

TRAVELLING KNOWLEDGE: THE GLOCALIZATION OF PHYSICIANS' PROFESSIONAL KNOWLEDGE AND PRACTICE.

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At first sight the medical field appears to be thoroughly globalized. In Germany, 11.4 % of hospital physicians hold a foreign citizenship. Many more have been educated abroad but adopted German citizenship. Similar numbers can be found in other OECD. Temporary sojourns abroad as part of medical training and research are common for migrant and non-migrant physicians alike. Finally, patient populations also have become more diverse in terms of ethnic origin and migration status.

The high degree of international mobility and of ethnic and cultural diversity in the medical field constitutes a challenge for medical training both in university and on-the-job settings. On the one hand, we might expect medical training to be globally versatile as medical professional knowledge is based on international state-of-the-art natural science evidence. On the other hand, day-to-day professional practice and in particular the interaction with patients can vary locally. Recent innovations in medical training, namely teaching with the help of actors in simulation patient programs, imply that medical knowledge cannot be taught in an abstract manner but must be applied in clinical settings. Nationally specific institutional settings, such as the organization of medical education and the administration of health care, also have an impact on the content of professional knowledge and on the ways it is trained. We therefore expect the medical field to be both “globalized” and “locally specific”, thus “glocalized” according to Robertson (1992).

The sociological research project “Travelling knowledge: the glocalization of physicians’ professional knowledge and practice (GloPro)” compares the training and professional practice of physicians in a quasi-experimental setting. In cooperation with the Essen Program for Simulation Patients we will first compare the training and skill assessment of future professionals in simulation patient programs across various nation state settings. Secondly, we will observe the treatment of patients in everyday clinical practice. On the basis of these comparisons across countries and between training and clinical settings, we will be able to assess which aspects of professional medical knowledge and practice are similar across national borders and which aspects of medical knowledge are localized. We will also take a closer look at those components of medical knowledge that differ between national or organizational settings. Some of the differences may be perceived as local by local actors but in fact confirm to cross border standardization. For example, a German university may become renowned for an innovative treatment method, even though this method has in fact been invented by a university in the USA and is merely spreading across the globe from there. At the same time we would not be surprised to find out that some apparently universal standards are closely connected to specifics of a place. For example, physicians in Germany may believe that morphine is the best drug for treating severe pain while US physicians may routinely utilize Codeine.

The project will focus on one frequent and severe diagnosis, chronic systolic heart failure, and the first steps of diagnosing and treating it in order to ensure a meaningful comparison between countries and settings of practice. Standards for the training and skill assessment of future professionals will not only be analyzed on the basis of text books and expert interviews, but also through the observation of simulation patient programs, i.e. in actual, albeit simulated, practice. In simulation patient (SP) programs a standardized patient is simulated by an actor and the physician-

to-be acts the part and afterwards receives feedback both by observing teachers and the actor. SP programs offer us a unique chance to observe the ideal of medical practice in an accessible and controlled setting.

The clinical practice of diagnosing and the first steps of treatment will be observed through participatory observation and analyzed with ethnographic methods. As it is more difficult to access clinical practice both in terms of ethics and in terms of language and cultural competence we expect to compare simulation patient programs in more than eight countries whereas we will focus on two country settings in observing clinical practice.

The project will clearly show which components of medical knowledge and practice converge and which are difficult to transport across national borders. It contributes to the sociology of globalization and of highly skilled labor migration by conceptualizing the connection between professional knowledge and the socio-territorial extension of the settings in which it is acquired and practiced on the basis of empirical findings. The project will also develop empirically grounded hypotheses as to ways in which knowledge universalizes and remains locally bound, even though it may prove difficult to prove that specific mechanisms are indeed causal for the observed glocalization processes.

The project contributes to medicine by identifying those components of medical knowledge that can be transported easily across borders and used with diverse patient groups. Considering the fact that the medical profession is quite heterogeneous in terms of migration status and ethnicity anyway, our findings will help medical schools to focus training programs on components that are globally versatile. It will also improve our understanding of those parts of knowledge that must be adjusted in the process of professional migration and/or the treatment of migratory patients. The project thereby contributes both to the success of internationally diverse teams of medical professionals and to the education of physicians who will staff these teams in the future.