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# Developing Role Concept in Medicine

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## I. Introduction

The attitude and actions that professionals exhibit when confronted with ethical dilemmas are based upon how they perceive their professional roles. For example, when a patient with a breast cancer cannot pay the medical treatment fee, some doctors may not provide services to the patient because they believe health care is a privilege rather than a basic right, whereas other doctors may take the view that there should be no discrimination on the basis of a patient's ability to pay.

Moral development theory[1] hypothesizes that professional behavior is related to the way individuals conceptualize their roles and responsibilities, their ability to resolve conflicts between competing values in a way that is consistent with the profession's espoused values, and their personal commitment to live by the profession's ethics. Professionals' concepts of their roles are seen as a factor of moral motivation and commitment. Professionals are expected to prioritize professional values over self-interest, career pressures, and established relationships.[2,3,4]

There are few studies to discuss role concept which is based upon psychological perspective, especially moral psychology, in Korea. The objective of this paper is to develop the role concept in medicine based upon moral developmental theory. In this paper, how roles are perceived will be called professional role concept. This paper will focus on five

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1) Rest JR. Morality. In Manual of Child Psychology, (Edited by P. Mussen), Vol.3: Cognitive Development. Edited by J. Flavell and E. Makrharm. 1983: 556-629, New York: Wiley
2) Rest JR. 1983
3) Bebeau MJ, Born DO, & Ozar DT. The Development of a Professional Role Orientation Inventory. J of the American College of Dentists, 1983: 60:2: 27-33
4) Bebeau MJ. Influencing the Moral Dimensions of Dental Practice. In J.R. Rest & N. Darcia (Eds.), Moral Development in the Professions, 1994: 121-146. Hillsdale, NJ: Erlbaum Associates

professional role concepts: authority, responsibility, personal efficacy, interpersonal control, and sociopolitical control. Authority and responsibility as professional role concepts come from philosophical perspectives, while personal efficacy, interpersonal control, and sociopolitical control as personal role concepts draw from psychological views of "Spheres of Control" proposed by Paulhus.[5)]

## II. Authority and Responsibility as Professional Role Concept

### 1. Authority

Many researchers[6,7,8,9,10)] have agreed that professionalism includes the acquisition of specific knowledge and skills in the areas to which the professionals belong as a fundamental qualification. In general, the term "professional" refers to one who practices a "learned profession," i.e., "one who has special knowledge and skills used to benefit the public, regardless of personal gain." Professional knowledge is not propriety but communal, dedicated to the welfare of society through the transmission and extension of knowledge. The medical professional group has a social responsibility because of the specific knowledge and skills that distinguish the professional from the layperson. Highly professionalized groups (e.g., law and medicine) might obtain power and privileges in their own field because society views the provision of medical care, for example, as essential for its health and welfare.[11)]

"Learned professions" have a different quality unlike professions or occupations such as hairdressers, artists, and housekeepers. The "learned professional" groups conduct their practices based on the latest scientific knowledge. The degree of possession of knowledge represents their power, and our trust of professionals is based upon their commitment to use this power for the social good. Also, professionals have an implicit or explicit code of conduct by which they profess to use their special skills for the welfare of others.

Bebeau and her colleagues (1993) defined authority as "the degree to which the dental

5) Paulhus DL, Molin J & Schichts R. Control profiles of football players, tennis players and nonathletes. J of Social Psychology, 1979; 108:199–205
6) Nash AD. Ethics in Dentistry: Review and Critique of Principles of Ethics and Code of Professional Conduct. JADA, 1984; 109:597–603
7) Reed RR. & Evan D. The deprofessionalization of medicine: causes, effects, and responses. JAMA, 1987; 258: 3279–3282
8) Reynolds PP. Professionalism in residency. Annuals of International Medicine, 1991; 91:91–92
9) Reynolds PP. Reaffirming Professionalism through the Education Community. Annuals of International Medicine, 1994; 120:7: 609–614
10) George LA & Harrison JL. Professional Ethics and the Profession: Yesterday, Today and Tomorrow. Texas Dental Journal, November, 1997:32–37
11) Bebeau MJ. & Kahn JP. Ethical Issues in Community Dental Health In GM. Glueck & WM Morganstein (5th Ed). Jong's Community Dental Health 1998: 425–445), St.Louis: Mosby

professionals recognize the self as being knowledgeable, a good judge of outcomes, and deferred to for expertise."[12] In other words, authority is defined as a basic and common concept achieved through the acquisition of distinctive knowledge and skills, and based upon the ability to create new knowledge and skills to solve problems and to apply scientific knowledge to practice in a technically proficient way.

Medical professionals with a strong sense of authority know "what is best for the doctors themselves and the patients in medical matters,"[13] understand all medical situations only on the basis of their professional knowledge and skills, and take ownership of their special information, knowledge, and skills by acquiring them. In contrast, medical professionals with a weak sense of authority are unsure of their medical treatments because of the unreliability of their knowledge and skills. Others' views are more important than their own perspective because they regard everyone's opinion as equal to their own perspective. In this case, because the doctors have a lack of distinctive knowledge and skills, they cannot perform the basic role of medical treatment or diagnosis as well as might be expected from the patient.

## 2. Responsibility

Many researchers[14,15,16,17,18] have emphasized the element of responsibility along with authority when discussing professionalism. Said (1994) suggested new professionalism as "fuelled by care and affection rather than by profit, selfish, and narrow specialization,"[19] a professionalism based not on "doing what one is supposed to do" but on asking "why one does it, who benefits from it, how can it reconnect with a personal project and original thoughts."[20] The point is that the practice of medicine cannot be reduced to only a technical and instrumental action.

Being consistent with this context, the "Code of Ethics" describes the concrete directions to professional responsibility. It gives a prominent place to the acquisition of the virtue of responsibility. For instance, Ozar (1988) suggested that the doctors take responsibility for a patient's well-being, awareness of other doctors' questionable work, support for public medical health initiatives and for research programs, and care for persons with dangerous infectious diseases.

12) Bebeau MJ, Born DO, & Ozar DT. 1993:27
13) Bebeau MJ, Born, DO, & Ozar DT. 1993:28
14) Nash AD. 1984
15) Moline JN. Professionals and professions: A philosophical examination of an ideal. Soc.Sci. Med, 1986; 22:5: 501–508
16) Ozar DT. On Ethics at Chairside. J of the American Dental Association. 1988:116:697
17) Said E. Representations of the Intellectual. 1994 London: Vintage
18) Cruess RL, Cruess SR., & Johnston SE. Professionalism: An ideal to be sustained. The Lancet, 2000; 356:8: 156– 159
19) Said E. 1994:61
20) Said E. 1994:62

More recently, Bebeau and Kahn (1998) suggest six essential attributes of professional social responsibility: 1) to obtain the latest scientific and distinctive knowledge for professional judgment; 2) to learn changing knowledge through continuing education; 3) to make a commitment to the professional ethics to prioritize the interests of patients and society to discourage the self-interests of the professionals; 4) to abide by the profession's code of ethics; 5) to be dedicated to society; and 6) to participate in the monitoring and self-regulation of the profession. Medical professionals also have social responsibility to promote the medical health of society through preventive education of medical disease and open discussions of community health issues, and to learn changing knowledge in order to provide the best diagnosis and treatment, and to follow the "Code of Ethics" to guide appropriate behavior as a medical professional. Finally, the power and privileges as medical professionals is awarded from society in terms of how widely and seriously they take professional responsibility or obligations.

Drawing from sociologist conceptions of the expectations of professions, Bebeau et al., (1993) defined responsibility as "the breadth of an individual's commitment to others,"[21] that is, to the patients, to disadvantaged people, to the medical professional organizations, and to society. More concretely speaking, the responsibility of the medical professionals might be summarized as follows: first is to consider what is good for the patients or to think over the best medical health delivery to patients[22,23,24] as the main and basic obligation. The medical professional ought to have an obligation to place the well-being of the patient ahead of every other consideration including the professional's own self-interest; second is to have the co-responsibility with other doctors' concern for clinical mismanagement or malpractice of patients[25] as being related to professional organization. They also take responsibility for cooperatively working on their tasks or goals even though the medical professionals themselves sometimes work independently or individually; third is to carry out the societal responsibility of social well-being and social justice for disadvantaged people or uninsured people as one of the fair medical health policies. Social responsibility is associated with professional public services to take responsibility for contributing to societal and public interest.[26] Professional responsibility proceeds toward an ideal society on the basis of societal interest

21) Bebeau MJ, Born DO, & Ozar DT. 1993:28
22) May WE. The Physician's Covenant: Images of the Healer in Medical Ethics. Philadelphia: Westminster Press, 1983
23) Nash AD. 1984
24) Moline JN. 1986
25) Nash AD. 1984
26) Gary NE, Boelen C, Gastel B, & Ayers W. Improving the Social Responsiveness of Medical Schools: Proceedings of the 1998 Educational Commission for Foreign Medical Graduates/World Health Organization Invitational Conference. Academic Medicine,

rather than self-interest.

In addition, Bebeau et al., (1993) suggested that doctors with a strong sense of responsibility have a strong sense of obligation for the well-being of the patient and disadvantaged people and for self-improvement or training as a medical professional. These characteristics concentrate on taking care of uninsured people as well as insured patients as the most important obligation of the profession. These medical professionals emphasize honest advertisements that provide accurate information and demonstrate the co-responsibility for other doctors' malpractice. They are also sensitive to inequality in medical health care and would try to treat patients justly, and have a sense of obligation regarding doctors' activities within the professional organization to ensure social justice. In contrast, doctors with a weak sense of responsibility possess a lack of recognition of cooperative work. They have little partnership and limited shared vision with other doctors. They believe that individuals can take care of themselves and think that it is reasonable to give priority to their own self-interest.

## 3. The relationship between Authority and Responsibility

In general, laypersons evaluate the quality of professional by the degree of authority to be characterized as the distinctive knowledge, information, and skills; and the breadth of responsibility to the patient and disadvantaged people as a professional. A professional's characteristics of authority and responsibility are to fairly serve laypersons with the professional's scientific and distinctive knowledge and skills. When professionals perform these obligations, patients or society grant them power and privileges.

Many philosophers pointed out that authority and responsibility were suggested as representing general ideas which are embodied in the various models. Veatch (1972) proposed four models, the engineering model, the priestly model, the collegial model, and the contractual model, based upon the moral relationship between a physician and patient in the medical field. The engineering model is that the physician presents the facts to the layperson and leaves all the decisions to the layperson. The priestly model is that the physician, like a priest, can make completely exclusive ethical judgments by the principle, "benefit and do no harm"[27] and plays a paternalistic role in the relationship with the patient, as a sort of religious relationship. The collegial model is that the physician and patient are seen as equal colleagues who share their common interest and pursue their goals. The contractual model is that the physician and

1999; 74:8: S3-S94

27) Veatch RM. Models for Ethical Medicine in a Revolutionary Age. Hastings Center Report, 1972; 2: 5-7

patient do not have equal status before making a contract between them.

Based upon the philosophical perspectives of Ozar (1985)[28] and Veatch (1972),[29] Bebeau et al., (1991) suggested four models to explain the professional role concept of the medical professional. These models are made from four possible combinations of the authority of specific knowledge and skills and the responsibility of preserving others' well-being based upon the relationship between the doctor and patient. The four models are: the commercial model, high on authority and low on responsibility; the guild model, high on authority and high on responsibility; the service model, low on authority and high on responsibility; the agent model, low on authority and low on responsibility.

1) The Commercial Model

Persons ascribing to the commercial model recognize oral health care as a commodity which the doctors sell and which patients buy. This model is essentially marketplace oriented and competitive. There are no obligations for either the doctor or patient before making a contract. If the doctor and patient agree upon the contract, the patient is willing to pay for the treatment fee and the doctor is willing to give medical information and improve the patient's medical health.[30] In other words, the patients are intentional in seeking to minimize the cost as a consumer, and the doctors make an effort to maximize profits as a producer.

These doctors continuously comment on the patient's need for care and motivate the patient to purchase medical services. In this model, the patients are not in the least inactive in the decision-making process. The patients can choose information and advice and then select further commodities. Ozar (1984) stated that this model may seem to insist on the patients' autonomy in health care decision-making extremely well. Bebeau (1989) also mentioned that public direction and involvement in the doctor's activities ought to be downplayed because such participation represents an intrusive pressure on the dentists' ability to exercise their services freely and unfettered.[31]

2) The Guild Model

In contrast to the commercial model, the guild doctors' obligations are emphasized due to the responsibility of medical health delivery

28) Ozar DT. Three Models of Professionalism and Professional Obligation in Dentistry, J of the American Dental Association, 1985; 110: 173–177.

29) Veatch (1972) and Ozar (1985) described authority and responsibility as the concepts needed to solve these complicated situations that medical professionals experience. They emphasized that the ethos of ethical responsibility, established by the appropriate selection of a model for the moral responsibility between the professional and the lay communities, will be significant. They also argued that primary in the process of problem solving is the relationship between the doctor, patient, and community and how the power and privileges of medical professionals are determined within the relationship.

30) Ozar DT. Patients' Autonomy: Three Models of the Professional–Lay Relationship in Medicine. Theoretical Medicine, 1984; 5: 61–68.

31) Bebeau MJ. Dentists' Perceptions of their Model of Professionalism, Center for the Study of Ethical Development, University of Minnesota, 1989; Report No. 27

to the patient. In this model, the doctor is the dominant person as an expert because the doctor has distinctive knowledge, skills and wisdom in medical activities, in contrast to the patient. In this sense, this model is similar to the priestly model of Veatch (1972) and the guild model of Ozar (1985) based upon paternalism in that medical decisions belong not to the patient but to the "the priest," used as the metaphor for the doctor.

The patients should follow the medical professionals' adequate choices about outcomes due to the patient's lack of specific knowledge and skills. Medical professionals and their patients keep a trusting relationship even though the patient might be passive, receptive, and inactive. For this reason, doctors ascribing to this model ought to affirm the use of their knowledge and skills in solving particular health problems and meeting particular health needs of individual humans, and actively demonstrate the obligation of a medical professional to consider the public or the poor for equal treatment.

The public in this model is less likely to control doctors because doctors belonging to this model consider their social obligation for the patient's well being, even when the service may be inconvenient or unprofitable.[32] That is, the supporters of this perspective believe that the doctor contributes to the good of society without public regulation and involvement.

3) The Service Model

Persons belonging to the service model are more likely to take social responsibility for other people rather than authority, and specific knowledge and skills of medical professionals as the most important professional quality. These doctors give special priority to public health and welfare and commit to serving humanity, as in the guild model. These medical professionals can often be self-sacrificing of personal needs and desires in the pursuit of the well being of their patients and the good of society.

The doctors in this model have adequate status and position only when they have a prior commitment to serve the patient's needs and promote social good[33] Because this model emphasizes social responsibility beyond the concern for caring for the patients, public regulations and involvement should be supported in order to restore a true professional mind set to the medical professional.

4) The Agent Model

Doctors who exemplify the agent model give last right of decision-making to the patient because their primary obligations are to satisfy the patients' needs and comply with the patients' perspective. Furthermore, they have no sense of obligation to governmental agencies or to nonpatients and disadvantaged people[34] and might not have any social

32) Bebeau et al., 1993
33) Bebeau et al., 1993
34) Bebeau et al., 1993

responsibilities for their own activities.

The doctors in this model are independent operators who advance their own careers in the most advantageous way. Doctors who insist only on their own way do not develop competence and a more confident self-identity because career development is seen as a mutual process of interaction with the work environment. Also, if the skills are not profitable for the acquisition of self-interest, the doctors do not use their spare time to learn new knowledge and skills related to the medical practice.

## III. Personal Efficacy, Interpersonal Control, and Sociopolitical Control as Professional Role Concept

The doctors must predict or guess what the patient is likely to do without knowing completely the exact nature of each situation in which the patients find themselves. The doctors could control or manage the behavior of others, such as the patient, the patient's family, peers, and personnel, in unpredictable and complicated circumstances which are unknown to the doctors. Medical professionals are under unpredictable and complicated medical situations and they can handle them for taking care of their patients. Therefore, Rotter's original ideas[35] are restricted in explaining the medical situations.

The concept of multidimensionality[36] of "Locus of Control" to be shifted from the concept of "Locus of Control" of Rotter (1966) might be useful in order to explain these medical situations. It is more likely to explain behavior of the medical professional to put in many diverse situations rather than Rotter's idea. Especially, Paulhus and et al., (1979) and Paulhus (1983), particularly, conceptualized and specified the space in terms of three primary behavioral spheres: personal efficacy, interpersonal control, and sociopolitical control. These three types of "control" were categorized by the "target control" of self, others, and mankind and he finally suggested the "Spheres of Control."[37] His idea is useful and helpful in explaining unpredictable and uncontrollable medical situation. The three

35) Rotter (1966) suggested two dimensions to describe controllability of outcomes that influenced the evolution of situations. He also distinguished the concept of "internal and external Locus of Control" on the basis of people's beliefs about the relationship between behavior and reinforcement. Rotter (1966) stated that a person is "internal" if he or she expects that a certain behavior leads to the desired reward, whereas a person is "external" if he or she expects that reinforcement is determined by uncontrollable external events like fate and luck. Rotter, J. B. Generalized Expectancies for Internal versus External Control of
Reinforcement. Psychological Monography, 1966:80:1-28

36) The multidimensionality of "Locus of Control is used over two dimensions of Rotter's Internal-External locus of control and the dimensions are independent from one another. For example, Levenson (1973) suggested three dimensions of "Locus of Control": internality, powerful others, and chance. Levenson H, & Miller J. Multidimensional locus of control in sociopolitical activists of conservative and liberal ideologies. J of Personality and Social Psychology, 1976:33:199-208

37) Paulhus DL. Sphere-specific measures of perceived control. J of Personality and Social Psychology, 1983:44:1253-1265

spheres might give details the role concept of medical professionals in complicated medical situation which doctors, patients, and social pressure or constraints together exist.

## 1. Personal Efficacy

Paulhus (1983) defined the personal efficacy as "individual vies for control with the nonsocial environment in situations of personal achievement"[38] such as the mastery of crossword puzzles, or climbing challenging mountains. Drawing from his definition, personal efficacy is the individual own controllability in the situation of mastery of medical tasks or problems. It is to urge toward competence in the medical situation. Personal efficacy includes the self-reliance of the mastery of a task and the satisfaction to be derived from it. Self-assurance and satisfaction come from the feelings of efficacy upon the attainment of competence as perceived by the individual.[39,40,41]

The notion of "personal efficacy" in the field of medical environment is the personal controllability to be able to explore, manage, and achieve effectively, persistently, and arduously something involving resistance from difficult and unpredictable external entities. It need to deal effectively with medical circumstances is intrinsic and produces inherent pleasure when satisfied. Personal efficacy is related to the ability or competence to achieve medical tasks and the satisfaction after achieving them.

In this sense, it could be assumed that medical professionals with the strongest personal efficacy might be more likely to be persistent in obtaining their goals, to be receptive to information relevant to their situation in information processing, to be resistant to attempts at persuasion and coercion, and to be more perceptive, inquisitive, efficient, and cooperative than the weakest agency group. That is, the medical professional with the strongest personal efficacy might be usually active, courageous, challenging, effective, resolute, persistent, tolerant, and less procrastinate[42] and might perceive themselves as can-do persons who can offer various techniques for relieving stress such as informing the patient about upcoming treatment. They can also further help patients learn and gain competence in building effective educational programs for patients who suffer from medical anxiety or phobias and who can feel alienation.[43]

On the other hand, the medical professional

38) Paulhus DL. 1983:1254
39) White RW. Motivation reconsidered: The concept of competence. Psychological Review, 1959; 66:297–333
40) Bandura A.. Social Learning Theory. Englewood Cliffs, NJ: Prentice Hall, 1977
41) Harter S. Effectance Motivation Reconsidered toward a Developmental Model, Human Development, 1978:21:34–64
42) Reasinger R, & Brownlow S. Putting off until tomorrow what is better done today: Academic Procrastinations as a function of motivation toward college work. 1996; ED401811
43) Seeman M, & Evan JW. Alienation and learning in a hospital setting. American Sociological Review, 1962; 27: 772–783

with a weak sense of personal efficacy might be inactive, lazy, indecisive, hesitant, and tend to procrastinate. For example, if medical professionals are lacking in physical competence like hand-eye coordination, they may hesitate or give up their medical practice and ultimately, they may show apprehensive or timid personality traits. Also, procrastination is purposely delaying the start or completion of a task to the point of experiencing discomfort,[44] and is considered to be chronic or dysfunctional when such behavior disrupts normal everyday functions.[45] In addition, procrastinators avoid an aversive task they dislike,[46] are more pessimistic,[47] and experience higher levels of anxiety.[48] Reasinger and Brownlow (1996) examined a relationship between procrastination and motivation in undergraduate students in which they found that high procrastinators were motivated by both external and internal factors more than low procrastinators.[49] When a patient complains about medical care or the patient has HIV, the medical professional with a weak sense of personal efficacy may tend to show a delay or procrastination such as being reluctant to make an appointment, or may come in late to care for the patient. It might be hypothesized that the medical professional with a weak sense of personal efficacy might either be content with the current status quo, or have a negative perspective of his or her life as a medical professional.

## 2. Interpersonal Control

Paulhus (1979) defined "interpersonal control" in terms of keeping harmony or balance in the process in which "the individual interacts with others in dyads and group situations."[50] On the basis of this definition, Paulhus et al., (1979/1983) found that football players oriented toward team coordination with cooperative relationships have higher interpersonal control scores.

Let us consider Paulhus's suggestion that the target of control is "other." The interpersonal control of medical professional might be showed by controlling "other" within the "relationship." In this case, independent or autonomous medical activities could be guaranteed through overcoming the negative meaning of control. Rotter (1980) emphasized "trust" and its degree in the interpersonal

44) Solomon LJ, & Rothblum ED. Academic procrastination: Frequency and cognitive-behavioral correlates. J of Counseling Psychology, 1984; 31:503-509
45) McCown W, & Johnson J. Personality and chronic procrastination by university students during an academic exam period. Personality and Individual Differences, 1991; 12:413-415
46) Ferrari JP. Psychometric validation of two procrastination inventories for adults: Arousal and avoidance measures. J of Psychopathology and Behavioral Assessment, 1991;14: 97-110
47) Lay CH. Trait procrastination and the perception of person-task characteristics. J of Social Behavior and Personality, 1992; 7: 483-494
48) McCown W, & Johnson J. 1991
49) Reasinger R, & Brownlow S. 1996
50) Paulhus DL.1983;1254

relationship in his article of "Interpersonal trust, trustworthiness, and gullibility."[51] "Interpersonal trust" is an important variable affecting the doctor-patient relationship. The perception of "trust" affects not only decisions about personal lives but also about our roles as a medical professional. Using the "Interpersonal Trust Scale,"[52] Wright and Kirmani (1977) found that if "low trusters" feel that other people cannot be trusted, there is less moral pressure on them to tell the truth, and under some circumstances they may feel that lying, cheating, and similar behaviors are necessary for defensive reasons.[53] Accordingly, interpersonal trust is assumed for the independent activities of the medical professional.

In addition, Rotter (1980) described the negative consequences of "high truster" as naivet? or foolishness. In the doctor-patient relationship, rather, the negative connotation caused by a highly and extremely truthful relationship might hinder the dentist's autonomy. For instance, the patients give up their rights to participate in all medical decision-making processes and the doctors might perceive these patients as "naive patients." In this case, the doctors sometimes might ignore the autonomy of patients and thus might distort their autonomous medical decision-making on their way because of not respecting and sharing their own perspectives with their patients.

Next, let us discuss the degree of dependency between the doctors and their patients. The doctor-patient relationship assumes an interdependence or equal condition unlike the parent-adolescent relationship. Patients implicitly and explicitly accept their doctor's autonomy while the doctors accept their patients' autonomy for a successful and flexible medical practice. However, in a real medical situation, the patients are dependent on their doctors as experts in medical health delivery and the doctors try to control their patient's autonomy through independent diagnosis and treatment in the medical practice, simultaneously. If patients are extremely dependent upon their doctor, or if patients show high trust toward their doctor without consciousness, could the authentic autonomy of the medical professional be exercised?

Interestingly, if the control way of medical professionals is similar to that of their patients, the medical professionals are more likely to manage the rights or autonomy of their patients. Foon (1985/1989) investigated the relationship between the "Locus of Control" of clients and practicing Australian therapists

51) Rotter JB. Interpersonal Trust, Trustworthiness, and Gullibility. American Psychologist, 1980; 35:1: 1–7
52) Rotter JB. A new scale for the measurement of interpersonal trust. J of Personality, 1967; 35:651–665
53) Wright TL, & Kirmani A. Interpersonal trust, trustworthiness and shoplifting in high school. Psychological Reports, 1977; 41:1165–1166

through two consecutive studies with different samples.[54,55] He found that a "therapist with an 'Internal Locus of Control' expected to be more autonomous with internal clients while external therapists anticipated greater success with external clients."[56] He (1989) also reported that a therapist's "Locus of Control" orientation interacted significantly with the control orientation of the client in predicting success in therapy. In this case, therapists with an "Internal Locus of Control" are more likely to keep harmonious relationships with their patients, and if the medical professionals have a similar perception as their patients, they could deal with conflicts with others.

When turning to the patient's side, patients could implicitly accept decreasing their autonomy or giving it up for the medical health care in the medical practice. Pellegrino (1979) reported that patients often demand that medical professionals care for their medical illness by lessening their autonomy.[57] Miller and et al., (1988) found that when physicians permit the expression of their patients' autonomy, the patients feel a higher level of anxiety.[58] Also, when inferring from Folkman's (1984)[59] paper to theoretically analyze the relationship between perceived control and coping processes, the patients simply want to get more information about medical health care and tend to be passive in the medical treatment without insisting their autonomy and rights. The patients' inactive attitudes on the expression of their autonomy or rights might influence the autonomous activities of medical professional.

Therefore, medical professionals might conduct autonomous activities by appropriately controlling their patients' goals, plans, and desires. For instance, there are autonomous characteristics such as working with patients to develop an appropriate and realistic care plan directed towards achieving the patient's own goals, listening to and, especially, believing the patient. It might also be hypothesized that the interpersonal control of medical professionals might be different in terms of the degree of emotional independence from their patients and the type of social context.

In summary, the concept of interpersonal control is related to "the relationship" and is focused on freedom "from what." The meaning of "what" is an external factor such as the patient, patient's family, the patient's financial

54) Foon AE. Similarity between therapists' and clients' locus of control: Implications for therapeutic expectations and outcome. Psychotheraphy. 1985; 22: 711-717
55) Foon AE. Mediators of clinical judgment: An exploration of the effect of therapists' locus of control on clinical expectations. Genetic, Social, and General Psychology Monographs. 1989; 115: 245-266
56) Foon AE. 1989:259
57) Pellegrino E. Towards a Reconstruction of medical morality: The primacy of the act of profession and the fact of illness. J of Medicine and Philosophy, 1979; 4:32-56
58) Miller SM, Brody D, & Summerton J. Styles of coping with threat: Implications for health. J of Personality and Social Psychology, 1988; 54:142-148
59) Folkman S. Personal control and stress and coping processes: A theoretical analysis. J of Personality and Social Psychology, 1984;46:839-852

status, the interference or pressure of medical staffs related to medicine, etc. The interpersonal control is defined as interdependence to make decisions without being influenced by patients and peer group pressure or the dictates of powerful others. Medical professionals with a strong sense of interpersonal control are more likely to demonstrate autonomous activities and maintain equilibrium of different perspectives. They have built up a strong expectancy for good interpersonal relationship and have the willingness to create a friendly atmosphere in the medical situation. In contrast, medical professionals with a weak sense of interpersonal control are less likely to defend their interests or autonomy and are more likely to be controlled by other persons in the medical situation.

### 3. Sociopolitical Control

The sociopolitical control is the last role concept as a medical professional. Paulhus (1983) defined sociopolitical control as solving and mediating "the individual's goals conflict with those of the political and social system."[60] This concept is similar to the professional role concept of "legal and societal constraints" to be discovered in one validation study[61] which examined role concepts of dentists. In sociopolitical control as a more expanded relationship, medical professionals might have to deal with conflicts occurring within the political and social system such as the insurance company, licensing board, professional association, or government.

According to previous studies,[62,63,64,65] persons with low "sociopolitical control" are attracted to ideologies that emphasize the importance of "societal" determination of behavior, whereas persons with high "sociopolitical control" prefer ideologies emphasizing "self determination."[66] Levenson and Miller (1976) conducted three studies to examine the pattern of "Locus of Control" of sociopolitical issues. In the first study, 98 male college students completed a measure of conservatism-liberalism[67] and "Locus of Control" Scale of self-report assessment.[68] In the second and third study, 40 female college students who differed in the extent of their participation in leftist political activities or

60) Paulhus DL. 1983:1254
61) Thoma SJ, Bebeau MJ, & Born DO. Further Analysis of the Professional Role Orientation Inventory. J of Dental Research, Vol.77, Special Issues, 1998:Abstract #116:120
62) Fink HC, & Hejelle LA. Internal-External control and ideology. Psychological eports, 1973:33: 967-974.
63) Levenson H, & Miller J. 1976
64) Paulhus DL. et al., 1979
65) Paulhus DL. 1983
66) Fink HC., & Hejelle LA; 1973:968
67) Kerpelman LC. Student political activism and ideology: Comparative characteristic of activists and nonactivists. J of Counseling Psychology, 1969; 16: 8-13
68) Levenson, H. Multidimensional locus of control in psychiatric patients. J of Consulting and Clinical Psychology, 1973; 41:397-404

feminist causes responded to the same "Locus of Control" Scale. They found that powerful others are positively associated with increases in activism, while for conservatives there is a negative relationship. That is, many liberal activists feel that they are controlled by others, and institutionalized barriers and policies are seen as more constraining. Especially in the third study, lesbians (highly active liberals) scored higher on perceptions of control by powerful others than less active feminists, but they also felt that they had significantly less personal control over their lives.

These studies, however, might not deal with the current medical issue because they examined only the patterns of "Locus of Control" of important issues at that time such as civil rights, the feminist movement, and anti-war demonstrations. The last dimension as "sociopolitical control" needs to include current sociopolitical issues like insurance coverage and fiscal money for the public medical health system. Therefore, it could assume that at least the medical professional with a strong sense of "sociopolitical control" will try to change unreasonable and inefficient management of the medical health system for innovation, to be involved in conflict resolution between the medical profession and the sociopolitical system, and further to take part in a demonstration of the unfair medical health system or the lack of resources or practical constraints in spite of the pressure of insurance companies and the government.

## 4. The Relationship among personal efficacy, interpersonal control, and sociopolitical control

The relationship among personal efficacy, interpersonal control, and sociopolitical control as personal psychological characteristics is interrelated and interdependent. For instance, when a patient or patient's family insists on an alternate treatment that the doctor does not recommend, how does the doctor handle this situation? If doctor primarily considers the family's opinion and follows their demands without persuading patient or his (her) family and acknowledging medical policy, he (she) may show low personal efficacy, low interpersonal control, and low sociopolitical control. Whereas, if the doctor is willing to accomplish medical task as expertise as a task-oriented person, to persuade his (her) patient considering his (her) autonomy, and to accept fair medical policy even under the limited situation, he (she) may have high personal efficacy, high interpersonal control, and high sociopolitical control. Also, if doctors feel coerced into the practice of new treatment skills because of internal and external pressures, i.e., patient, patient's family, and medical staff related to medicine, medical policy how does the doctor control this coercion? If doctor complies with the coercive actions, he (she) may show low personal efficacy, low interpersonal control, and low sociopolitical control. The doctor might feel

helpless or hopeless in the medical situation and lost role concept as medical professional. Finally, doctors might experience diverse spheres and act under interdependent relationship among three medical spheres.

## IV. Conclusion

This paper focused on developing five role concepts in medicine. The first dimension is authority which, as a basic and common quality, means the major quality of "learned professions" to possess special information and knowledge that could help them render better service to their patients. Second, responsibility refers the prominent quality of obligations fairly distributing social resources and taking care of the patient, the disadvantaged, and the public. The other three dimensions, personal efficacy, interpersonal control, and sociopolitical control, are personal qualities or characteristics to be associated with decisions made by the medical professional. These three concepts emphasized the personal characteristics of medical professionals, unlike the previous perspective of professionalism. First, "personal efficacy" dimension is self-competence of the performance of the medical professional to control the professional life including positive personality attributes shown in the achievement process. Second, "interpersonal control" factor is to manage the "relationship" with "others" such as the patient, the patient's family, and medical staffs related to medicine. Third, "sociopolitical control" was defined as settling or resolving differences or conflicts between individual's goal and sociopolitical system's goal.

Based upon developing these five role concepts, the suggestions of this study are as follows: First, the role concepts of medical professional might be explained more widely and accurately in psychological as well as philosophical background; second, the developing of these five dimensions will be helpful to expand role concepts in medicine; third, they could be used to develop a valid instrument for assessment of educational effectiveness and treatment. For example, Kang (2005) have already made and developed a measure like PROI (Professional Role Orientation Inventory).[69] Fourth, these role concepts could be applied to explaining those of other professional groups like nurse, lawyer, teacher, etc. Fifth, the relationship between authority and responsibility is needed to investigate for appropriate training in the medical educational program because the perception of authority and responsibility among medical professionals might differ. ME

Keywords:
authority, responsibility, personal efficacy, interpersonal control, sociopolitical control

69) Kang, YJ. A Validation Study of the Professional Role Orientation Inventory(PROI). Doctoral Dissertation. University of Minnesota, 2005

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# 의료분야에서의 역할 개념 정립에 관한 연구

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## 국문초록

의료 전문인들에 대한 역할 개념의 탐색은 주로 철학적 관점에서 진행되고 있다. 한국 의료분야에서도 예외는 아니다. 본 연구는 의료분야에 종사하는 전문인들의 역할 개념을 철학적, 심리학적 관점에서 탐색해보는 것이다. 철학적 관점에 근거해서 본 역할개념으로는 권위와 책임감, 심리학적 관점에서는 개인적 효능감, 대인관계 통제감, 사회정치적 통제감이 역할 개념으로 제안되었다. 본 연구에서 제안한 다섯가지 역할 개념은 다음과 같다. 첫째, 권위는 환자들에게 서비스를 제공하기 위해 필요한 특별한 정보와 지식를 소유한 의료 전문인으로서의 질로 정의되었고, 둘째, 책임감은 환자의 사회적 신분과는 무관하게 환자를 위해 제공해야 할 서비스를 공정하게 제공하는 의무감으로 정의되었으며, 셋째, 개인적 효능감은 의료 전문인의 심리적 특성의 하나로서 의료 전문인의 성격과 삶을 통제함으로써 얻게 되는 자기 성취감과 자기 확심감으로 정의되었다. 넷째, 대인관계 통제감은 환자나 환자의 가족등을 포함해서 의료 활동에 관여하는 모든 사람들과의 관계를 통제하고 관리할 수 있는 능력, 다섯째, 사회정치적 통제감은 사회정치적 체계의 목표와 전문인으로서의 개인적 목표사이의 갈등 혹은 차이를 해결하는 능력으로 정의되었다. 본 연구를 통해 몇가지 제안을 하면 다음과 같다. 첫째, 역할 개념을 탐색하는 방법을 철학적 관점이외의 심리학적 관점 더 나아가 다른 관점들에 비추어 폭넓게 역할 개념을 조명해볼 수 있을 것이다. 둘째, 본 연구에서 제안한 다섯 가지 역할 개념을 기초로 해서 의료 전문인들의 역할 개념과 윤리의식을 측정할 수 있는 타당한 검사지를 개발할 수 있을 것이다. 셋째, 의료 전문인이외의 다른 전문가 집단의 역할 개념을 탐색하고 설명하는 데에도 도움이 될 것이다.



## 색인어

권위, 책임감, 개인적 효능감, 대인관계 통제감, 사회정치적 통제감




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