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Health Professions and Occupations

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Over the past 30 years, sociologists have debated the state and future of the health professions. While the theoretical discussion in the 1960s was characterized by a belief in the future of powerful professions, the debate in the field since the mid-1980s has predicted the demise of such groups. It has even been argued that the distinction between health professions and occupations is an artifact of the vocabulary of sociologists. In fact some languages, such as French, make no distinction between a profession and an occupation and have but one word for both concepts.

Here the theoretical discussion in the field of the past decades is reviewed. First, the classics that focused on the medical profession are described, followed by an overview of the theoretical reinvigoration of the field that took place during the ten-year period between about 1975 and 1985. Finally, the main strands of research on health professions and occupations in the 1990s are presented.

Physician-centered Theories: Health Care as the Care of and Trust in the Physician

The sociology of professions is a rather narrow field of research despite its vast literature. It covers economic restructuring and changes in knowledge and service delivery by trained experts. There is a clearly identifiable scholarly debate in the field. In fact, few other fields in sociology present such a linear development of the theoretical discussion as in the sociology of the professions. Each decade has been characterized by a dominant theoretical perspective that has first been gradually challenged and then superseded by alternative interpretations. These have subsequently become dominant in the field and have served as

the interpretative frameworks for empirical research. The focus of this review will therefore be on the theoretical perspectives rather than the ensuing empirical studies where single health professions or occupations have served as case studies.

Seven theoretical perspectives on the power and structure of health professions and occupations will be reviewed: the functionalist, interactionist, neo-Weberian, neo-Marxist, feminist, social constructionist, and neo-system theories. A summary of the characteristics of these theoretical frameworks is presented in figure 8.1 that lists each perspective by level of analysis, the assumptions about the structure underlying the power of various health professions, and the characteristics of the internal structure of health professions and their relations to each other.

The classical theory on professions in sociology derives from a functionalist sociological approach represented by Emile Durkheim and Talcott Parsons. For Durkheim, the role of intermediary organizations and the organic solidarity, growing out of the modern division of labor, signaled the rise of the functions that professions and occupations would come to occupy in modern society. A functionalist perspective on professions was also the interpretative framework used by the American sociologist Talcott Parsons (1949, 1951) in his work on professions. Parsons saw in the profession of law, but especially in the medical profession, the prototype of occupations based on expertise in modern society. The role of the professions was based on expert knowledge, a service- and collective-orientation that guaranteed the kind of expertise and trust that individuals needed to handle their intimate problems. The professions harbored a particular relationship of trust *vis-à-vis* the client compared to the morality of the businessmen whose interest in profit was the underlying motive for a different kind of behavior. Hence, Parsons distinguished the "professional man" from the "business man." He viewed the former as an altruistic servant of his clients, whereas the latter pursued his own self-interest (Parsons 1949: 186). Although a consensual view of society and a view of professions based on mutual trust between the client and the professional has been attributed to Parsons, Parsons was not unaware of the special character of the American medical profession. He pointed to the growth of the American industrial economy characterized by giant corporations and mass commodity production, while at the same time the medical profession was acting outside of this industrial economy and even defending the entrepreneurial character of American medicine and its ties to the private character of the family and the residential community (Parsons 1963: 26).

The functionalist theory of professions became the dominant perspective for studying the medical profession in the 1950s and 1960s. Yet it is important to remember that another perspective was also launched during those years, representing a social interactionist perspective. Everett Hughes's (1958) collection of essays *Men and their Work* offered an alternative interpretation of work, occupations, and professions. For Hughes (1958: 53), the focus of a study of any kind of occupations was the "social drama of work." In his view, most occupations bring together people in definable roles and it is in the interaction that the content of work and status are defined. An occupation is not a priori by means

of its expertise and knowledge a profession but a social status that is socially constructed (Hughes 1958: 44–5). According to Hughes (1958: 48), the aim of the study of work of occupations and professions should therefore be "to *penetrate more deeply* into the personal and social drama of work, to understand the social and social-psychological arrangements and devices by which men make their work tolerable, or even glorious to themselves and others."

The dramaturgical approach to health care as work was also represented by Erving Goffman (1961). He viewed an occupation as a service relation between the server and the served. Similarly to Hughes, Goffman (1961: 325–6) did not view professions as intrinsically distinct from occupations but rather as a particular type of personal-service occupation based on expertise. An expert provided a special type of "tinkering service," a service that Goffman defined in the following way: "the ideals underlying expert servicing in our society are rooted in the case where the server has a complex physical system to repair, construct, or tinker with – the system here being the client's personal object or possession." Tinkering services contain a series of distinct phases, which constitute the "repair cycle" (Goffman 1961: 330). The medical version of the tinkering-services model confronts, however, a major problem – the body. It is a possession of the served that cannot be left under the care of the server while the client goes about his or her other business. A large part of the medical encounter contains therefore "non-person treatment" or ways of handling the patient/the body as "a possession someone has left behind" (Goffman 1961: 341). Furthermore, the verbal part of the server's exchange contains three components: a technical part that contains the relevant repair information, a contractual part that specifies the terms of the repair task, and the sociable part that involves courtesies, civilities, and signs of deference (Goffman 1961: 328–9). During the past decade, the dilemma of the presence of the body in medical encounters and the physician's preference to focus on the technical part while being oblivious to the social part of the verbal exchange have been in focus of a whole new genre of research. Based on the interactionist framework, several studies have examined the interaction between clients and health care experts. A new method – conversational analysis – has been one of the outcomes of this research (Atkinson and Heritage 1984; Silverman 1987; Peräkylä 1995; 1997; Psathas 1995).

While Goffman has continued to inspire sociologists interested in the dynamics of the patient–physician relationship, Hughes's work seems to have been less referred to in the 1970s and 1980s. Those were the decades of rebuttals of the functionalist view of professions, much of it inspired by Hughes's work. The initial challenge came from Eliot Freidson's book *The Profession of Medicine* (1970). Freidson challenged the basic assumptions of the Parsonian model of the physician's behavior, that is, its normative basis. For Freidson and the approaches that were to follow, the assumption was that the medical profession's power was based on its appeal to its service orientation and scientific expertise that legitimated its mandate and autonomy. Yet the profession was also seen as a group acting to preserve and confirm this position.

Later critics have argued that Freidson's theoretical foundation is diffuse (Coburn 1992) and even inconsistent, not to mention that it completely lacks

an empirical foundation. Such criticism seems to miss the point about the role of *The Profession of Medicine* (Freidson 1970) and its path-breaking influence in the field. At the time it was published, it offered a fresh look at an old theme and showed a way forward from the theoretical stand-still that had characterized the field for well over a decade. Freidson's book sparked a debate in American research on health professions that went on for over two decades. The positive aspect of this debate was the ensuing alternative interpretations of the power of the medical profession and a mushrooming of case studies of the development and power of the medical profession in various countries. The drawback of this debate was that it retained the focus on only one health profession – physicians – and postponed in this way the exploration of the character, clientele, and function of other health professions and alternative health occupations.

The intense phase of research on the American medical profession that followed between 1975 and 1985 was in retrospect related to the dramatic change of the American health care system that began during those years. There were two main trends in this research: one approach focused on the extraordinary power that the medical profession had acquired in the American health care system, and the other projected the demise of this power as a sign of a structural change of American health care characterized by a bureaucratic and consumer-challenging structure. The neo-Weberian perspective became the major theoretical framework for those who tried to explain the united power of the medical profession and the challenges or professional projects pursued by other health professions and occupations. Larson's (1977) work was influential in starting this genre of research, and the concepts professional projects and social closure were used to describe the jurisdictions, mandates, licensure, and power of professions *vis-à-vis* occupations (see figure 8.1). This theoretical framework has been the one most used in empirical studies of the history of the (allopathic) medical profession and of how it succeeded in becoming a united professional body among competing medical sects in various national contexts. It has also been applied in studies on how certain types of physicians managed to achieve a specialty status, and on the professionalization of a variety of health occupations and the steps they had to take to achieve a professional status. Furthermore, this framework has been used by American and European scholars to explain the division of labor within their health care systems (e.g. Wilsford 1991; Hafferty and McKinlay 1993; Moran and Wood 1993; Johnson et al. 1995).

The neo-Marxist perspective on the power of the medical profession, introduced by McKinlay and his colleagues (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Marceau 1998), foresaw the gradual decline of the professional dominance of the American medical profession due to the growing corporate and bureaucratic structure of American medicine. American physicians, they argued, were increasingly becoming salaried and the power was no longer in the hands of the profession but in those of large health care corporations that composed the expanding medical industrial complex (see figure 8.1). This process was not an isolated American event but a more global development or as they argued "no country or health care system can be considered immune. Indeed US experience may be instructive for doctors and

Perspective	Underlying structure	Focus of analysis	Structure of the profession
Functionalist: Parsons	Normative consensus	Professional role of physicians	United body
Interactionist:			
Hughes	Social drama of work	Occupational culture	Contractual and relational power
Goffman		Tinkering service	
Freidson	Professional knowledge	Medical work	Professional dominance of physicians
Neo-Weberian	Modern society and rationalization	Professional projects	United profession due to professional closure
Neo-Marxist	Capitalist economy	Corporate and bureaucratic structure of health care	Corporate control of health care and proletarianization of physicians
Feminist	Patriarchy/gendered structures	Gendered organization of health care	Gendered Professional projects
Postmodern/social constructionist	The medical discourse/the medical gaze	Discursive practices/strategies	Fragmented character of power
Neo-system theories	Marketization of medicine	Jurisdictions and allies	Pluralist notion of power

Figure 8.1 Theoretical perspectives on the power of health professions

health care researchers in other national settings as to what they may expect" (McKinlay and Stoeckle 1988: 191).

This debate originated in the responses to Freidson's (1984, 1985) addendum to his original monopolization or professional dominance thesis. In his addendum – the so-called restratification thesis – Freidson proposed that despite changes, the American medical profession would be able to maintain its dominance because it had adapted by differentiating into three segments, each with its specific task: an administrative segment, a knowledge elite, and a rank-and-file group. This internal differentiation would guarantee a status quo of the profession's traditional power position. Although such an internal differentiation indeed has taken place, critics have argued that the managerial positions are no longer filled by physicians and that the knowledge elite itself is internally differentiated into small expert circles, with their own associations and little affinity to advance the interests of the profession as a whole. Furthermore, the statistical facts have added strong evidence to McKinlay's argument: The growth of corporatized medical care and the proportion of salaried physicians have increased dramatically in American health care during the past 15 years. For example, in 1983, only 23 percent of American physicians practiced as salaried employees but in 1994 the figure had already reached 42 percent and it is steadily increasing among the younger physicians, the majority of whom now practice as salaried employees (Kletke et al. 1996: 557).

A more general theory of professions was introduced by Abbott (1988) in *The System of Professions*. According to Abbott, the power of a profession lies in its jurisdiction and the profession is linked to other professions through a system of professions, where boundaries are constantly negotiated (Abbott 1988: 33). This approach is exemplified by three case studies: a presentation of the historical roots of the jurisdiction of information professions, law, and experts on personal problems. In his more recent work, Abbott (1999) has tended to move even further into a neo-functionalist framework by viewing the "system" as an "ecology" with fluid boundaries between interacting groups and audiences. Abbott's model seems to have been more used in studies of service occupations than in studies of health professions or occupations that have tended to be well organized and strive for professional recognition and status (Benoit 1994). As MacDonald (1995: 14–17) suggests, Abbott's concept of system is a theoretical hybrid, suggesting partly an interdependence (systems theory) and partly a market model of actors (Weberian theory). A similar hybrid is Light's concept of "countervailing powers" which he, by references, locates in the neo-Marxist tradition of professional theory (e.g. Light 1995: 26), even though his own theoretical arguments suggest a pluralist perception of power in the area of health care. In this respect, both Abbott and Light fall into the category of neo-system theories listed in figure 8.1.

Gender and Health Care Work

All the theoretical perspectives mentioned above have been gender-neutral or tacitly gendered in the sense that physicians have been viewed as men and subordinated health professions as composed of women (which until recently has been a statistical fact in most countries). Yet this gendered division of labor was not problematized and explained but taken as a given in mainstream theories on medical work. Already in the 1970s, feminist scholars began to challenge the gendered character of medical work and to portray medicine as a patriarchal institution (e.g. Ehrenreich and English 1978; Oakley 1980) and the medical profession as composed of men (figure 8.1). Furthermore, nursing has not only been portrayed as a caring profession but also as a subordinated female profession (Abbott and Wallace 1990; Witz 1992; Davies 1995). The identification by British sociologists (e.g. Witz 1992; Davies 1996) of the gendered structure of medicine, the gendered character of professional projects in health care, and the gendering of profession, has constituted a significant new addition in the otherwise gender-neutral literature on health professions and occupations. According to Davies (1996: 623), "acknowledging that what contemporary professions profess is masculine gender may then prove to mark an altogether new stage in the sociology of professions."

Yet the increasing number of women in the medical profession in most countries has constituted a welcomed statistical figure (see table 8.1) for many feminists, but also a complex question in feminist terms. Will medicine remain a masculine culture, as propagated by the patriarchal theorists, despite women's presence at various levels in the medical profession, or will women constitute a

vanguard that will change the culture of the profession as a whole? These issues have been raised over the past decade by many women's health advocates and researchers alike. Empirical studies on women physicians in various countries tend to confirm a drastic increase of women in medicine since 1970, but marked gender segregation of medical specialization and type of practice is still found in the United States, Great Britain, and the Nordic countries (Lorber 1984, 1993; Riska 1993; Pringle 1998). Women physicians tend to practice in specialties that fit their assumed, traditional female-gender qualities: they tend to work in primary-care areas that are high-interaction fields and other fields that cater to children and elderly, such as pediatrics, child psychiatry, and geriatrics. By contrast, low-interaction fields and fields associated with heroic medicine tend to be male-dominated, such as surgery, sports medicine, and internal medicine.

Two types of explanation have been given for the gender-segregated character of medical work: a structural and a voluntaristic. The structural explanation points to barriers that prevent women from advancing in medicine, e.g. lack of mentors (Lorber 1993). The voluntaristic interpretation covers a broad range of frameworks, including the socialization theory and essentialist explanations. According to the former, women are socialized to follow stereotypic gender expectations and tend therefore to make occupational choices that fit these expectations. According to the latter, women are essentially different from men – more empathic, less interested in the heroic aspects of medicine than men – and tend therefore to choose specialties that provide them opportunities to practice the kind of medicine that they prefer and in areas where they can use their gender-specific skills (Altecruse and McDermott 1987: 85).

Table 8.1 Percentage of women physicians in various countries

Country	*Percentage of women physicians*	*Year*
Nordic countries		
Denmark	35	1999
Finland	49	1999
Iceland	20	1999
Norway	30	1999
Sweden	38	1999
Great Britain	28	1990
Italy	20	1990
France	31	1990
Germany	26	1990
Spain	41	1990
Soviet Union	68	1990
United States	17	1994

Source: Nordic Medical Associations 1996: 44; 1999; Bickel and Kopriva 1993: 142; Kauppinen et al. 1996: 166.

The Division of Labor in Health Care and Alternative Medicine

The feminist research on health professions has raised the issue of the broader underlying power structures in health care. While the American theorizing and research has almost exclusively focused on the medical profession, it is characteristic of British research that it has covered a broad range of health care practitioners. In the British context, Freidson's work did not have as much influence as other representatives of the power approach: Johnson (1972) and Parkin (1979). Parkin's development of the Weberian notion of closure became a framework for studying intra-and inter-professional competition and control and a useful analytical tool for the empirical study of a variety of health professions and occupations. The broader division of labor in health care seems to characterize most British research on health professions and occupations and includes even lay carers as health workers (Stacey 1988). This broader view of the division of labor in health care has been evident in studies that have covered single professions. Dingwall's studies on health visitors (1979) and nursing (Dingwall et al. 1988) were suggestive of such a framework. Furthermore, traditional views of nurses as a passive and homogeneous group have been challenged by British sociologists, who have pointed out the social class and race divisions within nursing (Carpenter 1993) and reconceptualized nurses as actors dealing with their subordinated status as a group of women (Porter 1992; Witz 1992; Davies 1995).

The specific feature of British sociological research on health professions and occupations is, however, its coverage of alternative medicine and its practitioners – homeopaths, chiropractors, acupuncturists, osteopaths (e.g. Saks 1992, 1995; Sharma 1995) – compared to the American focus on predominantly the practitioners of bio-medicine. Studies on alternative practitioners tend to remind its readers of the power structure of regular medicine and its specific therapy tradition in western societies compared to developing societies. Even in western societies, regular medicine has become more tolerant of the coexistence of alternative therapies and most European societies have allowed some of these therapies to be reimbursed/delivered within the the national health system/ insurance schemes.

The Social Construction of Medicine

The social constructionist perspective on medical work is not primarily focused on the medical profession but rather on medicine as an institution of social control and the medical profession as its agent (figure 8.1). Some perceive the central task to be the identification of the cultural basis of contemporary medical knowledge (bio-medicine) and practice, while others take an interactionist stance and suggest that the sociological inquiry should focus on how medicine is constructed and confirmed in the interaction between the patient and the physician. In the 1990s, these approaches have found a common denominator.

The body is seen as the site and contested terrain where the cultural conceptions of illness and disease, the lay and professional knowledge, the taken-for-granted character of biology and culture, and the readings of signs of symptoms and experience of illness are projected and negotiated.

In the literature on medical/health sociology, the social constructionist view traces back to the Brandeis school of medical sociology represented by the concept of medicalization and medicine as an institution of social control (Zola 1972; Conrad 1992, 1999). The medicalization thesis is based on the notion of the power of the medical profession to define and even expand its jurisdiction to include phenomena that are social rather than biological. A refurbished version of this thesis is Conrad's (1999) gene theory, by means of which he denotes a trend in society to present a new reductionist explanation for illnesses and behaviors supplanting the germ theory: the media and public discourse present genes as the cause not only for diseases but also for a variety of behaviors, such as alcoholism, mental illness, homosexuality.

As Lupton (1998) points out, there is a clear difference between the social constructionist perspective and its medicalization argument and the Foucauldian notion of medical knowledge and the power of medicine and the medical profession. While the medicalization thesis presents medical knowledge as a form of ideology, there is a tacit assumption that lay and experiential knowledge represents a more "authentic" medical knowledge, at least as represented in the works of Illich (1976), Fisher (1986), and Martin (1989) to mention a few. In these works, the medical profession is viewed as an all-powerful body and patients as almost the "victims" of the practice of the physicians' abstract medical knowledge (Atkinson 1995: 33). Current society, characterized as "late modernity," is predicted to provide a fertile ground for a process of demedicalization, whereby a lay "reskilling" – viewed as the reappropriation of the skills and knowledge about health and the body – is going to take place (Williams and Calnan 1996: 1616).

The Foucauldian view, deriving from the works of the French philosopher Michel Foucault (1975), presents medical knowledge as a discourse, a way of seeing and reading the body. The medical profession is the applier of a medical discourse, which in the age of bio-medicine is a certain medical gaze that constructs the body as a body of organs and tissues. The task of the physician is to read the signs of the disease and thereby read the body and the disease within it. The power of the medical profession and the way that it has organized medicine around this medical discourse have been in focus of a number of sociological studies. For example, Armstrong (1983) has used the Foucauldian framework to explain the rise of the British medical profession, the public health orientation within the British national health system, and the more recent preventive and lifestyle orientation of medicine that he calls "surveillance medicine" (Armstrong 1995). Others have looked at how certain groups of specialist physicians, for example surgeons (Fox 1992) and haematologists (Atkinson 1995) construct their work by means of certain discourses and discursive strategies. The power of the medical expert is perceived as embedded in the medical context, a characteristic that Atkinson (1995) calls the "liturgy of the clinic."

The Foucauldian view of the power of the medical profession seems at first sight similar to the medicalization thesis. Yet, in the Foucauldian approach the concept of power is seen as fragmented: power is a relationship that is localized, dispersed, and operates through various practices (Lupton 1998). There exist competing discourses, even if the medical discourse is the dominant one. Furthermore, practices cannot merely be conceptualized as expansive and exploitative characteristics of the medical profession since they operate as disciplinary regimes at different levels, including self-regulatory practices in constructing the self. In this regard, the patient is not primarily an object of a medical discourse. The status of patienthood presupposes an internalization of the concepts and the gaze of medicine but entails also its contestation. As Lupton (1998: 107) notes, according to the Foucauldian perspective, so-called de-medicalization does not lead to more "authentic" modes of subjectivity and embodiment but merely to a different frame of reference.

Conclusions

This chapter has reviewed seven theoretical perspectives on the power and structure of health professions and occupations: the functionalist, the interactionist, the neo-Weberian, the neo-Marxist, the feminist, the social constructionist perspectives, and neo-system theories. A summary of the characteristics of these theoretical frameworks, shown in figure 8.1, lists each perspective by level and focus of analysis, the assumptions about the structure underlying the power of various health professions, and the characteristics of the internal structure of health professions and their relations to each other. The advent of this field of sociological research was based on the functionalist framework, which saw the institutionalization and authority of the medical profession as based on the trust in the profession. These assumptions were, and continue to be, challenged by alternative theoretical frameworks. The issues of the benevolence of and the trust in the medical profession continue to characterize the debate.

American research in this field has been heavily focused on the medical profession. The concept of "medicalization" was introduced early as an analytical tool to describe the unique power of the medical profession not only in its own domain but also in its expansionist endeavors to integrate many aspects of life and behavior under its jurisdiction, as, for example, birth, adolescence, aging, alcoholism, and PMS. Feminist researchers have shown that these expansionist endeavors have primarily been directed at women's bodies and therefore perceive medicalization as evidence that medicine is a patriarchal institution. Empowerment of women as patients and the care by other health professions – midwives and nurses – and practitioners of alternative medicine became a central theme in the non-physician-oriented research.

British research on health professions and occupations has been less physician-centered than American research and has presented a broad view of the division of labor between various health professions, which even included lay carers as health workers. Furthermore, European, Canadian, and Latin American

research has given the state a central role in shaping the conditions of health professions (see Jones 1991; Hafferty and McKinlay 1993; Johnson et al. 1995) and for obvious reasons: health care systems with publicly financed and run medical care, with a large fraction of physicians being salaried employees, and public health nurses and general practioners working at local health centers constitute a different arena for the relationships between various health professions than the market-oriented American health care context. This research has also illustrated how external economic and political conditions have influenced the internal divisions within the medical profession in, for example, Spain, Israel, Belgium, and the Netherlands (Rodriguez 1995; Shuval 1995; Schepers and Casparie 1997).

There are, however, a number of issues that have been but sparsely covered in current research on health professions and occupations. There are, for example, only a few sociological studies of work pursued in the hospital setting. A number of sociological classics on the hospital as a social organization – studies on work done at the ward and on the external ties of hospitals to the community – were done in the 1960s, but presently this institutional setting of medical work seems mostly to be a research field of health services researchers. While clinics and office-based practice have been in the focus of sociologists using an ethnographic and symbolic-interactionist approach, the hospital setting has received less attention. The changing nature of the hospital (Armstrong 1998) might partly explain this void.

Another area related to hospital medicine is the vast array of health professionals, who do work that does not entail any caring. Laboratory medicine, medical research, and health care managers include a variety of occupational groups that have diverse educational backgrounds and occupational loyalties (Nettleton 1995). These groups have so far been largely ignored in the sociology of health professions and occupations. Furthermore, efforts to control and regulate the therapy traditions of physicians by means of evidence-based data sources constitute a new feature of public health policy. In many countries (e.g. Sweden and Canada), evidence-based medicine and its emphasis on clinical guidelines and rules for "good practice" represents a professional reform movement, which is composed of an interesting coalition of various health professionals. But to what extent these endeavors constitute a symbolic or real control over the clinical and professional autonomy of the medical profession is an issue that needs further sociological study. Obviously, more studies on the occupational culture of specialist physicians and other health professions will provide a greater understanding of how health workers construct the content of their work, and how they accommodate with or overrun the effects of the large structural changes that are currently taking place in most health care systems. Here the work by Hughes, Goffman, and Foucault provide useful theoretical frameworks for understanding the workplace, the larger institutional settings, and the cultural arrangements and practices embedded in health care work.

The interactionist and phenomenological accounts of the work conducted in health care settings provide a much needed understanding of what Hughes and Goffman called the social drama of work. In these days of the revival of the

micro-level analysis of health care work, it is, however, important to continue the examination of two powerful macro-level systems – the market-driven economic system and the gender system. Both systems shape the broader structural framework within which the members of health professions and occupations conduct their everyday work.

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