also allowed for further explain about the study aims and gave the respondents an easy channel to either accept or refuse the interview request.

One respondent was, introduced by a relative, recommended two other doctors known to him from medical school and through family relations. One of these respondents was approached by letter and the other by phone. The recommendation from one respondent to interview another was not seen as problematic since the purpose of the study was to study medical professionals' personal experiences of and attitudes towards the patients' internet use and, therefore, there are no 'textbook' answers that could have been formulated or shared prior to the interview.

On three occasions the potential respondents were approached by phone: in two cases to arrange a suitable time and place for interview and in to the third case to request an interview. The attempt to arrange an interview by phone with a potential respondent recommended to me by another contact proved difficult and time-consuming. The potential respondent was contacted on three different occasions by phone without success. He is employed in a busy municipal health centre in which doctors are only available for phone contact for a short period of time each day. Priority is given to patients with health complaints or prescription issues. After three unsuccessful attempts (incorrect phone number, an engaged line and the unwillingness of the receptionist to connect the call) the potential respondent was contacted by email. Despite these efforts and a recommendation from another respondent, he refused the interview.

All but two of the interview arrangements were made via email, which was an invaluable communication tool for contacting respondents and arranging interviews. It worked as a low-barrier tool in contacting the potential respondents and it also allowed relatively large numbers of prospective candidates to be contacted easily, affordably and non-intrusively. Email also enabled the respondents to either agree to or refuse the requested interview with relative easiness. This prevented a long list of pending interview requests, and it was possible to conduct the interviews within the planned timeframe.

Email was also a helpful tool in arranging times and places for interviews. It allowed the respondents to check their schedules and then agree a suitable time. It is possible that the usage of email in the recruitment of the study participants resulted in the study employing respondents that are more aware and comfortable technologically than the Finnish medical profession as a whole.

On the other hand, the majority of Finnish doctors use the internet and email as a routine part of their employment, for such tasks as research, diagnostics and accessing patient records, so it is possible that the use of email as the tool to contact respondents may not have resulted in a sample that is more technologically aware than the medical profession as whole. Also, all doctors who are members of the Finnish Medical Association (FMA) are provided with an FMA email address. It is therefore unlikely that the use of email resulted in highly biased sampling. Often studies are somewhat predisposed in relation to their subject matter and therefore it is likely that the agreement or refusal by a respondent to participate in a study is dependent on the subject matter of the inquiry. (Eskola &Vastamäki, 2001, 37)

7.1.2 The respondents

I conducted eleven interviews around the Pirkanmaa region between November 2006 and January 2007. Seven of the respondents were female and four male. Six are identified to be working in the public sector, four in the private sector and one in both sectors.[8] The respondents were aged between 29 and 68 years, and the years of employment as a doctor varied from six months to forty years. Five of the respondents were specialist doctors in the areas of dermatology and venereology, diabetes, general practice, geriatrics, internal medicine, neurology, and obstetrics and gynaecology.

Table 6. Description of respondents

Respondent	**Years in profession**	**Sector of employment (main)**	**Other information**
(R01) Female	27 years	Private	Specialist
(R02) Male	16 years	Private	Specialist
(R03) Female	10 years	Public	
(R04) Female	6 months	Public	On maternity leave
(R05) Male	40 years	Public/Private	Specialist, retired but acts as a substitute doctor
(R06) Male	23 years	Private	
(R07) Female	2.5 years	Public	
(R08) Male	17 years	Public	Specialist
(R09) Female	10 years	Public	
(R10) Female	26 years	Public	
(R11) Female	20 years	Private	Specialist

[8] Some of the doctors employed in the public sector also undertake some private sector work, but as their full-time employment is in the public sector they are identified as ‘public sector doctors’ for the purposes of this study.

7.1.4 Interviews

As Kvale (1996) has stated: “Interviews are particularly suited for studying people’s understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world.” (105). The purpose of interviews is to allow the researcher to enter into the other person’s perspective. (Patton, 2002, 341) By conducting these “conversations with a purpose” (Berg, 1989, 13) the researcher aims to capture something that is meaningful from the perspective of the respondent. Interviews were chosen as the method for data collection for the study as this method gives the researcher a chance to discover through interaction the things that are important to the respondent about the topic under study. (Eskola & Vastamäki, 2001, 24)

The structure of the interviews and the questions presented in the interview situations were predetermined. There were a few reasons for choosing semi-structured interviews to gather data. As a relatively inexperienced researcher, I felt that having predetermined questions and a clear structure for the interview would work as support tools in a situation that was new to me. The advance preparation of the interview questions gave me confidence and helped me to feel comfortable in the role of interviewer. The idea of group interviews was abandoned for similar reasons. Group interviews with elite segments of society are problematic in terms of access, and such interviews also require the interviewer to have a good knowledge of the topic in order to keep up an informed conversation. (Hertz & Imber, 1995 in Kvale, 1996, 101.)

Secondly, despite the implementation of predetermined questions, I was left with some room to spontaneously interact with the respondents outside the structured questions. Thirdly, by using semi-structured interviews I was able to focus on the aspects and features that are significant to the topic of my research. Finally, although all the respondents were presented with the same questions, the semi-structured interview structure allowed me to change the order of the questions if required by the interview situation. (Saaranen-Kauppinen & Puusniekka, 2006) For example, if a respondent provided me an answer that took the interview in a particular direction, I adjusted the order of the questions to fit the situation.

The interviews varied from half an hour to almost two hours in length. The language used was Finnish and the respondents were notified that the research report was to be written in English. The respondents

were informed about issues of anonymity (that no personal details such as the respondent's name or place of employment, or any other information from which the respondent may be recognised, would be published), confidentiality (the taped interviews would be handled by the researcher only and the interviews would not be used for any other purposes than the study in question). The respondents were also given a brief summary of the topic and aims of the research, and consent to tape the interview and use extracts from it in the research report was acquired.

Contrary to the advice given by Patton (2002, 352) to leave socio-demographic inquiries for the end of the interview, I asked the respondents to answer some socio-demographic questions regarding matters such as age, number of years in employment and about their level of use of the internet at the beginning of the interview. The respondents were also asked which term they prefer to use, patient or client, and the preferred term was then used throughout the interview. Rather than having significance for the topic of the research as such, the socio-demographic questions and the preference of the terminology were used as 'ice breakers' in order to "establish an atmosphere in which the subject feels safe enough to talk freely about his or her experiences and feelings" (Kvale, 1996, 125).

Three of the interviews took place in the respondents' homes, one in a café, six in an examination room and one in a respondent's office. Eskola and Vahäjärvi (2001, 27-29) have reviewed issues regarding the effect of the interview location on the course of the interview. For example, the interviews that take place on the respondents' 'home ground' have better rates of success with regard to fulfilling the aims of the research. Not only does the interview location have an effect on the respondent, it also affects the interviewer and, thus, the outcome of the interviews.

The interviews that took place in examination rooms or the respondent's office felt at first very formal, and it was more difficult for me to relax than in the interviews that took place in respondents' homes or in a café. In an examination room, it was challenging to switch from the normative role of a patient to the role of a researcher, but the interviews that took place in the homes of the respondents or in a café also had their drawbacks. During an interview that took place at the home of one respondent, the respondent had unexpected visitors and phone calls, which interrupted the interview. The interview that took place in a café was interrupted when the respondent encountered an acquaintance. In all cases, when the interviews were interrupted the tape player was turned off and the interviews resumed after

the interruptions had passed. As the interviews were being transcribed and analysed, it became clear that the issues with the interview locations had had less of an impact on the quality of the interview data than I initially assumed.

7.1.4 Content analysis & social constructionism

Content analysis may be "applied to substantive problems at the intersection of culture, social structure, and social interaction, and used to generate dependent variables in experimental designs and used to study small groups as the microcosms of society" (Weber, 1990, 11). As the position and structure of professions in a society are said to mirror the society in which they are embedded it was decided early on in the research process that for this study, content analysis was an appropriate technique for analysing the data. Content analysis, together with constructionist theoretical framework which puts emphasis on the knowledge being socially constructed, provided me with suitable 'scientific tools' to gain understanding of the subject under study and also to analyse the research material gained through the interviews.

Social constructionism is an approach that gives a central role to social matters in the construction of self and the world. Gergen (1994) has highlighted the basic suppositions of social constructionism. The terms we use to describe ourselves and our worlds are not dictated by our objects but by the terms through which we understand the world. We are ourselves social artefacts that are produced over historic time through exchanges between people within cultures. Therefore, any account of the world or self is sustained not by its objective validity but by social processes. (Victor, 2006, 39)

The constructionist approach can also be understood as claims of knowledge that are specifically constructed to satisfy the needs and interests of certain groups in society. As the interests and needs vary between different social groups, so do the definitions of knowledge and the accounts of social reality. (Vogt, 2005, 379).

The constructionist understanding is that people produce social reality through their speech. (Eskola & Suoranta, 1998, 139) Therefore, to understand the construction of social reality in relation to the subject matter under study, the interviews were analysed as representations of the social reality of the study participants. The aim of the study was to examine how doctors construct their professional autonomy

and authority in the context of patients' increased use of the internet and access to medical information. How is the medical profession and professional identity constructed in this context? Are these descriptions something new or do they relate to or fit existing models and theories of the medical profession?

Research projects often generate more data than is needed to examine the phenomenon under study in detail. Therefore, the data needs to be reduced to make it more manageable in order to study and understand the chosen aspect of social life. (Marvasti, 2004, 92) Regardless of the theoretical perspective of the study, all forms of qualitative analysis seem to be based on three procedures: 'data reduction,' 'data display,' and 'conclusion: drawing/verifying'. (Huberman & Miles, 1994, in Marvasti, 2004, 91)

Klaus Krippendorf (2004, 18) claims that: "content analysis is a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use." In its simplest form, content analysis is a research technique that can be used to systematically organise text into condensed, more manageable bits of data. The text is condensed into content categories that are pieces of text, phrases or even single words that are presumed to have similar meaning or connotations. (Weber, 1990, 12) However, this reduction of data should be done in a way that the material in question does not lost its informative content. (Tuomi & Sarajärvi, 2003, 110) At the same time, the data should be organised and analysed in such a way that drawing conclusions from the categorised and reduced content, in relation to the phenomenon under study, is possible. (Eskola & Suoranta, 1998, 61)

When analysing the content, the researcher must be systematic in the classification process. In order for the data to be considered as reliable it has to be consistent. The simplest way of conducting content analysis is to classify the data into categories. In the thematic analysis of the data, the data is organised under themes that either emerge from the data itself or are determined prior to the analysis. A step deeper from categorising the data under themes is to organise the data according to the special characteristics that appear central, typical or intrinsic in the data for the phenomenon under study. (Hirsijärvi & Hurme, 2000, 177; Tuomi & Sarajärvi, 2003, 95)

In theory, if another researcher would take on the research data, he or she should classify and code the data in a similar way. (Krippendorf, 2004, 18) Also, the classification process should produce valid variables, meaning that a variable should measure or represent what the researcher intends it to measure. (Weber, 1990, 12) The content analysis can be considered objective if the categories of the analysis are defined with sufficient accuracy so that the categories can be applied again and the same results are achieved.

According to Tuomi and Sarajärvi (2002, 93) the aim of inductive, content-driven analysis is to form the research material into a theoretical entity by isolating the information that is essential for the purpose of the study. When using content-driven analysis, the researcher is aiming to understand the data from the point of view of the interviewee or other source of the data. By employing inductive approach to the data, the analysis moves from the specific to the more general.

8 ANALYSIS & FINDINGS

I began the data analysis by reading the individual interviews several times in order to familiarise myself with the material again as quite a long time had passed since the interviews were conducted. However, I found it hard to 'let go' of the person behind each interview and, therefore, I also found it difficult to identify any themes or categories just by reading the interviews in their original form.

I decided to try another approach to organise and analyse the data. I took each individual interview and read it carefully. I created an Excel file in which the all the interview questions had their own column and then I copy/pasted text under the relevant columns. Not only did this process enable me to organise the data into more manageable form, but it also allowed me to get rid of any data irrelevant to the research questions. However, I still had 214 printed pages of Excel file consisting of 31 question categories (ranging from two to 24 comments under each category).

This stage may have been very time consuming but it helped me thoroughly familiarise myself with the data. Using Excel also made it easy to highlight relevant comments, key terms and phrases, as well as add my own comments, thoughts and observations to the matrix of data. Using Excel as part of the data analysis also helped me keep track of what material has been disregarded and which interview a sentence, comment or phrase came from. Most importantly, it enabled me to get rid of the strong association between an individual respondent and his or her replies.

As the amount of data was still vast, the next stage of the analysis was the reduction of the data. In this stage I found it necessary to remind myself of the research questions to keep me from getting sidetracked and so that I was left only with data that was central to the subject under study.

After the reduction of the data I started carefully reading the material that was left. I began to look for similarities and differences in the data and at the same time form subcategories to organise the data under. The number of subcategories was vast; I decided not to panic, but to rely on the fact that these numerous subcategories would be helpful when moving on to the next stage of analysis – forming broader upper categories based on the content. The data was conceptualised by joining the upper categories together when it was feasible to do so. These upper categories were then further classified

into main categories for the data. The process of data categorisation is illustrated in the tables that can be found under each main category of findings.

8.1 Background and context: Doctors' experiences of patients' internet use

The purpose of this section is to describe the patients' internet use as reported by the doctors and provide background information on the extent of patients' internet as well as to describe the patient population doing so and the purposes of use as experienced by the doctors.

All of the doctors were aware that some of their patients have used the internet for searching health-related information. Even thought the patients' internet use in relation to health was regarded quite a new phenomenon at the time of the interviews (2006-2007), it was also acknowledged by the respondents that the patient populace doing so is rapidly growing.

Some of the respondents noted that they discuss internet use for health information or internet-based health information with their patients on a daily basis. Some of the respondents reported seeing at least one patient like this, while some other respondents reported seeing several such patients daily.

Many of the doctors reported that their patients had mentioned during the appointment that they have used the internet for health information. Some respondents also mentioned that patients sometimes have questions to ask about the information they have found or they want the doctor to give an opinion on it. More often than not, the internet information is brought up verbally by the patients, but some of the respondents had experienced their patients bringing them actual printouts of information found online.

Some of the respondents had met patients who had used the internet for health information prior to the appointment, but the doctors were also aware that some of the patients were likely to go online after the appointment. One respondent recalled an experience where a patient had asked them to write down the name of the diagnosis so he or she could go and search the internet for further information.

The respondents were aware that many of their patients are interested in increasing their knowledge on an acquired diagnosis or an offered treatment independently. Two of the respondents considered this to be a natural response to an acquired diagnosis or offered treatment or medication.

A few respondents experienced patients' internet use as a means to find alternatives in situations that the diagnosis or treatment offered was considered incorrect or unacceptable by the patient. It was also noted by one respondent that patients use the internet to search for more affordable forms of treatment or medicine that they can then suggest to their doctor.

Also few of the respondents noted that patients do not necessary disclose the fact that they have used the internet for health information. Some of the doctors felt that patients mentioning their internet use for health-related purposes may be beneficial for both the doctor and the patient. Some other respondents, however, felt that it was not necessary to know of their patients' internet use with regard to health-related information. One respondent commented about such information being personal and the 'patient's own business', while another respondent felt that if the patient had nothing to ask about the internet-based information, she did not need to know about the patients' internet use with regard to health-related information.

Even if the patients do not disclose their internet use, sometimes the doctor just 'gets the feeling' that the patient has been using the internet for health information from the terms the patient is using during the discussion, what type of questions the patient is asking, or the way in which the patient brings his or her own ideas forward on the possible diagnosis or treatment during the appointment. A few of the younger respondents also expected their patients to be active in searching health information from the internet.

The doctors interviewed felt that the factors supporting the use of the internet were younger age, higher education and computer use in employment. Many of the doctors mentioned that women were more active users of the internet in relation to health matters. One respondent explained the difference between male and female use by the fact that men are perhaps less likely to mention that they have used the internet for health information during an appointment rather than actually being less active health information seekers. In the case of age, some of the doctors with elderly clients mentioned that

often the family members of such patients use the internet to find information on their loved one's diagnosis or treatment, and this information is brought forward during the appointment.

A few of the respondents also noted that educated patients were more likely to bring up the information found independently from the internet during the appointment. Some of the respondents considered employment as an important factor with regard to their patients internet use for health information in terms of having both access to such technology and the skills to use it.

Many of the respondents had an understanding of why patients use the internet for health information and the reasons behind the use. It was noted by a few of the respondents that it is no surprise to them that patients use the internet for health information as it is a tool that people use for so many other things in life, with health information being one of them. The easiness of use, availability and quickness of internet were identified as factors supporting use.

One of the respondents assumed that patients are sometimes motivated by worry, and the internet acts as an intermediate tool that enables them to assess if there is a need for medical assistance. In such cases, the respondent felt that the availability of health information on the internet may encourage patients who would not otherwise see a doctor to book an appointment.

Some respondents felt that those patients who take an active interest in their heath and well-being are more likely to use the internet for health information. Such patients use the internet as a tool for finding information and then use the information to actively take their matters forward for example by suggesting alternatives in terms of treatment, medication or diagnosis to their physician.

The internet use by patients was very accepted by the respondents in cases where a patient had a very rare condition (in terms of finding information and peer support) or if a person had an illness or condition that they felt uneasy or embarrassed about. In such cases, the respondents thought that the internet was used by patients because of the privacy factor, to find information that may have not be otherwise available to them, or to find peer support that would not be available in any other way (for example, because of geographical distance from other peer-group members).

8.2 New possibilities: The benefits of patients' internet use

When examining how the respondents experienced the benefits of their patients' internet use, six subcategories and three mid-categories were formed under the main category.

Increased knowledge	Patient	New possibilities
Increased interest in health		
Increased level of communication	Doctor-patient relationship	
More equal relationship		
Management of care	Doctor	
Own expertise		

Through the analysis, it became clear that as the internet and its use amongst patients is a relatively new phenomenon for many of the respondents. Similarly, the respondents regarded the advantages of internet use as something novel. Therefore, the patients' internet use was also perceived as something that offers new possibilities for the patient, the doctor, and for the relationship between the doctor and the patient.

"*mun mielestä siinä on potentiaalia vaikuttaa positiivisesti. Mitä se tällä hetkellä on niin vaikee ottaa kantaa mut mä näen siinä suuria mahdollisuuksia." (H11)*

"I think it has the potential to affect positively. What it is at the present time, I find difficult to have an opinion on, but I see great opportunities in it." (R11)

8.2.1 Patient: increased knowledge

Many of the respondents experienced patients' internet use for health information as beneficial in terms of patients' increased levels of awareness and knowledge of health matters that are important to them.

"pääpiirteissä se on ihan hyvä, että on mahdollista saada tietoa itselleen tärkeistä asioista…" (H01)

"in general it is good that there are opportunities to obtain information on matters that are important to oneself …." (R01)

To further increase their knowledge, the internet-using patients ask their doctor more questions than the 'regular patients'. Some of the respondents felt that such patients also expect to have further and more thorough discussions with their doctor.

“potilaat on ehkä sitten jotka käyttää sitä sitten niin jollain tavoilla valveentuneempia, osaa esittää heti eka kerralla vastaanotolle tullessa niin kuin kysymyksiä enemmän” (H02)

“the patients who use it are then maybe in some ways more conscious. When they come to the surgery the first time, they are able to present more questions right away.” (R02)

One respondent also noted that due to their increased knowledge, patients using the internet for health information are more likely than non-internet-using patients to bring up their own thoughts relating to their health matters.

“Hyöty on ehkä just se, että potilaat tuo esille rohkeammin niitä omiakin ajatuksia että mistä voisi olla kysymys koska se on tosi hedelmällistä nimenomaan keskustella yhteistyössä potilaan kanssa että mitä sille itselle tulisi mieleen, et mistä vois olla kysymys.” (H04)

“The benefit is maybe that the patients bring up more openly their own ideas and what could be the matter because it is precisely very fruitful indeed to discuss together with the patients what he or she thinks and what the issue might be.” (R04)

The respondent welcomed the patients’ own ideas as she considered them a fruitful addition to the collaborative care process in terms of increasing the dialogue between the doctor and the patient. Also, one respondent felt that the information available on the internet can help the patient to accept a diagnosis more easily when they are already familiar with the health matter.

“kyllähän se helpottaa, että ne on vähän perehtyny […]niin, ne tosiaan hyväksyy sitten diagnoosin paremmin.” (H03)

“it makes does makes it easier if they have prior knowledge[…] then they do accept the diagnosis better.” (R03)

8.2.2 Patient: increased interest in health

The respondents considered patients who use the internet for health information to be more actively taking a stance on health matters than non-internet-using patients.

“ne on niin kuin asennoitunut ehkä sillä tavalla aktiivisemmin kun semmonen, joka nyt pähkäillyt itsekseen eikä ole mitään tietoa hankkinut ja tulee ihan pystymetsästä …” (H02)

"they have somehow a more active mindset than someone who has just been mulling over themselves and not obtained any information, and come there unprepared…" (R02)

The internet is seen as a useful tool for engaging the patient in taking better care of his or her own health through independent information searching. One respondent also believed that the information available through the internet can act as an incentive for some patients to make an appointment to see a doctor that they would have not otherwise made.

"ehkä se internetistä saatu tieto on ohjannut sen potilaan yleensäkin hakeutumaan lääkäriin " (H07)

"maybe the information acquired from the internet has generally directed that patient to see the doctor." (R07)

A few of the respondents also felt that patients benefit from using the internet for peer support in health matters.

"Vertaistuki on aina tarpeen varsinkin mitä harvinaisemmasta sairaudesta on kysymys niin ilman muuta." (H04)

"Peer support is always important even more so if the illness is rare, then certainly." (R04)

By using such groups for discussion and increasing their knowledge, a few of the doctors felt that patients were able to obtain an additional source of support more easily than before.

"se on tapahtunut traditionaalisesti näissä potilasyhdistyksissä, jossa potilaat tapaa toisiaan …mutta tässä netissähän se on tietysti sitten helposti osallistua siihen…" (H02)

"it has traditionally taken place in patient associations where patients meet each other…but of course the internet makes it easier to participate." (R02)

Peer support is also something that some of the respondents felt that the internet could be really good for if the information and discussions are somehow controlled. It was felt that the wide availability of the internet can increase the willingness and possibilities to participate in peer support groups. The additional support of, and engagement in, peer support groups may encourage the patients to take better care of themselves than they would otherwise.

8.2.3 Doctor-patient relationship: increased level of communication

Many respondents had experienced situations where the patients' internet use had resulted in them as doctors having to be more communicative and use more time for dialogue with their patients.

“Tosin se kyllä tietyllä lailla lisää sitä työtä, siinä on se kuuntelu ja keskustelu tärkeämpää kuin aikaisemmin.” (H09)

“Although in some cases it does increase the workload, as listening and discussing have become more important than before.” (R09)

It was also suggested by a few respondents that the patients’ internet use has highlighted the importance of listening and having a discussion with the patients as a central part of the doctor-patient relationship.

“jos ihminen on vielä lukenut näitä niin se sitten hurjan tärkeä mun mielestä käydä lävitse, että sopiiks nää nyt yleensä tämmöseen ja sitten se, että millä tavalla lääketieteellinen päättely etenee. Et kyllähän meidän täytyy päästä semmoseen yhteiseen ymmärrykseen tästä asiasta[…] ehkä kaikista huonoin vaihtoehto on se, että potilas ajattelee jotakin ja lääkäri ajattelee jotakin muuta ja jos ei tää kommunikaatio synny niin sehän on aika huono vaihtoehto, koska sitten kummallakin on sen jälkeen oma agenda miten edetä.” (H11)

“if a person has been reading these things, then it is really important to go through, if it is relevant to the matters and how the medical reasoning proceeds. We have to reach a mutual understanding on the matter […] maybe the worst option is that the patient is thinking of something and the doctor is thinking of something else, and if there is no communication then it is quite a bad situation to have when both have their own agendas on how to proceed.” (R11)

Some of the respondents suggested that having experience of patients who have good levels of knowledge and awareness of their health matters due to internet use is reflected in the doctor-patient relationship as a certain level of easiness and speed in communication.

“ ja siinä tavallaan päästään niin kuin nopeammin […]tietyllä tavalla sanotaan ehkä helpottaakin, sitä potilaan kanssa kommunikointia.” (H02)

“and it makes it quicker[…]in some ways it maybe makes communication with the patient easier.” (R02)

The patient’s prior knowledge was seen as especially beneficial for both parties in cases where a patient has a rare medical condition.

“esimerkiksi potilaalla on joku harvinaisempi tauti, joka on mulle tuntematon niin useammalla tämmösellä potilaalla on sitten mahdollisuus tietää itse siitä taudistansa valmiiksi jo aika paljon jolloin sitten se vastaanottotapahtuma on mulle helpompi kuin se ihminen itse tietää siitä taudista.” (H01)

“for example, if the patient has some rare disease, unknown to me, many of these patients have the opportunities to gather quite a lot of prior knowledge on it. This then makes the appointment easier for me when the person already knows about the disease.” (R01)

It was also noted by one respondent that the duration of the appointment with such patients can also be shorter as it takes less time for the doctor to explain the diagnosis or treatment than it would to a non-internet-using patient.

"[Jos potilaalla] on jo valmiiksi hyvä käsitys siitä ja eikä tarvi niin paljon sitten puhua siitä koska aikahan on aina rajallinen." (H10)

"[If the patient] already has a good understanding of it, then there is no need for that much discussion as the time is always limited." (R10)

Some of the respondents still felt that patients' use of the internet has not affected the way in which they explain the diagnosis or treatment to patients.

"musta on tosi tärkeetä että joka tapauksessa puhutaan ihan selkosuomella ja alustavasti ja pohjamutia myöten ne asiat. Et jos mä lähtisin olettamaan, että tai suhtautumaan potilaaseen sillain että no et sähän tiedät nää jutut niin se ei ois kovin reiluu häntä kohtaan koska jos siellä onkin tiedossa joku aukko sitten se jää."(H04)

"I consider it really important that in any case we talk the matters over in clear Finnish, cautiously and covering all aspects. If I would assume or take an attitude that you know these things, then it would not be very fair on the patient if they have some gap in their knowledge, because it might stay that way." (R04)

Alternatively, some of the other respondents had experienced the patients' prior knowledge as the patients' ability to ask additional or more detailed questions on the matter than those patients who have not used the internet. Consequently, these doctors felt that they were able to provide these patients with a more advanced level of information than those who have not gained prior knowledge.

"Jos ihmisellä itsellä on jo tietoa, se osaa sitten kysyä siitä taudista jotakin, ettei tarvi ihan ö:stä alkaa…"(H03)

"If the person has already acquired some information, he knows to ask questions and we don't need to begin from the letter ö."(R03)

However, most of the respondents had experienced that the communication after the diagnosis had been made easier by patients' acquiring prior knowledge from internet sources.

"Jos nyt ajatellaan vaikka näitä lapsettomuushoitoja joista netissä on tosi paljon niin on toisia joilla ei oo hölkäsenpöläystä käsitystä niistä asioista ja sitten on taas sellasia jotka on lukeneet netistä ihan hirveän paljon. Kyllähän näiden potilaiden kanssa keskustellaan hyvin eri tavalla sitten ja lähdetään siihen keskusteluun." (H04)

"For instance, if you think about these treatments for infertility on which you are able find so much information on the internet, you have some who don't have a clue about these things and then you have those who have read a lot on the internet. With these patients you do begin the discussion at very different levels." (R04)

8.2.4 Doctor-patient relationship: a more equal relationship

According to the respondents, patients' use of the internet for health information has also contributed to the doctor-patient relationship in terms of making it more equal.

"Niin, että on sellainen tasavertaisempi suhde, joo kyllä… siinä on se kuuntelu ja keskustelu tärkeämpää kuin aikaisemmin."(H09)

"Well, yes that kind of more equal relationship…in which listening and discussion is more central than before." (R09)

As identified by the respondents, the increased level of communication is also a significant factor that has contributed to this development. One of the other factors that has played a role in the development of equality in the relationship is the fact that patients can now base their decisions on both the information provided by the doctor and that which they have gathered themselves as part of the decision-making about their own health matters, for example about treatment.

"*kyllähän me entistä enemmän varsinkin pitkäaikassairauksien hoidossa lähdetään siitä, että lääkäri ja hoitaja on näitä hoidollisia asiantuntijoita ja sitten taas ihminen tekee itse elämässään valintoja sen perusteella mitä me annetaan tietoja ja mitä hän on hankkinut tietoa …tässä on paljon semmosta keskustelua, että kuinka paljon se on niin kuin potilaan vastuulla ja kuinka paljon luotetaan lääkärin asiantuntemukseen."(H11)*

"with the treatment of long-term illnesses we are increasingly starting off from the situation where the doctor and the nurse are the experts in treatment but the person makes choices in his life on the basis of the information we provide to him or her and what he or she has acquired for themselves…there is a lot of talk about how much responsibility the patient has and how much weight is placed on the doctor's expertise." (R11)

A few of the respondents recognised the importance of patients' use of the internet as one of the factors that has been shifting the responsibility in the relationship towards more joint or shared decision-making.

"Tällä hetkellä tuntuu kuitenkin siltä, että ollaan päästy siihen normaalitilaan, että ensinnäkin numero yksi lääkärikin voi olla erehtyväinen, ei ole enää jumala jalustallaan ja tota sitten tämä tällainen neuvottelusuhde joka tapauksessa potilaan asioista näin nykymaailmassa täytyy ollakin… "(H06)

"At the moment it feels like that we have reached the normal state of things, in that number one doctor can get things wrong and is not some kind of god in his stance and number two there is this relationship based on negotiation on the patient's matter, and that is how it should be these days." (R06)

8.2.5 Doctor: management of care

A few of the respondents had experienced that patients' internet use can save time in the management of patient care. In some cases, patients' prior knowledge of health matters can have an effect on the time efficiency of the doctors' management of care in two ways: The patients' prior knowledge can mean a shorter appointment, or it can mean that matters can be covered in more detail during the appointment.

"hyödyt on varmaan on tämä et sinne voi sitten sitä aikaa säästää kun ihminen on jo tietoinen monista asioista." (H10)

"the benefits are probably that you can save time when the person is already knowledgeable about many things." (R10)

The other benefits that patients' internet use can have for the management of care as experienced by the doctors were that it may be possible that is easier for the patient to comprehend and absorb the diagnosis or the information when it is obtained from two different sources: their doctor and the internet.

"Se niin kuin syventää sitä tietoa kun se tulee kahdesta eri lähteestä tavallaan korvista ja silmistä niin se menee paremmin sitten sillä tavalla jakeluun." (H02)

"It intensifies the information as it is acquired from two different sources, the ears and the eyes, and then in that way it is also absorbed better." (R02)

It was also felt by some of the respondents that patients' independent information searching from the internet can contribute to the adherence of patients but also have an effect on the receptiveness of the patient to the doctor taking his or her matters forward.

"hyödyt tulee juuri siitä, että niin kuin paremmin asioista tietoinen henkilö … se niin kuin edesauttaa asioiden eteenpäinviemistä ja hoitoon sitoutumista." (H11)

"the advantages come exactly from that if you have a person who has good levels of knowledge…then it aids taking things forward and the commitment to the treatment." (H11)

It was also felt by some of the respondents that the patients' interest in using the internet for health information offers new possibilities for the current and future management of care.

"Se tarjoo mahdollisuuksia ja omalla tavallaan se, että niin kuin tätä intergroidaan tähän normaaliin työhön niin sehän on niin kuin tulevaisuutta." (H11)

"It offers possibilities, and in its own way when it is is intregrated as part of the normal work tasks, that is how it will be in the future."(R11)

One of the new ways identified by the respondents was the possibility to provide patients with reliable sources of online information. It was felt that patients could then use these sources to find out additional information on the diagnosis or treatment outside the appointment time.

"Tää vastaanottotilanne on kuitenkin aika lyhyt eikä siinä jää sitten kaikkea mieleen potilaalle niin vois sanoa et kato tästä, tää on niin kuin hyvä." (H09)

"This appointment time is, however, quite short and the patient is not able to take all of it in; then you could say have a look at this, this is one is good." (R09)

Some of the respondents felt that the provision of online sources to patients as part of the management of care is beneficial, as such information is not tied to the appointment time only. Patients are able to make use of such information at a time convenient or suitable to them. The patients are also able to concentrate on the matters that they themselves personally see as most significant in relation to the diagnosis or treatment.

"varsin usein mä puhun niille jotain juttuja niin ne unohtaa niin kuin 95% siinä vaiheesa kun ne kävelee ovesta ulos mut tuolta saa sitten kun vähän niin kuin alkushokki on ohi, että pystyy vähän sulattaan sitä informaatiota…" (H08)

"often, when I talk over some things with them they have forgotten 95% of it by the time they walk out the door, but then you can get some information from there after the initial shock is over and they can digest the some of the information a little bit…" (R08)

Additionally, a few of the respondents felt online sources could also be beneficial in preparing a patient for treatment or surgery and managing their expectations.

" Näissä hoidoissa oon ohjannut saamaan tietoa [x]sivuille ja sitten mulla on suomen kielellä erittäin monipuoliset sivut, josta saa ihan tietoa mitä pitäis tehdä ja mitä pitäisi välttää ennen hoitoa, miten se hoito toteutetaan ja mikä on sitten se niin kuin tavallaan hoidon jälkeinen tilanne ja ohjeet siitä hoidon jälkeisestä tilanteesta ja sitten sitä semmosta psyykkistä valmentautumista siihen, että nää odotukset olisi jollain tavalla realistiset ja muut että ne potilaat valmennetaan tavallaan siihen etukäteen." (H02)

"Regarding these treatment,s I have directed them to obtain information from [x] pages and then I have myself versatile pages in Finnish where one can get information on what you should do, what you should avoid before the treatment, how the treatment is implemented, what the situation will be like after the treatment, and instructions for aftercare; it is like training for the mind in that the expectations of the treatment would be realistic when you have already educated the patient about it beforehand." (R02)

8.2.6 Doctor: own expertise

It became clear from some respondents remarks that patients' internet use for health information has had an impact on doctors' own expertise. The respondents identified factors that support this observation.

A few of the respondents commented that as the patients have become more knowledgeable on health matters solely due to the health information available on the internet, the doctors feel they have to take better care of their knowledge base and expertise.

"No kyllä se laittaa enemmän lukemaan tietysti." (H03)

"Of course it makes you read more." (R03)

The respondents maintain their knowledge and keep it up to date by reading medical publications (both in traditional format and online) and by subscribing to services that provide them with news feeds on the latest studies and developments in their specialist field. Other than forcing the doctors to maintain their knowledge, the patients' use of the internet for heath information has increased the feedback doctors get from their patients.

" palautetta me lääkärit tarvitaan ja mulla on onneksi ollut semmosia potilaita, jotka jolta mä olen missannut jotain, jotka on sitten ottaneet muhun yhteyttä ja sanonut, että tää oli nyt tää juttu ja sää et huomannut sitä ja tota se on tärkeätä mun mielestä lääkäreille, että koska se on koko ajan lääkärinä oleminen on koko ajan prosessi jossa tietysti toivois et tulis aina vielä paremmaksi ja hoksaavammaksi ja kaikkea." (H01)

"Us doctors, we need feedback, and luckily I have had patients who have told me if I have missed something, they have contacted me and told that this and this you did not notice and I think that is important for doctors as being a doctor is an ongoing process, and in that process you hope to become better and more sharp, and everything." (R01)

Similarly, another respondent felt that the patients' internet use has made her reassess and re-analyse the ways in which she works.

"sillain voi vähän itekin miettiä ja katsoa et oliko nyt kaikki just niin kuin esimerkiksi vastaanotolla sanottiin ja tuliko puhuttua kaikki oireet."(H10)

"You also think yourself and check that everything is like you said in the appointment, for example, and if you mentioned all of the symptoms." (R10)

Some of the respondents felt that they have to think further ahead than normally, review their own expertise on the subject matter, or consider in more detail the comments when they encounter patients who use the internet for health information.

"Jollain tavalla laaja-alaisemmin pitää miettiä sitä jos joku jo tulee valmiin ajatuksen kanssa." (H10)

"In some ways, you have to think further ahead when someone comes with their ready-made thoughts." (R10)

Some of the respondents have also been in situations where the patient has been more knowledgeable than them on a matter as a result of internet-based information. A few of the doctors have experienced such situations as having a positive impact on their expertise in terms of giving them an incentive to update their knowledge accordingly with appropriate information.

"*jos se kertoo jostakin asiasta josta se on lukenut sieltä joka mulle ei ole ihan hirveän tuttu taikka ei ole viime aikoina ollut tekemisissä niin kyllähän se sen saa aikaiseksi, että menee ja tarkistaa ja ottaa siitä selkoo että mikä se tämän hetkinen tilanne on." (H10)*

"if someone tells me about something they have read from there and it is not really familiar to me or I have not been in contact with it for a while, it does motivate me to go and check to find out for myself what the current situation with it is." (R10)

8.3 Drawbacks of patients' internet use

Some of the respondents had had negative experiences patients' use of the internet for health information. The drawbacks identified were not so much to do with the actual use of the internet by the patients, but more regarding the quality and quantity of the information available as well as the lack of patients' skills with regard to assessing the information. Many of the respondents also felt that the patients' use of the internet for health information can cause unnecessary stress, worry and anxiety. Some respondents had also experienced that the patients' internet use is reflected on their tasks and content of their work negatively.

Quality and quantatity of information	Internet	Drawbacks of patients' internet use
Lack of skills	Patient	
Anxiety		
Reflections on doctors' tasks	Doctor	

8.3.1 Quality and quantity of health information

Many of the respondents' main worries about the patients' internet use concerned the quality of information.

"Internet nyt on tietysti semmonen mistä on helppo hakea et nythän tää ongelma on tietysti se, että mikä luotettavaa tietoa." (H11)

"The internet is, of course, something that is easy to search, but the problem is what is reliable information?" (R11)

Another drawback of patients' internet use identified by the respondents was the quantity of information available.

"On se just et kun sitä tietoa on niin paljon ja sitä semmosta….puolueetonta niin kuin tietoa voi olla vaikea löytää ja siellä on ihan mitä tahansa, saattaa olla että laatu voi olla joskus heikompaa."(H07)

"The facts is that there is so much information and that kind of…unbiased information can be hard to come across, and there can be anything; it might be that the quality can sometimes be poor." (R07)

Several respondents felt that as the information available on the internet is not quality controlled, meaning that quality varies from site to site, it makes it hard for patients to discover objective and reliable information.

"Sehän on varmaan kaikkien mielestä vähän kaksipiippuinen juttu mutta tosiaan tiedon taso voi nyt sitten vaihdella kauheasti ja se riippuu siitä mihin sattuu lättäämään sen sormensa sitten ja mihin tutkimukseen." (H01)

"To most, it is probably a matter that has two sides to it, but the quality of the information can certainly vary tremendously, and it depends where you happen to stick your finger and to which research." (R01)

In regards to quality of information, many respondents were concerned about the fact that anybody can upload information to the internet and that health information sites exist without anyone, especially health care professionals, controlling them.

"No lehdissäkin vielä jonkinmoinen kontrolli on…mutta tuonne chatti-palstalle voi, kai sielläkin vissiin vähän mutta kyllä sinne voi melkein mitä hyvänsä kirjoittaa, niin kyllähän sieltä voi kaikenmaailman tuota levitä tämmönen puppukin tieto." (H05)

"Well, you have some kind of control in magazines…but to the chat rooms anyone can. I suppose there is a little bit of control, though anyone can write anything, and then all sorts of information, even nonsense, can spread." (R05)

A few respondents also mentioned that a further drawback was the pace that information spreads on the internet in particular when the information is misleading or incorrect.

"tieto leviää niin kuin kulovalkean tavoin Internetissä.." (H02)

"information on the internet spreads like a forest fire." (R02)

For a few of the respondents, patients' internet use for health information was considered problematic as some sites are unable to clearly distinguish factual information from advertisements. This may not only confuse the patients, but also have an effect on both the objectivity and quality of the information.

The concern of one respondent with regard to patients' internet use was not to do with the availability of poor-quality information, but rather with the fact that patients are able to access sites meant for health professionals. She felt that the drawback in this case was the patients' lack of skills in terms of understanding and reviewing such information.

"Nimenomaan pitäis mun mielestä olla sillain että hakee sitä tietoa sitten niiltä sivuilta mitkä on potilaille tarkotettuja."(HO7)

"It should be precisely so that if one searches for information, then it should be from the sites that are meant for patients." (R07)

8.3.2 Patients' lack of skills

Many respondents also raised concerns about the patients' skills and abilities with regard to using the internet for health information. Some of the respondents were worried about the patients' level of computer skills. Some also made a connection between the level of computer skills and the quality of information the patients come across.

"Kyllä se varmaan just tää, että jotka sitä paremmin osaa käyttää niin myöskin sitten löytää enemmän..." (H09)

"It is probably just that those who know how to use it wll also find more…" (H09)

The majority of the respondents felt that the patients' lack of skills in assessing and evaluating the information they come across was a major disadvantage in relation to their internet use. The

respondents felt that patients do not necessarily have the skills to critically assess the information they find.

”se on sitten vaan se, että osaako siihen suhtautua kriittisesti vai ei niin sehän on se kysymys.” (H04)

“Then there is that if one is able to assess the information critically or not. That is the question. (R04)

The respondents were also concerned that the patients may be lacking the necessary skills for filtering factual from commercial information.

”Ne ei sitten välttämättä löydä sitä osuutta sitten siitä, että mikä osuus internetissä olevaa on mainosta ja mikä on sitten faktaa.”(H06)

“They are not necessarily able to find those parts from there, which parts on the internet are advertisements and which parts are facts.” (R06)

According to the respondents, one of the drawbacks of their patients’ independent use of the internet for health information was the patients’ inability to distinguish between relevant and irrelevant, and valid and invalid information.

“ne ei pysty suodattamaan sitä ja sitten tota siellä on paljon semmosta turhaa tietoa mikä ei itse asiassa pidä paikkaansa.”(H08)

“They are able to filter it and there are is much of the kind of pointless information that simply is not true.” (R08)

The respondents also felt that patients often lack objectivity when searching for health-related information.

” se ihmisen objektiivisuus häviää siinä vaiheessa kun se sairastuu.”(H08)

“a person loses his objectivity at the point in time when he or she becomes ill.” (R08)

A major concern held by many of the respondents was that many of the patients are drawn to details or concentrate too much on fractured pieces of information in their information searches that are insignificant in relation to the overall health issue.

“ihmiset aika usein saattaa sitten kiinnittyä semmosiin yksityiskohtiin, jotka ei ole kokonaisuuden kannalta ehkä kuitenkaan olennaisia.” (H11)

“people are often drawn to those kinds of details that are not relevant for the big picture.” (R11)

One respondent also noted that sometimes, the patients use the information acquired from the internet to self-diagnose without the necessary skills or an understanding of medical terminology.

”jos se itse lähtee diagnosoimaan niin yleensä mennään mettään, koska he ei sitten välttämättä ymmärrä sitä terminologia eivätkä osaa monikaan tietysti tutkia itseään.” (H03)

“If the person begins to diagnose themselves, it often goes wrong as they don’t necessarily understand the terminology. Needess to say, not many know how to examine themselves either.” (R03)

8.3.3 Anxiety in patients

The majority of the respondents commented that one noticeable disadvantage of patients using the internet for health information is the anxiety and worry that the acquired information can cause in some patients.

“Enemmän ehkä haittaa on ollut just siitä, että on tullut huolestuneisuutta siitä, että on kuvitellut, että on joku tauti.” (H01)

“It has caused more harm in terms that it has increased worrying, that one has imagined that one has some disease.” (R01)

The respondents felt that often, patients search for information in relation to symptoms they are experiencing.

”Jos on esimerkiksi pelko jostain taudista jonkun oireen perusteella sitten ne helposti vahvistuu nää vääränlaiset asiat, et tulee niin kuin pelkoja.” (H09)

“For example, if one has a fear of some disease on the basis of some symptoms, it can strengthen the incorrect matters and bring about fears.” (R09)

Harmless illnesses can have similar symptoms to more serious illnesses. Sometimes patients use the information to ‘match’ their symptoms or to self-diagnose, and this can cause unnecessary worry.

“… jos on yhtään taipuvainen löytämään itsestään erilaisia oireita niin varmaan löytää. Ja kun on muutaman sivun lukenut niin on hirveän sairas.” (H10)

“…if one is at all prone to finding different symptoms from oneself, then one certainly will. And if one reads a few pages then one becomes very ill.” (R10)

The respondents felt that a further disadvantage was that because patients have access to all types of pages, the information available could scare and upset them. It was also noted that this could have negative effects on the well-being of the patients.

“joku syöpäpotilas oli käynyt jollain syöpäsivuilla kanssa, niin siellähän saattaa olla tosi rajujakin juttuja kyllä, että siinä on se vaara että sitä sitten ahdistuu vielä lisää.” (H09)

“a cancer patient had visited some cancer sites, and there can be brutal things there; there is then the danger that one becomes even more anxious.” (R09)

One respondent felt that sometimes patients are excessive in their information searching, aiming to find all the information available on a particular subject matter. She had experienced that the patients are rarely in need of all the health information that is readily available for them. These patients are risking ‘information overload’.

“Niin elikä ettei sellaiset herkät helposti panikoituvat ihmiset ei ne tarvitse sitä kaikkea informaatiota. Ne voi huonosti siitä jos sitä informaatiota tulee liikaa.” (H10)

“So those sensitive people who panic easily do not need all that information. They suffer if there is too much information around.” (H10)

8.3.4 Reflections of patients internet use on doctors’ tasks

Several respondents felt that the patients’ use of the internet for health information increases their workload. Internet-using patients often have questions to ask based on the information they have come across.

“Siihen kommunikointiin menee enemmän aikaa tietysti.”(H06)

“The communication, of course, requires more time.” (R06)

Also, internet-using patients may be more interested in health matters in general and therefore also more willing to discuss health matters in addition to the internet-based information with their doctors. Some of the respondents felt that the patients’ internet use has increased the time pressures in their daily work.

“Eihän olenkaan kaikki potilaat tuo näitä asioita esille mutta ne jotka tuo niin kyllä siinä keskustelussa helposti aikaa menee sitten enemmän kuin mitä muuten menisi[…]Siinä [internetissä] on just tää et se tekee lisää kysymyksiä.” (H09)

“It is not that all patients bring these matters up, but with those who do, the discussions easily take more time than would otherwise be used[…]That is exactly it, as it [internet] increases the amount of questions .” (R09)

In addition, the respondents noted that patients' internet use is reflected in their employment as extra work.

"joskus se teettää tosiaan ylimääräistä työtä." (H08)

"sometimes it does indeed cause more work. (R08)

According to the respondents, patients' use of the internet for health information can sometimes complicate matters in terms of diagnosis and increased interaction with the patients.

"sanotaan niin, että se hieman monimutkaistaa jossakin tilanteessa."(H10)

"let's say that it complicates things a little bit in some situations." (R10)

The respondents felt that compared with regular patients, with internet-using patients they have to justify their decisions in more depth and provide more detailed explanations.

"…vie tosi paljon aikaa sitten perustella et minkä takia jotain tutkimuksia ei esimerkiksi tehdä…et pitäis sitten niin kuin vastata kaikkiin niihin kysymyksiin mitä se Internet on herättänyt tässä ihmisessä..." (H07)

"…it takes a lot of time to provide explanations about why some tests are for example not taken…then one should answer all those questions the internet has brought up for that person…"(R07)

The respondents also noted that changing the patient's mind when their opinion is based on incorrect or inaccurate information found on the internet can be very difficult.

"kun on liikaa informaatiota jonka oikomiseen menee aikaa ja sitten se että tosiaan että uskooko se ihminen mua." (H10)

"there is too much information that needs to be corrected, and then there is also the question of whether the person believes me or not." (R10)

The respondents have also been faced with demands based on the information the patients have found on the internet.

"Jos sattuu olemaan sellainen potilas joka lähtee vaatimaan hirveesti eikä oikein suostu kuuntelemaan sitä mikä se normaali hoitoketju on niin silloinhan se vaikeuttaa toki." (H04)

"If you happen to have the type of patient who demands a lot and will not listen to what the normal procession of care is, then it complicates things, obviously." (R04)

One respondent felt that it was sometimes difficult to give the patient good reasons for why something is not available or the norm for treatment in Finland, as the patients have access to information (for example, treatment guidelines or criteria) that may only be valid in other countries.

"No lähinnä just varmaan tää, että mitkä on Suomessa, mitkä hoidot olemassa ja ylipäätänsä diagnoosi." (H03)

"Well, mostly that what is in Finland, what treatments exist and the diagnosis overall." (R03)

A few respondents mentioned times when they have been in a situation with their patient that had resulted in a conflict due to disagreement over the diagnosis, required tests, treatment criteria or medication.

"*ehkä joutuu ottamaan jos ei joku usko niin kuin jonkun tutkimuksen, jonkun labratestin" (H03)*

"if someone does not accept something, maybe then one has to carry out some check-up or some lab test or something." (R03)

Contrary to the general assumption, the respondents felt that patients' use of the internet for health information is not reflected in their employment as patients who are more health conscious or healthier than those who do not use the internet.

"Riippuu aika paljon kyllä tilanteesta mutta kaiken kaikkiaan vois melkein sanoa, että se on enemmän niin kuin negatiivisesti vaikuttanut…ne jotka hoitaa tavallaan terveyttään hoitaa …Sitten taas nää jotka ei hoida terveyttään, ei sitten välttämättä etsi sieltä Internetistäkään mitään" (H09)

"It depends a lot on the situation, but all in all it can be said that it has had more negative effects…in a way those who take care of their health do care…Then there are those who do not take care of their health and do not necessarily search anything from the internet." (R09)

Interestingly, the respondents also brought up the fact that the ever-expanding quantity and availability of information is reflected in their employment as a pressure to keep up with the latest news and research in their field.

"..tuntuu että se tietotulva on niin valtava kun on lehtiä ja kirjallisuutta ja sitten se Internet ja sitten kun on oikeasti se päivätyö ja siitä pitäis pystyä irrottamaan erikseen aikaa. […]Et koko ajan itellä on semmonen olo et haluis lukee enemmän kuin mitä ehtii. "(H04)

"…it feels like the information flood is so massive and there are magazines and literature and then the internet; then one has the daily tasks and one should find time away from those to have some time for that. […]I feel all the time that I want to read more than I have time to read." (R04)

8.4 The impacts of patients' internet use on the medical profession

The two previous chapters of analysis have concentrated on the benefits and drawbacks of patients' internet use for health information as experienced by the respondents. This third and final chapter focuses on describing how the respondents have experienced the patients' use of the internet in terms of the impacts on their profession.

The impacts of patients' internet use on doctors' profession		
Autonomy	Authority	Responses

As discussed in the previous chapters of analysis, the patients' internet use has had an effect on the relationship the respondents have with their patients, on the content and tasks of their employment, as well as having an impact on the patients themselves.

The ways in which the respondents experienced the impacts that patients' internet use have had on their profession varied greatly. Some of the respondents felt that in the eyes of the profession itself or in the eyes of the public, their profession has not been affected significantly by the patients' internet use.

"En mä nyt mitenkään kauheasti koe sen muuttaneen asemaani millään lailla." (H10)

"I don't feel like it has changed my position at all." (R10)

Conversely, other respondents were even able to recall a specific situation when they felt that their professionalism had been challenged by an internet-using patient.

"hän tuli vaatimaan, että pitäis näitä kalium-arvoja ja muita seurata ja [...] mä olisin suositellut kuitenkin ihan tavallista tämmöstä painonhallintaryhmää ja muuta ja siinä meillä meni ihan vähän sukset ristiin siinä." (H07)

"he came demanding that his calium and other levels should be followed [...]I would have recommended just a normal weightwatching group or something, and that is where we disagreed." (R07)

8.4.1 Autonomy

Many of the respondents felt that the patients' use of the internet for health information is just one of several factors that have had an effect on the autonomy of their profession. The respondents noted that

the other aspects that are having an impact on their ability to function independently and make decisions without involvement from others are time pressures, lack of training opportunities, scarcity of resources (public sector), work quality assessments, commercialisation, political decisions and judicial matters.

"No ne resurssit esimerkiksi jos mä ajattelen sitä itsemääräämisoikeutta että, tarttis et usein tuntuu et tarttis paljon enemmän aikaa hoitaa sitä potilasta kun mihin oikeasti on mahdollisuuksia." (H04)

"For example, the resources in regards to the autonomy, I often feel that much more time is needed to treat a patient than we really have the possibilities for." (R04)

A few of the respondents felt that some patients come to the appointment with their own set of ideas on the diagnosis, which can have an effect on the doctor's thought process and the process of diagnosing.

"jos on joku semmonen simppeli juttu ja että heti näet että tällä on tämä ja sä sanot et sulla on tämä niin se ei ole enää nykyisin niin helppoa koska se ihminen on voinut katsoa jo ja sillä on itsellänsä kymmenen eri diagnoosia et sitten sitä alkaa vähän miettimään…" (H10)

"If it is some simple thing and you straight away see that it is this and you tell the patient that, it is not so easy nowadays as the person may have had a look beforehand and he or she then has ten different diagnoses in mind. It also makes you wonder…" (R10)

Some respondents felt that due to the patients' internet use for health information, their expertise and professional judgment is no longer the exclusive tool used in diagnosis and making decisions. Doctors also now have to take patients' knowledge into account.

"kyllä se ennen oli ehkä helpompaa tai se on väärä sana mutta ….vapaammin pystyi niin kuin miettimään niitä asioita ja ja ajattelemaan mikä se nyt."(H10)

"it used to be easier, or easier is the wrong word but…you used to be able to ponder and think about things more freely than you can nowadays." (R10)

Few respondents also noted that patients might question their doctor's ability to make decisions or to diagnose if the decision or diagnosis differs from the information they have acquired from the internet.

"on olemassa ihmisiä, jotka sitten kyseenalaistaa kaiken sen mitä se asiantuntija eli lääkäri sitten sanoo sillä perusteella mitä ne on jostain löyhästä tiedosta Internetistä saanut niin se on joskus semmonen aika hankala tilanne." (H01)

"There are some people who question everything the expert, the doctor, says on the basis of some loose information that he or she has acquired on the internet; that can sometimes be a difficult situation." (R01)

One respondent noted that patients who use the internet may speculate over the decision or diagnosis their doctor has given more than non-internet-using patients.

"Kyllä se on muuttanut, että nyt siinä on tämmönen niin kuin spekulaatiopuoli esiin siinä että, tässä kuin on näin ja näin niin onko tällä merkitystä." (H09)

"Yes it has changed it. There is this kind of speculative aspect present there, is it like this or like that? Is this meaningful?" (R09)

The patients' internet use is also forcing doctors to keep up their own knowledge in order to maintain autonomy in their work.

"Ei se niin kuin uhkia sinänsä aseta mutta kyllä siinä ehkä semmonen puoli on olemassa jollain lailla pitäisi itse pysyä skarppina siinä mitä on et pystyis niin kuin vastaamaan ja ottamaan kantaa…" (H09)

"I don't think it is causing any threats as such, but there is that side to it that somehow you have to stay on the ball about things to be able to give an answer and express an opinion." (R09)

8.4.2 Authority

Doctors' authority is a legitimised form of power that is afforded them by the public. The authority that doctors possess is based on their claims of exclusive knowledge, skill and expertise over medical tasks. The majority of the respondents had experienced their authority being affected by the patients' use of the internet. Other factors the respondents felt had had an impact on their authority were prioritisation of patients and tasks, time pressures (familiarising themselves with new practices or guidelines, maintaining their expertise and skills) routinaisation of work and information overload.

"…niin se asiantuntijuuden uhkahan on tietysti aika… on paljon lääkäreitä, jotka ei…pidä kunnolla asiantuntijuudestaan huolta. Meidän asiantuntijuuden huolto on puutteellista. Sitten unohtuu ja sitten tietysti rutinoituu joihinkin juttuihin… tosiaan asiantuntijuuden uhkana on se, että ei ole uteliaisuutta ottaa selvää uusista tutkimustuloksista…" (H01)

"…well the threat to expertise is time…there are a lot of doctors who do not…take care of their expertise. Maintenance of our expertise is inadequate. You forget and then some things become routines…the threat to our expertise is that there is no curiosity to find out about the latest research…" (R01)

Some of the respondents have encountered patients who sometimes value the information they have independently acquired from the internet more highly than the information provided by their doctors.

"tämmönen niin kuin roskalaatikosta ammennettu tieto, niin se on heidän itsensä kohdalla, se on arvokkaampaa kuin se mitä terveydenhuollon ammattilainen sanoo 20 vuoden kokemuksella heille. Se on ristiriitaista…." (H08)

“This type of junk information, they consider it themselves in their case to be more valuable than what a healthcare professional with 20 years of experience says to them. It is contradictory…” (R08)

A few of the respondents described situations where they have found it difficult to persuade the patients to trust their expertise over the patient’s own internet-based information.

“sitä on vaikea sitten niin kuin saada kumotuksi oikeastaan paljon millään argumenteilla sitä, että miksi se tieto oli väärin.” (H01)

“it is difficult to invalidate, with any arguments, why the information was wrong.” (R01)

One respondent’s knowledge had been questioned by a patient in a situation where she and the patient did not share the same opinion on the suitable treatment.

“hän kans laittoi, et hän oli jonkun kautta siellä netissä saanut tiedon että, et se ei niin kuin olekaan tuo se hoitoalue, jossa se pitäisi olla vaan jotakin muuta.” (H10)

“She informed me that she had received information from somebody over the internet about the margin for treatment being not what I gave her, but something else.” (R10)

Some of the respondents have been faced with a situation where a patient is either demanding a certain type of treatment or test on the basis of internet-based information.

“on ollut tapaus josta jäi sellainen tunne, että hän ei ollut tyytyväinen ennen kuin sai sen reseptin ,jonka hän oli ilmeisesti internet haun perusteella katsonut itsellensä tärkeäksi.” (H06)

“There has been one instance where I got the feeling that he was not satisfied before he got the prescription that he himself regarded as vital.” (R06)

On this occasion, the respondent felt like he had to prescribe something to the patient that in his professional belief was not needed.

A few respondents noted that having to convince a patient that the internet-based information they have come across is not necessarily applicable or accurate is at times not only difficult, but also increases their workload.

”et kun oikeen kuuntelee sitä niin sitten tulee semmonen, että se aiheuttaa lisää työtä meille kun meidän pitää sitten niin kuin kääntää niiden päät, että ei niin kuin tää oo totta. Ja varsin usein se tilanne valitettavasti on se, että ne ei usko.” (H08)

“When you really listen, what comes from it is more work for us as we have to persuade them that it is not true. And unfortunately, the situation is that they often do not believe us.” (R08)

The experience of their authority being challenged by a patient on the basis of internet-based information had left a few of the respondents feeling like they had failed as professionals. Also, some respondents noted that as a professional it is hard to comprehend why their expertise and experience sometimes count for less than the information the patient has acquired from the internet.

“*vaikka se lääkäri tekisi hyvää työtä ja tietäisi mitä se tekee ja tekisi ihan oikein niin voi olla, että se saa huonon lääkärin maineen niin jos se ole päässyt samaan tulokseen kuin se potilas on tullut itse etukäteen etsimällä sitä tietoa netistä.” (H01)*

“even if the doctor does good work, knows what he or she is doing and does it right, it may be so that he gets a reputation as a bad doctor if he or she has not reached the same conclusion as the patient on the basis of information from the internet.” (R01)

Conversely, some respondents felt that the patients’ internet use for health information has not had a significant impact on their authority. These respondents felt that if they explain matters well and in enough detail to their patients, this appears sufficient justification of the respondents’ expertise over the patients’ internet-based information.

“aika harva potilas nyt varmaan niin kuin kuitenkaan nyt niin kauhean vahvasti ois siinä niin kuin kiinni niissä netin mielipiteissä, että useimmat kuitenkin luottaa siihen lääkärin sanaan enemmän.” (H09)

“not that many patients are so strongly attached to the internet-based views; after all, many of them still put more trust in the words of the doctor.” (R09)

8.4.3 Responses

As described in the previous chapters, patients’ internet use for health information has had an impact on the medical profession in Finland. From the experiences of the respondents, it was also possible to recognise the responses of the medical profession to the changes that have taken place. With regard to patients’ internet use, the respondents’ experiences vary from viewing it as beneficial to viewing it as harmful, and the ways in which the doctors have responded to the changes also vary.

Some of the respondents’ responses to the patients’ internet use were highlighted with preconceptions about the internet as a whole.

”nyt varmaan mennään siihen mitä mä olen tässä vähän kritisoinut. Siellä on epäasiallista tietoa tai ainakin sellainen mielikuva on tullut. Mut mä olen sikäli huono ihminen arvioimaan sitä, kun mä hyvin harvoin tai jos juuri koskaan käyn itse siellä sivuilla katsomassa mitä siellä on.” (H10)

“now we are touching that which I have criticised here along the line. There is inappropriate information, or at least that is the impression I have. But I am a bad person to assess that as I rarely or hardly ever use the internet to see what is available there.” (R10)

Most of the respondents use the internet or internet-based resource libraries daily and regard it as an invaluable tool in their employment. This could be one of the reasons why the responses of the respondents to the patients’ internet use were fairly positive in tone, since they themselves had an understanding of the benefits of the internet.

Some of the respondents’ responses to the patients’ internet use have been to accept it as a novel aspect in the doctor-patient relationship.

”potilas katsoo netistä, että tää on tää niin sitten se on niin kuin joillekin se saattaa olla semmonen niin kuin kolaus omalle arvovallalle lääkärinä...ei siihen mun mielestä tolleen saa suhtautua. Jos potilas löytää jotain niin sitten sä vaan kommentoit sitä.”(H08)

“a patient sees on the internet that something is like this; this can be a blow to some doctors’ authority…I don’t think you can react to it like that. If the patient finds something, then you just comment on it.” (R08)

However, it became apparent in the process of analysis that the patients’ internet use has had an impact on both the doctor-patient relationship and the autonomy and authority of the doctors. Interestingly, the patients’ internet use has also had an effect on the ways in which the doctors view their work, their own expertise and their professionalism. It can be observed in the novel ways that the respondents have constructed to deal with internet-using patients and in situations that may occur with such patients. From these experiences we can construct an image of a ‘new expertise’.

8.4.3.1 New expertise

This form of ‘new expertise’ can be understood, for example, in terms of how the respondents are aware of, and open to, their patients’ use of the internet.

”mun mielestä se on semmosta johon tarvii osata suhtautua, koska musta on luonnollista, että ihmiset lähtee hakemaan sitä tietoa.” (H11)

I think it is something you need to know how to react to. I consider it natural that people search for information." (R11)

One respondent felt that it is important for him as a professional to be knowledgeable about what is going on in the virtual world in relation to his field of expertise, in terms of what is being discussed by the public and the availability of information to the public. It was felt that this increased his understanding of why something is important to his patients and also why patients may bring up a certain matter during the consultation.

"joka toinen uusi potilas joka tulee... niin ensimmäisenä ottaa tän asian puheeksi, että hän haluaa sitten tällaisen ratkaisun sitten." (H02)

"every second patient that comes…it is the first matter they mention, that they want this type of solution to it." (R02)

The respondents have found new ways to interact with those patients who use the internet and bring up the information they have acquired during appointment.

"mä kuuntelen sen kyllä ja näin mutta mä en fiksoidu siihen ajatukseen minkä he itse esittää niin kuin sitten analyysina niin kuin niistä oireista, että mä niin kuin keskityn enemmän niihin oireisiin." (H02)

"I do listen but I don't get fixated with the thought they themselves propose as an analysis of their symptoms, I focus more on the symptoms." (R02)

A few respondents felt that they have had to learn how to handle patients who have independently obtained information from the internet. Doctors may aim to 'diagnose' the level of knowledge that the patients have in order to keep the discussion at a level appropriate to the patient's knowledge. Not only do they have to navigate between their own expertise and the patients' acquired knowledge, but they also have to find appropriate ways of correcting invalid information and justifying their reasons for doing so.

"täytyy löytää sopivat tavat keskustella tämän ihmisen kanssa siihen jos katsoo toinen on väärillä teillä ja täytyy perustella minkä takia tämä nyt ei ihan paikkaansa hänen kohdallaan. Ja siinä joutuu luovimaan eri tavalla. Et voi suoraan sanoa, että tässä on sinun tautisi ja lääkkeesi näkemiin vaan siinä tarvitsee keskustella enemmän. " (H06)

"You have to find suitable ways to discuss with that person if you consider that they are on the wrong track and you have to provide an explanation of why something does not apply to him or her. You have to navigate in certain ways, then. You cannot just say, 'Here is your disease and medication, goodbye.' You have to discuss more." (R06)

Some respondents felt that they are also having to assess the part that they give on the patients' information in the doctor-patient relationship.

"ei nyt kuiteenkaan ihan sivuuttanut sitä kuitenkaan että tota…kyllä mä olen huomioinut sen jollain lailla siinä mutta en ole kuitenkaan antanut sen hallita sitä vastaanottoa että lähettäis käymään niitä papereita läpi tai muuta." (H07)

"I have not just skipped it…yes I have noticed nit in some ways, but I have not let it dominate the appointment in such a way that we would go through the printouts or something." (R07)

The 'new expertise' may also include a readiness to assess the importance of the information to the patient and act accordingly, as one of the respondents had done.

"mutta voi sitten olla heille tärkeitä jolloin ne sitten tietysti tarvitsee käsitellä." (H11)

"but it can be important to them, so naturally it needs to be dealt with." (R11)

One respondent also noted that it is likely that the role of the patients' own information will increase in the future and play a part in some cases in the decision-making on treatment or tests. This form of 'new expertise' could be recognised in the way the respondents have searched for and reviewed information together with their patients. As one respondent had done, the new expert may also be providing their patients with internet-based sources for recommended reading.

The new expertise requires the doctor to increasingly look after their own knowledge base. One respondent felt that the patients' internet use for health information also encourages her to use the internet more. She uses it to check the information the patient had mentioned or to keep her knowledge up to date. One of the traits of the new expertise could also be recognising the fact that it is impossible to keep up with all of the latest information and still be an able professional.

"Enkä mä toisaalta kauheita paineita ota siitä, että pysyy ajan tasalla kun sitä tietoa tulee joka tapauksessa niin paljon ei sitä pysty kukaan hallitsemaan sillä lailla." (H09)

"I don't put huge pressure on myself to stay up to date as there is so much information around it is not possible for anyone to master." (R09)

A few respondents noted that the patients' use of the internet has opened up new possibilities for the construction of the doctor-patient relationship, too. Some of the respondents see their role increasingly being that of an objective expert or gatekeeper who negotiates with the patient instead of an authority

who tells the patients what to do. Some of the respondents also saw the patients' internet use as a factor that is bringing about a more equal relationship between doctor and patient, and in this way it is also having an impact on the way the medical profession is perceived by patients and the profession itself.

"*[…]terveydenhuollon henkilöstö joutuu miettimään tämän asiantuntijuuden uudestaan ja tää teettää että mä en näe sitä uhkana vaan mahdollisuutena." (H11*)

"[…]healthcare personnel are having to reconsider this expertise, and I think this makes me consider it not as a threat, but as an opportunity." (R11)

9 DISCUSSION & CONCLUSION

9.1 Discussion on findings

The aim of this study was to evaluate the impacts that the patients' use of the internet for health information has had on the medical profession in Finland as experienced by the doctors themselves. For many of the doctors participating the internet represented a novel aspect of the doctor-patient relationship, yet it is clear from the findings that the medical profession has been affected in various ways by patients' use of the internet. The ways in which the doctors have experienced the patients' use of the internet for health information was also varied. This chapter examines the effects of patients' internet use on the understanding and construction of the medical profession.

Some of the doctors felt that due to the use of internet, the patients have become more aware about, and conscious of, health matters. According to the doctors, patients who use the internet for health information are also more likely to formulate their own ideas and have an opinion on matters relating to their health. Similar findings have been reported from earlier studies with cancer patients and their family members as well as with women who are deciding on hormone replacement therapy. (Edgar et al., 2002; Hart et al., 2004)

As previously theorised by Cline and Haynes (2001), some of the doctors participating in this study suggested that the internet is a good tool for engaging a patient in terms of motivating them to take greater interest in their health; in some cases it can even facilitate the patients in accepting their diagnosis more easily. In addition, the doctors also felt that the patients' use of the internet has boosted the dialogue they have with their patients.

Earlier studies (for example Eysenbach, 2003) suggest that patients can benefit from using the internet for participating in online support groups. Similarly, the doctors in this study identified the ability of patients to access and take part in peer support groups as one of the benefits of the patients' use of the internet for health information.

Nevertheless, some of the doctors noted that they were concerned about the lack of professional control over the content of such sites. Uncontrolled content can be harmful in terms of incorrect and invalid information and can result in unnecessary anxiety in patients that doctors then have to alleviate. Cotton and Gupta (2004) identified the benefits of online support groups as the sense of empathy and understanding the patients gain from fellow members and something many patients feel that their doctor cannot offer. However, this was not recognised as a factor for patients' internet use by the doctors participating in this study.

Some of the doctors reported that the patients' internet use has had an apparent impact on the relationship they have with their patients. As suggested by Gerber and Eiser (2001), some of the doctors in this study also felt that the availability of health information on the internet has the potential to enhance the communication between them and their patients. In terms of the patients, the doctors felt that they are expected to be more communicative and open to their ideas. Some doctors also noted that the patients' internet use has reinforced the importance of listening and initiating discussion with patients.

The benefits of patients' increased knowledge on health matters due to internet use have in some cases resulted in easier and quicker communication with the patients. A few of the doctors also noted that the patients' internet use has contributed to the relationship becoming more equal in terms of both joint decision-making and allowing the patient to have a say in, and responsibility for, their health matters. As noted by Åkesson et al. (2004), access to the internet can make the patients feel more independent, confident and empowered, which in turn encourages active participation.

The doctors also felt that the patients' internet use has had an impact on the ways in which they manage patient care. A few of them also suggested that the patients' internet use has led to increased adherence of patients but that sometimes the patients independently acquired prior knowledge also saves time during the consultation. Corresponding to the findings in Drake's study (2009), some of the doctors also felt that if the patient obtains information from their doctor in addition to other sources, it can help the patient to more easily understand the information. In relation to just obtaining information solely from their doctor, the benefit of internet information for patients is that they can access and make use of it at their own convenience and also select the information that they feel is best suited to them

personally. These factors may not only increase the sense of control patients have over their own health matters, but also ease the workload of the doctors.

The internet can benefit the patients and have positive impacts on the doctor-patient relationship. However, as noted by earlier studies (for example, Potts & Wyatt, 2002; Hart et al., 2004) and the findings of this study, the doctors' experiences of patients' internet use is not entirely positive. Often, the doctors are required to spend more time communicating with the patients who have used the internet in order to correct invalid information, justify their viewpoints and explain their decisions. In terms of their tasks, the doctors felt that the internet-based information obtained by the patients can unnecessarily complicate matters and result in increased workload and time pressures.

As reviewed in studies such as Sillberg et al., 1997 and McLeod, 1998, for many doctors the main concern with patients' internet use is the quality of information. In the same way, the doctors in this study criticised both the quality and quantity of internet-based health information in relation to the patients' internet use. These quality and quantity issues, together with the fact the patients lack the skills to assess the objectiveness and reliability of the information as well as the skills to apply it, is reflected in the doctors' work not only as increased workload, but also as patients' anxiety and stress, inappropriate demands, and aims to self-diagnose. However, as noted by Hardey (1999, p.827), sometimes the issue of the quality of information is used by the medical profession as an "attempt to retain and redefine boundaries around medical expertise."

What, then, are the impacts on the medical profession? According to a few of the doctors interviewed for this study, in regards to their profession nothing has changed as a result of patients' use of the internet for health information. As evaluated in the sections above, others felt the patients' internet use had had an impact on the role of the patient, the doctors' interaction with their patients, the construction of the doctor-patient relationship, as well as on the maintenance of their expertise and the ways in which they manage care and take care of their tasks.

The findings suggest that the patients' internet use has had an impact on the autonomy of the medical profession. Patients who use the internet can have their own set of ideas about a suitable diagnosis or treatment prior to the appointment, and the doctors' ability to diagnose and make decisions

independently is compromised. Patients may also question or challenge the doctors' expertise, knowledge and professional judgement on the basis of the information obtained from the internet.

It appears that doctors are increasingly having to take into account the patients' interests, knowledge and opinions on health matters. This more prominent role of the patient in the provision of healthcare is impacting the ability of doctors to control the content of their work. In addition, in order to maintain their autonomy and opportunities for independent decision-making, the doctors are required to keep up with the latest information in order to retain the knowledge base on which their profession is based.

Some of the doctors in this study noted that they have encountered patients who sometimes value the information that they have themselves acquired from the internet above that which is presented to them by their doctor. This factor, along with other experiences reported by the doctors, gives credence to the fact that the patients' internet use has also had an impact on the authority of the doctors. The doctors in this study had experienced difficulties in persuading and convincing their patients that the diagnosis they have made or treatments or medications they have prescribed were appropriate.

On a few occasions the doctors have had to either prescribe medications or provide a referral for further tests due to demands from the patients. Patients also challenge doctors' authority when they question the doctors' knowledge and expertise based on the information they have found on the internet. These findings indicate that if not diminishing, the authority that the doctors possess is at the very least changing in its form.

The impacts on their profession experienced by the doctors can and should be examined in the light of the theories of profession. As many of the theories of profession are Anglo-Saxon in their tradition, there are a few factors which we should keep in mind when examining the impacts of patients' internet use on the medical profession in Finland. Firstly, it is important to remember the historical and social context in which professions developed in Finland. The development of professions in Finland has been affected by the unique environment characterised by the strong role of the state, the class structure, the development of the welfare state, and the existence of state-led universities as the sole educational pathway to professions. (Konttinen, 1996) Secondly, we have to take into account that there are many other factors affecting the medical profession, its status, and its autonomy and authority.

Patients' internet use has had an effect on two of the core characteristics of professions as identified by Sarah Nettleton (1995). For an occupation to be considered a profession it has to have specialised knowledge at its core. Only the members of that profession have access to this knowledge, on which their expertise and authority is also based. The other characteristic that the patients' internet use has had an impact on is the professions' assumed freedom from external interference. Not only do the patients have access to the specialised knowledge, but they are also able to use that knowledge to voice their own opinions or challenge those of the doctor.

However, if we evaluate the impacts on the profession resulting from patients' internet use from a functionalist perspective, the changes to the construction of the medical profession can be seen as necessary. Professions are important for the functioning of the society. As the society develops in the direction that is needed, the professions are also required to change in order to ensure the functioning of the society. Hence, it can be argued that the process of the informatisation of society could be used to explain the need for the medical profession to further specialise or even sub-specialise, as the patients are increasingly becoming 'general experts' on health matters.

Johnson (1972) stresses that the position a profession has gained in society is based on the dependence of the consumer on the services provided by the profession resulting in the dominance of the profession. However, as can be observed from the findings of this study, patients do not seem so dependent on the doctors being the sole providers of expert knowledge. It can therefore be argued that internet use by patients has shrunk the traditional knowledge gap that exists between the medical profession and the patients. Rather than being a relationship characterised by uncertainty from the patients' side, having access to information has enabled the patients to have a say in the relationship with their doctor.

For Larson (1977), the position of the medical profession is often explained by the need for its services. The medical profession has been successful in gaining and maintaining its monopolistic position through its claims of superior skills and knowledge as well as its devotion to human welfare. As patients now have an access to the same information as the medical profession, the profession's credibility and authority based on claims of superior knowledge is being challenged by the patients' use

of the internet. Also, due to the patients' use of the internet, the doctor-patient relationship is no longer protected from external influences, resulting in a weakening of the control held by the medical profession.

Freidson (1970) argues that the position held by the medical profession in society is explained by the protection it has received from the state. Freidson believes that the medical profession uses its skills and expert knowledge to justify the position it has in society but this position would have not been achieved without the support of the state and the elite. This arrangement has enabled the medical profession to have total occupational control over medical matters – a professional monopoly which has merely been beneficial for the profession itself despite the claims that such a monopoly is for the protection of the clientele, too. State protection may no longer be sufficient to secure the position of the medical profession in society, as the patients now have access to the expert knowledge. This challenges the justifications the medical profession has had for the maintenance of its dominant position.

Oppenheimer (1973) and Haug (1973, 1988; Haug & Lavin, 1983) already suggested some decades ago that the dominance of the medical profession was in decline. They note that increased specialisation of information, technologisation of medicine, and rationalisation of activities, together with an increasingly educated and critical patient population, have led to the decline in the authority of medicine and the reduction of its monopoly. The findings of this study seem to some extent to support some of Oppenheimer and Haug's ideas, as some of the doctors reported that they struggle to keep themselves up to date with the vast amounts of information available. Also, the patients' internet use is having an effect on the content of their work and the doctors are no longer in charge of the tasks that define their profession. For example, doctors now have to take into account patients' preferences in terms of medication, treatment or even diagnosis. The increased need for communication is both adding to doctors' workload and increasing time pressures. In addition, the doctors have to find novel ways to interact with the increasingly knowledgeable patients that are not only suitable to them, but also to the patients.

In the light of these findings, it is good to note that Haug already in 1977 predicted the impact that computerisation of occupational knowledge has on profession: it is likely to lower the public legitimacy afforded to the medical profession and the degree to which the profession is able to control its work.

Nevertheless, in order to determine whether or not the cultural and social authority of the medical profession has been challenged, we would also have to examine the patients' experiences. The theories of proletarianisation and deprofessionalisation lack specificity and do not offer alternative outcomes on how the medical profession may evolve and respond to the challenges it will encounter in the future.

It seems so that the major issue is in fact that the characteristics or attributes that have been used to define the medical profession are changing. The position of the medical profession in society has to a certain extent been explained by the profession's expertise, skills and knowledge. As patients have access to health information through the internet, the medical profession is unable to justify its position by using past characteristics of the profession such as exclusive access to knowledge. The internet has acted as a tool that has enabled the patients to question and challenge the foundations on which medicine as a profession is based. It is also possible that the changes initiated by the patients' internet use have changed the medical profession own understanding of profession and also had an impact on the way the general public conceptualise the medical profession.

Becker (1970) was right in stressing that the concept of profession is never static. People use their moral criteria to construct 'the ideal of profession', an unwritten standard that evaluates the worthiness of an occupation. This image of 'the ideal of profession' is used by people to determine whether or not they can put their trust in the occupation. The ideology linked to the ideal of profession legitimises the autonomy and authority that a profession has over its tasks. However, as society changes, so do the criteria that are used by people to form the ideal of profession.

As can be observed from the findings of this study, the doctors had experienced situations in which they felt that their role as a medical professional had been challenged by the patients. The doctors were able to describe the ways in which they have experienced patients' internet use and its impacts on their role, tasks and relationship with patients. As patients now have access to the same information as their doctors, it is likely that this has had an effect on the criteria that the patients use in evaluating the merits of the medical profession.

This change in the criteria may explain why the patients are questioning the expertise and knowledge of their doctors and therefore challenging their authority and autonomy. It is difficult to determine the

extent to which the patients' internet use is responsible for the change in the criteria or in the changed expectations patients have of their doctors. Nevertheless, it cannot be denied that something is changing in the way in which the patients perceive and assess the essence of the medical profession. One example indicating such a change, as experienced by one of the doctors in this study, is the willingness of patients to place their trust in internet-based information rather than in the expertise of their doctors.

Interestingly, Abbott's (1988) approach to professions, which is more often used in researching service occupations, seems valid in evaluating the impacts that patients' internet use has had on the medical profession. Abbott stresses that rather than concentrating on the autonomy of professions, we should focus our interest on the processes through which professions constitute and reproduce themselves, including changes that take place in the arena that professions operate in and the way in which the professions respond to these changes.

It was discovered in this study that the doctors are responding to the impacts on their profession brought about by patients' internet use. This form of 'new expertise' includes doctors using internet-based resources themselves and using the internet as a tool to keep up with the latest information. A few of the doctors felt that an important aspect of being a professional nowadays is being aware of what is happening in the virtual word in terms of what is being discussed by the public and what information is available to them. One aspect of new expertise is also looking after their own knowledge base, as expert knowledge still remains a core characteristic of the medical profession.

The responses of the doctors to their patients' internet use also incorporate being aware and open to the patients' use of the internet, and finding new ways of dealing with such patients. The new expertise enables the doctors to reinforce their expertise in a new form by 'diagnosing' the level of a patient's knowledge and then using this diagnosis to match the level of discussion and information provided to the level of knowledge the patient has. The doctors have also responded to the new expectations patients have of them by learning suitable ways of correcting invalid information the patient may have. Doctors are also having to find new ways to reinforce their views as medical professionals, as they are increasingly expected to navigate between their own expertise and the patients' knowledge.

The doctors' ability to assess the importance that the patient's own information has for the patient and the ability to evaluate the role they are going to give on the patient's own information in the management of care as well as in the doctor-patient relationship can be considered as new forms of expertise. The medical profession may respond to the impacts resulting from by patients' internet use by adapting to the role of an objective expert or gatekeeper who negotiates with patients. Such a response may also offer new possibilities for the construction of a more equal doctor-patient relationship.

The doctor-patient relationship may benefit from the doctors' new expertise in terms of increased mutual trust. The doctor believes in the patient's skill to find suitable information and the patient openly discloses and discusses the information he or she has come across. Furthermore a form of new expertise can be the ability of the doctor to accept the patient's knowledge and expertise on certain matters. Patients may also expect that the doctors' role is shifting towards being an expert who digests or rationalises the information they have independently acquired. The descriptions of new expertise by the doctors follow the suggestions of contemporary theorist of late modernity such as Giddens and Beck. It is believed that the modern form of expertise is open and the expertise is based on the profession's ability to assess risks and solve problems. To respond to the demands of the late modernism, the profession's expertise may be more narrowly focused than before but this is seen itself as production of new expertise. (Giddens, 1991, 31-32).

These changes in the construction of medical profession that are at least partly initiated by the patients' internet use are challenging the doctors to assess and re-evaluate the core characteristics of their profession. The processes that the profession chooses in order to maintain the autonomy and authority of their profession in the future will have direct implications on the status given on the profession in society.

9.2 Conclusion

The theoretical traditions of the study of profession are diverse and, as noted earlier, the understanding of the meaning and function of professions differs greatly among social scientists. It is important to continue studying professions because they reflect the cultural, social and moral values of society;

therefore, changes in the definition, composition and function of professions can mirror deeper and wider societal changes.

For years, the medical profession has been successful in promoting its expertise based on skills and knowledge, which has enabled it to become part of the structure of the society, but also to control the conditions in which it operates. The medical profession has been well protected from major external challenges to its expertise, autonomy or authority by the protection of state, strong collegiality and solid labour market position. Doctors have been challenged by the patients in the past but not to this extent.

The changes in the perception of medical profession are the result of many factors; the availability of medical information via the internet is one of these factors, and is challenging a core element of the medical profession: monopoly over medical knowledge. The ease of access to understandable medical knowledge through online sources of health information is challenging the knowledge which characterises the profession. At the same time, this ease of access to knowledge produces increasingly aware and informed patients, who are transforming the tasks which define the medical profession. The changes in the perception of medical profession' are not only occurring externally, in the eyes of the public but also inside the medical profession.

The internet by use by patients has had an effect on the expectations patients' have towards their doctors. The patients' expectations are reflected in the tasks that define the medical profession. As patients are more demanding, knowledgeable, active and opinionated, in response the doctors are expected to be more communicative, supportive, co-operating and open to patients' ideas. In contrast, the internet using patients are more likely to be interested in health matters which make it easier for doctors to discuss with them, engage them in the doctor-patient relationship and recognise the value of patients' willingness to take responsibility of health matters. The medical profession has had to assess their role, find ways to respond to these expectations and learn to deal with patients who use the internet in relation to their health matters.

Whether or not a doctor considers the outcomes of patients' internet use as positive or negative, it must be taken into account because it has an impact on their work. Rather than concentrating on the

drawbacks that exists in regards to patients' internet use or ignoring the fact that patients use internet doctors have to learn how to take the patients internet use into consideration as part of their job. Taking patients' internet use into account could simply mean discussing about the information the patients have acquired or providing them guidance in their information searches. As the patients' internet use is likely to increase in the future, it may be that doctors will require additional training, guidance and protocols – a set of 'best practices' on how to successfully interact with patients who use the internet for health information. Also more attention should be paid on the quality and relevancy of information provided by doctors and other authoritative sources. What they may regard as high-quality and useful information may not be considered that by the recipients of the information. Subsequently, the role of the health care users as providers of health information should not be overlooked.

It is more likely than not that the number of patients using the internet for health information is going to increase in the future. The challenge facing the Finnish medical profession in relation to patients' internet use is the changing demographics (aging population). In years to come there will be a growing number of 'silver surfers', who will have time on their hands and the means to purchase the necessary technology to access and use the internet. Doctors have to be prepared for the fact that older patients may be using the internet for health information and be aware of the impacts it can have on their work. As the elderly population continues to grow, it may be expected that this section of the population begins to take more responsibility for its health in order to keep healthcare costs manageable. Integrating internet use into care management is one possible approach. The increase in the number of 'silver surfers' is likely to have an effect on the content of health information and on usability issues.

It is possible for some patients to become experts in finding suitable information on the internet that helps them to take care of their own health matters. Patients can use the internet information to become specialists in regards to a disease or condition. However, it is a misconception to think that all the patients who use internet want to become experts or use the internet for diagnosis instead of consulting their doctor. Patients' internet use is not invalidating the need for the expertise held by medical profession and the services provided by doctors.

As a social scientist I know that for this study to be considered reliable, it should in theory produce the same results when replicated by other researches. However, I believe that social scientists are people too and it is unrealistic to think that we are able to completely let go of our own social reality and value

judgements when conducting research. I do believe that the results of this research can be considered 'stable'; I do believe, however, that they are a reliable representation of the experiences of the respondents in relation to the topic under study.

In regards to the validity of the study, I believe I have been quite successful in both measuring what I intended to measure using the chosen methods and in accurately summarising the phenomena under study. However, if I were to undertake this task again, there are a few things I would do differently. Firstly, I would aim to define the scope of the study in the early stages of the research to stop me from reading and gathering vast amounts of information that is even loosely related the subject matter under study. Secondly, I would reduce the number of respondents, since I ended up with a huge amount of data that was fairly difficult for a first-time researcher to handle. Thirdly, I would use the experience I have gained from the interviews to help me more easily probe the respondents for supplementary information and to get them to clarify their replies. However, through the analysis of the data this time around I discovered information that I had not initially considered asking about, i.e. the responses of the medical profession to the changes occurring. Finally, I would take into consideration the effort that needs to go into accurately translating the interview extracts from Finnish to English without losing any meaning.

The subject under study is still a very topical one and were I to study if further, I would examine it from various angles, one being how patients experience doctors' responses to their internet use and what impacts this has on the patients. Additionally, it would be fascinating to go deeper into the subject matter by using Abbott's system approach to examine further the ways in which the medical profession responds to these changes and reinvents itself. Obviously, it would also be interesting to conduct a follow-up study to evaluate how the respondents experience their patients' internet use and its impacts now that five years have passed since the original interviews.

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10.1 Appendix 1: Request for interview

Hei!

Nimeni on Jenni Fredriksson-Bass ja olen viidennen vuoden sosiologian opiskelija Tampereen yliopiston yhteiskuntatieteellisestä tiedekunnasta. Opiskelen kansainvälisessä maisterinohjelmassa, jonka yhtenä pääteemana on tietoyhteiskunta ja sen kehitys Suomessa.

Olen valinnut pro gradu -tutkielmani aiheeksi tarkastella Internetin vaikutusta lääkärien asiantuntijuuteen ja työnkuvaan Suomessa.

Tarkoituksenani olisi haastatella noin 8-10 eri-ikäistä ja eri sektoreilla toimivaa lääkäriä ja näin ollen kerätä lääkärien omia kokemuksia Internetistä ja erityisesti siitä, miten asiakkaiden Internetin käyttö vaikuttaa lääkärin työnkuvaan sekä asiantuntijuuteen.

Nyt kysyisinkin kiinnostaisiko teitä lähteä haastateltavaksi?

Kyseessä olisi noin 45 minuutin – 1 tunnin pituinen haastattelu (jonka mielelläni äänittäisin, jos se teille sopii). Tutkielmassani en tule luonnollisesti mainitsemaan nimiä, työpaikkaa, työpaikkakuntaa tai en muutenkaan paljasta haastateltavan henkilöllisyyttä. Käsittelen vastaukset yleisellä tasolla, joten yksilöt eivät nouse merkittäväksi tutkimustulosten raportoinnissa. Jos teillä on kysyttävää tutkimuksestani, mielelläni annan lisätietoja.

Olisin hyvin iloinen, jos suostutte osallistumaan ammattianne koskevaan tutkimukseen. Pidän aihetta hyvin ajankohtaisena ja mielenkiintoisena ja olisin kiitollinen avustanne siinä.

Otan teihin uudelleen yhteyttä noin kahden viikon kuluttua ja siten mielenkiinnostanne riippuen sopiakseni haastatteluajankohdasta. Vaihtoehtoisesti voitte ottaa minuun yhteyttä joko sähköpostilla alla olevaan osoitteeseen tai puhelimella alla olevaan numeroon.

Ystävällisin terveisin

Jenni Fredriksson-Bass

Sähköposti: xxxxxxxxxxxxxxxxxxx
Puhelinnumero: xxxxxxxxxxxxx

Tampereen Yliopisto
Yhteiskuntatieteellinen tiedekunta
Sosiologian ja sosiaalipsykologian laitos
Master’s in Information Society and Russia

10.2 Appendix 2: Interview structure in Finnish

Haastattelun runko

- Nimi
- Ikä
- Kuinka monta vuotta olet toiminut lääkärinä
- Julkinen/yksityinen puoli vai molemmat
- Kuinka monta tuntia viikossa kliinistä työtä (noin)
- Erikoistumisala
- Sukupuoli
- Potilas vai asiakas? Kumpaa termiä haluat käytettävän?

1) Internetin käyttö

- Kuinka usein käytät Internetiä? (per päivä tai viikko)

- Mihin työhösi liittyviin tehtävissä käytät aktiivisesti Internetiä? Onko Internet osa kliinistä praktiikkaasi? Käytätkö Internetiä potilaan läsnä ollessa? (Jos kyllä, niin mihin?)

- Kommunikoitko tai voisitko kuvitella kommunikoivasi potilaan kanssa sähköpostin välityksellä?

- Yleisesti ottaen, mitä mieltä olet terveyteen liittyvän tiedon tasosta Internetissä?

2) Potilaiden Internetin käyttö

- Missä määrin potilaat käyttävät Internetiä terveyteen liittyvään tiedonhakuun? Mielestäsi miksi näin on?

- Mitä mieltä olet, siitä että potilaat käyttävät Internetiä lääketieteellisen tai terveyteen liittyvään tiedon etsimiseen? Käyttävätkö potilaat mielestäsi Internetiä liikaa, sopivasti tai liian vähän terveyteen liittyvissä asioissa?

- Oletko huomannut eroja potilasryhmien/tyyppien Internetin käytön suhteen? Voisitko kuvailla potilastyyppiä, joka käyttää Internetiä paljon tai päinvastoin vähän terveyteen liittyvissä asioissa?

- Mitkä tekijät mielestäsi vaikuttavat potilaan Internetin käyttöön tai sen käyttämättömyyteen?

- Onko potilaasi kertonut tai tuonut esiin Internetistä löytämäänsä tietoa sinulle? Mitä mieltä olet ollut tiedon laadusta?

- Miten potilaiden tietokonetaidot mielestäsi vaikuttavat hänen Internetistä löytämänsä informaation laatuun?

- Yleisesti ottaen, onko potilailla mielestäsi tarpeeksi tietoa, pätevyyttä ja taitoa etsiä, arvioida, ymmärtää ja käyttää lääketieteellistä tai terveyteen liittyvää tietoa mitä he löytävät Internetistä?

- Mitä mieltä olet terveyteen liittyvistä online tuki-ja keskusteluryhmistä?

- Oletko kannustanut potilaita käyttämään Internetiä lisätiedon hankkimiseen?

- Minkälaista tietoa ja miksi?

3) Professio ja Internet

- Onko sinusta lääkärinä tärkeää tietää jos potilaasi käyttävät Internetiä lääketieteellisen tiedon etsimiseen?

- Ovatko potilaasi tuoneet mukanaan sairauteen/terveyteen liittyvää informaatiota jonka he ovat esimerkiksi löytäneet Internetistä tai lehdistä? Jos kyllä, kuinka suhtauduit potilaan tuoman informaation?

- Miten potilaiden Internetin käyttö terveyteen liittyvissä asioissa mielestäsi vaikuttanut työnkuvaasi? Entäpä asemaasi lääkärinä?

- Onko tiedon saatavuus Internetissä mielestäsi vähentänyt mahdollisuuksia riippumattoman diagnoosin teolle?

- Onko potilaiden Internetin käyttö mielestäsi vaikuttanut positiivisesti, negatiivisesti tai neutraalisti heidän terveydentilaansa? (Esimerkiksi hallitsevatko he omaa terveyttään paremmin, ovatko he kiinnostuneempia omasta terveydestään, sairaudestaan, tilastaan?)

- Mitkä ovat Internetistä löytyvän informaation hyödyt ja haitat lääkäri/potilassuhteelle?

- Onko potilaan tuoma informaatio lisännyt omaa asiantuntemustasi?

- Näetkö mahdollista konfliktin vaaraa sinun antamasi ja potilaan löytämän informaation välillä?

- Oletko itse ollut tilanteessa tai oletko kuullut tapauksesta, jossa potilaan löytämä informaatio on vaikuttanut negatiivisesti potilaan terveyteen (esimerkiksi väärä itse-diagnoosi, paranoia, lääkityksen poisjättö tai muu väärinkäyttö?) Mitä mieltä olit tilanteesta?

- Kaiken kaikkiaan, asettaako Internet mielestäsi mitään uhkia professiollesi tai asiantuntijuudellesi? Jos, kyllä, niin minkälaisia ja mistä nämä haasteet tulevat?

4) Asiantuntijuus

- Kuinka itse ylläpidät tietojasi?
- Miten kuvailisit omaa asiantuntijuuttasi? Mistä se rakentuu?
- Mikä valitsit lääkärin uran?
- Miten määrittelisit ammattisi yhteiskunnallisen roolin?
- Mitkä tekijät mielestäsi haastavat ammattisi itsemääräämisoikeutta ja asiantuntijuutta?

10.3 Appendix 3: Interview structure in English

- Name
- Age
- Years of employment as a doctor
- Private/ public/ both sectors
- Hours of clinical work per week (average)
- Area(s) of specialization
- Gender
- Patient/Client? Which term is preferred?

1) **The use of the Internet**

    - How often do you use the Internet ? (per day /week)

    - What tasks related to your employment you do use the Internet for? Do you actively use the Internet as part of your clinical practice? Do you use the Internet when patients are present?

    - Do you already or would you use email to communicate with your patients?

    - In general, how would you describe the standard of health information available in the Internet?

2) **Patients' use of the Internet**

    - To what extent are patients using the Internet to find health-related information? Why do think are the reasons for that?

    - What do you think about the patients's use of the Internet for medical and health-related information? Do you feel that patients are using the Internet too much, about rightly or too little for health-related matters?

    - Are there differences between the usage of Internet between different patient groups? Could you describe the type of patient that uses the Internet a lot or in comparison little?

    - In your opinion, what affect the use or non-use of the Internet for health-related information?

    - Have your patients told you or presented you with information they have found in the Internet? What did you think about the quality of information?

    - How do you think that patients' level of computer skills affect have an effect on the quality of information they find?

- In general, do you feel that the patients have enough knowledge, competence and skills to find, evaluate, understand and use the medical or health-related information they find in the Internet?

- What is you opinion of the health-related online support and discussion groups?

- Have you encouraged your patients to use the Internet to find additional information?

- What type of information and why?

3) **Profession and the Internet**

- As a medical professional, is it important to know if you patients use the Internet to find and to use medical information?

- Have your patients brought information related to health/illness that they have found for example from the Internet or magazines with them to the appointment? If yes, how have you responded to the information brought by the patient?

- In what ways the patients' use of Internet in health-related matters affects your employment? Or your position as a doctor?

- In your opinion, has the availability of information decreased the opportunities for conducting an independent diagnosis?

- Do you feel that the use of Internet by patients has had positive, negative or neutral impact on their health outcomes? (For example do they feel more or less in control of their own health, are they more interested of their health, condition or illness?)

- What are the advantages and disadvantages of the Internet-based information to the doctor/patient relationship?

- Has the information brought in by the patient increased your knowledge?

- Do you see a potential conflict between the information provided by you and the information found by a patient?

- Have you personally been in a situation or have you heard of a case that the information found by a patient have had a negative effect on their health? (For example wrong self-diagnosis, paranoia, not taking medication or other misuse)? What was you opinion of that situation?

- Overall, does the Internet pose any threats to your profession or expertise? If so, what kind and where from?

4) **<u>Professionalism</u>**

- How do you maintain you knowledge?

- How would you describe your own expertise / professionalism? How is it made up?

- Why did you choose the career as a doctor? For example, the Doctor 2003 study found that the most popular factors to study medicine where ‘interest in human beings’ (83%), ‘valued occupation’ (65%), ‘versatile employment opportunities’ (54%), ‘success at school’ (50%), ‘well-paid occupation’ (47%) and ‘vocation’ (47%). Where these factors important in your own career choice?

- How would you define the social role of your occupation?

- Which factors, in your opinion, are challenging the autonomy and expertise of your occupation?

10.4 Appendix 4 :Purposes of use of the Internet in the past three months in 2010, per cent of Internet users

Purpose of use	**%**
Sending or receiving e-mails	77
Internet banking	76
Finding information about goods or services	74
Reading online magazines or TV channel Internet pages	74
Browsing travel and accommodation websites	59
Seeking health-related information	**57**
Obtaining information from public authorities' web sites	49
Listening to web radios or watching web television	44
Listening to music online or downloading music on computer or other device	42
Reading blogs	40
Looking for information about education, training or course offers	37
Consulting the Internet with the purpose of learning or increasing one's knowledge about something	37
Instant messaging	34
Downloading programmes to the computer	29
Looking for a job or sending a job application	27
E-learning	16
Internet phone calls	15
Playing games online	11
Internet video calls	8
Chatting or writing on discussion boards	7
Downloading games to the computer	7

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