MEDICAL DOMINANCE

Medical dominance of health care has traditionally been the organising principle in health care delivery. Medical power is manifested through the professional.

In a number of papers, the influential epidemiologist Abdel Omran has explored this changing disease patterning in a historical context. Whether the distinctions we have made are of more general applicability is an empirical and theoretical task requiring further work. The emergence of a theory of care transition, distilling many of the processes examined here, is based on four main observations. Transitions in the social relations of health care In recent years, the position of the medical profession, the state and the patient have undergone significant change. This feeds into one of the key long-term features of care transition: the decline of medical dominance. All that could be adumbrated were the claims made of success by the often prestigious surgeons themselves. The longstanding Community Health Centre model, however, displays the least financial hierarchy and the least multiplicityâ€”an environment least fertile for medical dominance. But changing demographic and epidemiologic profiles, together with rising expectations and educational levels, are accompanied by a greater desire for equity and protection in private systems and more consumer dynamics in socialized ones. Studies of shared decision-making, concordance and the patient's viewpoint all chime in with the processes of transition discussed here. As Omran indicates, a secular, that is, persisting decline in fertility, characteristic of developed countries such as England despite a small increase in the last few years , combined with low levels of childhood illness, provide further indicators of longer average life expectancy. From this viewpoint, the ageing of the population may be more complex than is often recognized when considering drivers of growth in health care expenditure. First, health care systems throughout the world face major cost containment problems. More positively, in the case of long standing conditions, it may not be the case that an older population has to mean a worsening health profile. It is hardly surprising, therefore, for much of the language employed to have a strongly rhetorical flavour. Medical power is manifested through the professional autonomy of doctors, through their pivotal role in the economics of health services, through dominance over allied health occupational groups, through administrative influence, and through the collective influence of medical associations. Even so, doctors report frustration with the idea of concordance. Ontario, Alberta, Quebec and potentially Newfoundland introduced system-wide policy changes to PC [52 , 53], an approach we refer to as top-down overhaul. Although this system has its own peculiarities stemming largely from its nationalized, universalistic origins , it can be argued that in any system of care where the above features are developing, care transition is occurring. The first is that predictions of a negative impact of demographic and epidemiologic transition do not always specify which aspects are of particular concern. Recommendations for the training of nurses and the implications of the findings for nurse practitioners are made, together with suggestions for further research.