& PROFESSIONS PROFESSIONALISM

ISSN: 1893-1049 Volume 7, No 1 (2017), e1611 http://doi.org/10.7577/pp.1611

**Werner Vogd**

# The Professions in Modernity and the Society of the Future: A Theoretical Approach to Understanding the Polyvalent Logics of Professional Work

**Abstract:** In this article, I draw attention to the societal arrangements that permit or produce the autonomy of professions since professionals have the task of holding the tension among different perspectives. To do so, they must apply differing, irreconcilable logics of reflection and balance them in their decision-making. To gain a differentiated understanding of the complexities of these processes, I propose a metatheoretical conceptualization of the dynamics of professions based on Gotthard Günther's theory of "polycontexturality," which can be used both to analyse the interactional processes and to embed them in society. I illustrate this argument with an example from the field of medical treatment. The proposed approach also lays the basis for a differentiated understanding of phenomena, which psychoanalysis has traditionally described in terms of transference and countertransference.

**Keywords**: Professions, sociology, systems theory, transference, society, institutional logics

In this paper, I propose a systems theoretical conceptualization of professions. Particularly, I suggest that professionals act in specific domains of social interactions where different operational logics interpenetrate, often creating tensions as well as uncertainties or paradoxical behavioural expectations or both. As a consequence, professionals have to develop specific reflexive capabilities that enable them to cope with these tensions and insecurities and to reconcile conflicting expectations. I propose Gotthard Günther's (1976) theory of "polycontexturality" as a suitable tool for capturing the logic of such reflections in sufficient depth to do justice to the subject.

One of the most important insights from viewing the sociology of professions from the standpoint of a polyvalent logic is that the professions are strongly confronted with aspects of a polycentric society that has more than one rationality, logic or locus of reflection. This is already evident in the interactional relationships that exist between the professions, which go beyond merely factual issues and must always also include the alterity of different, embodied subjectivities in the form of different logical and ontological domains (e.g., as described by Latour, 2013 in his book *An Inquiry into Modes of Existence*). While these subjectivities are not accessible epistemically, they still inform the actions of the members of the professionals. Thus, I open up a viewpoint from which the professions can be seen as expressions of the dynamics of a polycontextural society. In this light, they can be regarded as

*Werner Vogd,* University Witten/Herdecke, Department of Sociology, Germany

**Contact:**
*Werner Vogd,* University Witten/Herdecke, Department of Sociology, Germany
werner.vogd@uni-wh.de

***Received:*** 2 Aug 2016

***Accepted:*** 03 Jan 2017

resulting from epistemic and ontological uncertainties that arise from modern and postmodern reflective relationships. At the same time, it becomes evident that professions need to be able to trust the system that renders the actions of professional actors plausible.

## Outline of the problem

A glance at the current state of research on the sociology of professions reveals a confusing picture. I find both predictions regarding the further development of professionalization and concerns about a trend towards deprofessionalization.[1] Some authors equate professionalization with standardizing training in expert professions (e.g., Dent, Bourgeault, Denis, & Kuhlmann, 2016), some with a status group that persuades society to grant it a privileged position (e.g., McDonalds, 1999), while others prefer a stricter definition of the concept of profession, such as "orientation towards clients, possession of an intrinsic knowledge system, service ideals" (e.g. Stichweh, 1997, p. 97).

Likewise, there are quite diverse theoretical approaches to the phenomenon of the formation of professions, which at first glance even appear to contradict each other. Rather than playing the different theoretical approaches against one another, it seems more fruitful to regard them as complementary so as to make theoretical gains.

The most obvious starting point for theorizing about professions is occupational sociology. This can include both clarifying the subject matter of the expertise in question (distinguishing between the relevant fields of knowledge) and looking at the social dimension (i.e., who is authorized to employ and to act as representatives of the knowledge and how this expert status is achieved and consolidated).

On this level, as pointed out by Abbott (1988), we can gain some interesting insights which transcend the perspective of the theory of power. The starting point is the finding that the special status of the professions must be associated with a monopoly that is protected by statute. However, interwoven with this there is a more subtle systemic structure, (i.e., the calming of *internal* competition and tensions). If anyone were free to exercise his or profession, the work to which the profession's members would feel committed would be subject to competition, which could only be mediated by the market. This could all too easily lead to a corruption of the work. In this vein, Freidson (2001), who had previously been known for his more critical stance towards professional dominance (e.g. Freidson, 1970), discovered the *third logic* of professions as an element that would be both productive and necessary for compensating the tensions between the markets and bureaucracy.

Here already our attention is drawn in the direction of a societal arrangement that allows or produces the autonomy of professions since professionals have the task of *holding the tension* between *different perspectives*, requiring the application of *differing and irreconcilable logics of reflection* and *balancing* them in their decision-making. This does not deny that the stabilization and maintenance of professional power are always associated with micropolitical positioning games. However, such games must themselves be seen as part and parcel of an overarching arrangement since professional autonomy needs to be fought for and defended, not only to satisfy the profession's own interests but also to ensure that the professional decision maker's role remains institutionally validated. Alternatively, referring to Evetts' work (2013), the ideological and value-oriented elements of professional actions do not exclude or oppose but stabilize and legitimize each other, making the respective services of professional work possible.

---

[1] For the examples of contributions to this debate, see Filc (2006).

Many professionals—especially medical doctors—are also always obliged to decide for other people who, even if they make such decisions, are not in fact in a position to assess what consequences they will have for the development of their autonomy. Thus, professionals have the task, which initially appears paradoxical, of establishing what their clients actually want while it is not yet evident since their ability to formulate or even be aware of their will may be restricted or unclear. This may be due to illness, lack of insight into the decision's consequences or, in the case of children and adolescents, their not yet reaching the stage of maturity at which they can fully exercise their autonomy. In the last case, professionals may feel compelled to employ pressure or other communicative tricks to empower clients to do something without being able to understand why.

A doctor will accordingly attempt to induce some of his or her reluctant patients—by either using gentle hypnosis or painting a threatening picture—to agree to a treatment whose benefits they are unable to grasp and which initially appears associated only with pain and suffering.

Teachers act as professionals when they orient their curricula, the teacher-student interaction and the teaching materials stipulated by the examination requirements in such a way that their students can in the future more easily find their way around those cultures that require the knowledge imparted. The teachers may neither succumb to their students' superficial wishes to "have it easy" nor teach and sanction them mechanically without considering the consequences for their students' future development.

A lawyer who is qualified (as described above) and feels committed to the ideal of the professional-client relationship should not only establish whether some means of legal redress for his or her client exist but also whether the client will likely be embroiled in a detrimental spiral of hate. Over the long term, the latter's consequences could damage the client more than would be offset by the settlement obtainable with the expected outcome.

For a critical sociologist, the cited viewpoints must appear totally euphemistic. For example, why should a person believe that a doctor is really concerned about his or her patient's well-being and not simply about his or her own (covert) interests? Moreover, how can someone free oneself from the suspicion that the doctor is only interested in achieving self-gain?

However, from the sociological standpoint, it is more interesting that whether or not the professionals' talk about establishing rapport with their clients can be taken seriously *cannot be decided* by an external observer (as one cannot see into another person's mind). It is also true that the fact that one cannot know whether one can really trust a professional does not change one's dependence on doctors, lawyers, teachers, psychotherapists, and other professionals. On both sides—that of the professionals and that of the clients—there is thus great uncertainty as to what is the case, what is the right thing to do and what motives drive what happens (i.e., whether it is in the clients' interests or shaped by other interests). This dilemma can only be solved by reciprocal recognition of the subjectivity of the other since this is the only way that a stable and supportive relationship can develop, in which the critical decision processes can be balanced, and where there is trust in the honest and incorruptible attitude of the actor with the greater structural power (the doctor, lawyer, teacher, etc.).

Professionals and modern subjects would thus, in a sense, appear caught up in a circular way in an arrangement that both produces and presupposes the elements that constitute it. It is, therefore, crucial that there be confidence and trust in the system present in order to create both the professionals and the subjects who are enacted by it as individuals who act autonomously and also to stabilize their autonomy.

However, this also brings into relief the perspective of the theory of society, which any serious sociological theory of professionalization must address. On the one hand, this is a specific societal form of arrangement that permits professionality

and subjectivity to enter the foreground as two complementary poles of a functionally differentiated society. On the other hand, the arrangement itself must be considered both the product and the starting point of the social practice and its evolution (cf. Stichweh, 1997).

What conceptual and theoretical instruments are then suitable for describing and reconstructing these complex relationships? While the classical approaches of the theory of professions provide some important pointers, it has not yet been possible to generate a comprehensive picture of the genesis and dynamics of professional actions.

In the following sections, we, therefore, turn to Günther's (1976) logic of reflection, which takes its starting point at a level below the differentiation between subject and object (i.e., in the process of reflection as "doing ontology," which differentiates between subject and object or another subject as an individual whose actions are autonomous). This attention to issues of logic and the associated ontological attitudes is not a "glass-bead game" (Hesse, 1949) but highly relevant for empirical reasons. For instance, this becomes clear in the case of a doctor who treats a difficult patient in one situation as a subject, an object or both or is able to oscillate between these alternatives. The way that this happens (or not) in turn also depends on a reflection (i.e., a practice).

Precisely for these reasons, it seems useful to employ the resources of polyvalent logic to explore the possibilities of a protosociology that offer insights into the above-mentioned complex dynamics (first section). I then take this as a basis for tracing the developments of the different societal arrangements that produce and reify the specific significance of the professional. I show this by taking the medical profession as an example. Since I also find polycontextural arrangements in the activities of other professions, it could be interesting to use this model to analyse their specific intrinsic dynamics; however, space constraints preclude their inclusion here (third section). Finally, I examine possible future risks to professions.

## Expanding the focus by applying Günther's logic of reflection

To capture the unavoidable problem in the theory of professions (i.e., others' subjectivity is inaccessible to us yet needs to be considered), following Günther's works (1976, 1978), I start from the assumption of multiple logical spaces (i.e., social reality is *polycontextural*[2]). Expressed in formal and abstract terms (see below for examples), different relationships between subject and object and the associated divergent rationalities, ontologies and epistemologies exist side-by-side. They complicate, interfere with and lead to each other reciprocally, with no possibility of attributing them to each other in a logical or causal sense.[3] These spaces are linked to and nested within each other via various reflexive relationships, with no possibility of shifting them to an overarching *mode of existence* (for a similar view, see Latour, 2013).

It might initially appear unusual to use instruments of logical reflection to address issues in the sociology of professions. However, professionals have always been confronted with irreconcilable institutional logics[4] in their everyday work and with relationships between subjects that seem equally complicated from a logical perspective. Thus, whether they consciously will it or not, they have always acted as *empirical metaphysicists* who decide for themselves *ad hoc* what the case is and how the

---

2 For more information on polycontexturality, see Knudsen and Vogd (2015).

3 For more details, see Jansen, von Schlippe, and Vogd (2015, pp. 19 ff).

4 For more information on the institutional logic approach, see Thornton, Ocasio, and Lounsbury (2012).

boundary between subject and object must be drawn in each situation. For this very reason, it would seem expedient to conceive of professionals as experts in solving complex logical problems (i.e., problematic situations that cannot be dealt with in a trivial manner but need to be analysed with the instruments of a many-valued, polycontextural logic). For example, doctors must evaluate whether patients are so overwhelmed by their emotions that they are no longer able to decide what is good for them or conversely, whether they are capable of expressing these emotions and saying what they actually want. In the first case, the emotions appear to express the patients' subjectivity, and doctors may want to follow the associated implications for action, while in other cases, they may want to ignore or bypass these. Thus, doctors have to decide which course to take on the basis of perceptions that can be ambiguous, requiring a complex reflection. I, therefore, examine in more detail the theory of polycontexturality to develop the appropriate metatheoretical sensitivity.

The concept of *contexture*, as coined by Günther (1976), refers to a reflexive configuration that expresses and arranges specific relationships between the self and itself and the self and the world, respectively. Günther calls for the introduction of the logic that can work with many-valued structures. The basic assumption is that in classical two-valued logic, the operation of negation constitutes a step that transcends the two-valuedness itself. As a result of the axiomatic structure of classical logic—the laws of identity, non-contradiction and the excluded middle—a reversible relationship between *p* (*p* is) and ~*p* (*p* is not) is established, where each position is determined by its difference from the other (e.g., a rose is red or not red). Günther points out that negation must necessarily transcend two-valuedness since, without it, there can be no reversible relationship although the associated reflexive relationship itself is not determined by the axioms. (In my example, an observer position is needed to open the space where it can be asked whether the issue is *the rose is red* or *not red*).

Accordingly, for Günther (1978), negation is the starting point for the development of a many-valued logic. It must thus be considered a *transjunctional operation* because it is required to constitute the unity of a certain duality or two-valued structure as a contexture. However, directing the attention to this constitutive operation simultaneously transcends it and makes it possible to develop further contextures. In this sense, the *transjunctional operation* is a reference to the respective observer positions. It makes it possible to switch between the contextures as different logical positions of reflection. (In my example, I could open a different logical space with the question and observer position as to whether or not the rose is thorny).

Additionally, several individual contextures can be joined to form a common metastructure. In this context, Günther discusses *compound contextures* (1979, pp. 191 ff). He views the linking of three elemental contextures as the minimum requirement for such a compound structure, with the third contexture regulating the relationship between the other two. To give an example from the social sphere, a judge might decide, based on the laws of the land, whether or not a criminal offence has been committed (i.e., whether the defendant is guilty or innocent). In contrast, a psychiatrist would ask whether the defendant was, in fact, capable of autonomously carrying out an act of will when the crime was perpetrated. The psychiatrist might then conclude that the defendant was suffering from a mental disorder that deprived him or her of the capacity for criminal responsibility. The question of the illness moderates the one about the capacity to take responsibility for an act of will, which in turn opens the possibility of the judge's decision on the defendant's culpability. We could consider other compound contextures and ask which contextures (or institutions) moderate the distinction as to when the competence to decide on the issue of culpability should be made on the basis of the law and when this should be left to a doctor and why the case is not decided on the basis of religion (e.g., to examine whether the perpetrator was possessed by the devil).

At this point, it is important to realize that applying the instruments of the logic of reflection should not be considered an epistemological "glass-bead game" (Hesse,

1949). Instead, it primarily serves to provide analytical concepts that allow access to the arrangements of reflexive relationships, which are operative in the practice of professionals.

Above all, this approach presents a more accurate picture of the emergence of the nested subject–object relationships of human interaction. To start, "I" stands for a simple reflexive relationship (i.e., reflection on "it" by "I", whereby the subject, in reflecting, opposes itself to the world). Associated with the establishment of this relationship is the institution of a contexture (i.e., an epistemic centre with ontology since the subject that has been thus constituted is not only the world but also behaves towards the world).

However, as soon as we enter the social sphere (i.e., consider an alter ego), the world appears *polycontextural*. Whereas the "I-it" relationship implies that between a subject and an objectifiable object and accordingly creates a simple contexture, the situation with an "I-Thou" relationship is different. In this reciprocal relationship, another "I" behind "Thou" develops his or her own subject-object relationship – and thus also his or her own contexture with its ontology. Since the phenomenal perspective of "Thou" cannot be accessed from the monocontexture of "I", the reflection of "Thou" adds something to the individual's own reality that is not covered by the simple reflection of the material world ("it") in the subject. We have no access to the subjectivity of the other.

It is also possible for us to reflect upon the relationship between two contextures. For instance, the "I" can consider the "it-Thou" relationship (i.e., another person's perception and perspective). The reflective distance thus created allows the completion of an operation that *discards* the view, predicated on the binary structure, that a person's own perception is the only possible one.

As pointed out, this becomes relevant in the relationship between the doctor as a professional and his or her patient. The doctor first considers the patient from the "I-it" perspective. With the illness as the focus, the patient is reified as a body. At the same time, an "I-Thou" relationship also develops between the doctor and the patient. However, in the interactional process, the doctor has to switch back and forth between the "I-it" and the "I-Thou" relationships to assign some of the patient's statements to the illness and others to what he or she really wants. This becomes clear in the case of depression and resignation. The patient may state that he or she does not wish to go on living and, therefore, refuse further treatment. On the other hand, the doctor can view the patient's hopelessness as a symptom of the illness and suspect that behind it, the wish to live will be recovered when the illness has been overcome.

From the analytical perspective proposed here, neither the will to live that the doctor postulates nor the patient's hope or lack of it is real in the sense of possessing an ontological essence. Rather, both are systemic properties of an overarching arrangement that rests on attributions with no ontic foundation (in the sense of relating to something real) but gain significance at the latest when the polycontextural arrangement starts to be stabilized (i.e., when sufficient trust in the system develops to allow two subjects to emerge, who then both produce and stabilize the different reflexive perspectives that are required).

## *The lived body, community, and society*

Since my goal in this article is to link together the perspectives of interaction among individuals at the level of society, it is worth examining more closely some possible forms of relationships (i.e., between *I* and the *body*, *I* and the *community*, and *I* and *society*). As embodied selves, we are not logical units but can be considered compound contextures. This becomes clear when we think of the dynamic of the oscillation between "having a body" and "being a 'lived body.'" Consciously, we can feel identical or non-identical with our bodies. This is moderated in a complex way by language, which furnishes us with a socially provided meaning (Merleau-Ponty, 2012). The question of identification or non-identification with our own bodies can

also be understood as an expression of a polycontextural arrangement, which is in turn "formatted" by interaction and communication.

This point is important for the theory of professions because it helps us understand the transferential phenomena of professional interactions. Thus, in their encounter with depressive patients, doctors will have to attribute their feelings to either their own action impulses or their transference or countertransference reactions and then, either distance themselves from these or follow these in their decisions. The ascription of transferential phenomena is also not logically unequivocal or supported by ontological certainty. It can only be the result of a reflexive relationship, which can be informed by the negativity of not knowing (i.e., which itself appears again as the expression of a polycontextural arrangement).

Moreover, the communicative relationships among various perspectives in society should be more strongly emphasized than generally suggested by the theory of practice or the sociology of knowledge. Unlike the "I-Thou" contextures, which are anchored in the lived body (one feels oneself and can see and touch others), these contextures appear as asensory abstracta or intangible concepts. Although as reflexive perspectives, they are not anchored in the body, they must be considered to have an effect and thus *real* because they have an ordering influence on other processes.

Organizations, law, medicine, politics, religion, scientific and academic institutions and increasingly, the black boxes of technical processes and so on, each develop their own independent communicative contextures, which in turn moderate the relationships among other contextures. Formal rules, laws, power relations, gods, truths and so on intervene in people's relationships with themselves and other people.

Thus, professionals have no choice but to consider the organizational aspects of a process (limited time and the institution's rules), the economic features of their work (what work is paid for) and the medical and legal dimensions of their actions (assessment of the extent to which their patients may be a danger to themselves and others). Conversely, patients will unavoidably in some way become aware that rationalities are involved in the therapeutic process, which do not directly involve their treatment. Thus, on both sides, the question is how the diverse perspectives of reflection can be brought together in an arrangement in which what is at stake remains, on the one hand, the need to maintain trust in the system. On the other hand, it entails including or excluding all those social spaces where reflection occurs and which together create the basis on which professional relationships would be possible. From all these points, medical treatment processes must inevitably comprise a complex arrangement of affirmations (confirmation of a contexture) and negations (rejection of the logic of a specific contexture) on the doctor's side alone. An example would be leaving financial considerations out of the equation at certain times to devote the doctor's attention entirely to the patient's needs, while at other times, paying attention to cost management in order not to overburden the organization. On the patients' side, they are equally aware of these issues; they can (and must) differentiate and determine through reflection whether their own or the doctor's interests or the systemic rationalities of certain social institutions are being followed.

## Professions as arrangements of self-conditioning observational positions of reflection

In this section, I attempt to use the tools of reflective logic (as developed above) to trace how arrangements evolve in professional contexts and how they are initially stabilized by society and then again subjected to a renewed process of transformation.

Once again, I present the medical profession and the doctor-patient relationship as an example and start by considering pre-modern medical treatment.[5] Given how

[5] For a detailed history of medicine see, for example, Ackerknecht (1982).

medicine used to be practised, it seems to have been mainly based on interaction. As a rule, the doctor and the patient knew each other quite well. This led to mutually stabilizing arrangements where the doctor reified his or her patients, reducing them to mere bodies while perceiving them as autonomous subjects and likewise being perceived by them as a subject who respected their subjectivity and autonomy. Out of this, an interaction developed that gave rise to corresponding expectations, which in turn produced an arrangement by which trust in the interaction was created by that very trust in the interaction itself, which then motivated the patient to submit to the treatment procedures. This, in turn, was possible because it meant that in the interaction, the doctor could command credibility both in his or her formal role as a medical practitioner and as a person who is human (i.e., be in both the pathic and the empathic positions). If the resulting relationship became sufficiently stabilized, the patient could be expected to undergo the treatments that were typical of premodern medicine—which from our contemporary viewpoint, often did the patient's health more harm than good.

The characteristics of the arrangement that evolved with modern medicine are quite different. The establishment of the hospital was the birth of an institution (Foucault, 2003) where as a rule, doctors and patients encounter each other as anonymous individuals. The patient is now primarily reified, treated simply as a body, with the other side being the doctor's claim of objectivity. This, in turn, requires a frame in which the doctor appears disinterested and oriented exclusively towards the objectively observable facts of the patient's disease. This again requires academic and scientific knowledge to have become sufficiently stabilized as an independent perspective of reflection (medical knowledge now accordingly appearing as "objective knowledge," while alternative interpretations of illness (e.g., those of religion and magic) can be excluded as "subjective" beliefs.

Medicine should also be integrated into sufficiently stable institutions, which render it plausible that economic needs and political interests are set aside in medical treatment (i.e., the scientific viewpoint is not too strongly eclipsed by other rationalities). In France and Germany, this institutional stabilization was established by introducing a system of social insurance that provides the doctors with the means to act as medical practitioners, while the economic and political negotiation processes of this funding are left out of the picture.

The scientific objectivity and rationality of medicine thus appear as both an expression and an element of an overarching arrangement. This arrangement then produces trust in the system in which medical rationality appears rational and the patient is willing to endure the multifarious stresses and strains of medical treatment, including the violations of modesty, the infliction of pain during treatment and being forced to submit to the hospital as a total institution.

## *First crisis of modern medicine*

The first serious societal crisis of the arrangement of objective scientific medicine arose from dealing with the crimes of doctors in national socialism, during which the "Nuremberg Code," including the requirement of informed consent, was introduced into medical research in 1947 as a legally binding standard (Vollmann & Winau, 1996). Since then, the will of the patient has been regarded as a perspective of reflection that can no longer be easily negated. The theories of professions, particularly based on the works of Parsons (1951) and Oevermann (2000), addressed the issue of complexity that this point raised (see, for example, Oevermann, 2000). Doctors still seem to regard as instructive the "I-it" relationship in which the physician reifies the patient's body. However, patients must now also be perceived as subjects. Additionally, the "I-Thou" stance of the interactional process, in which the diagnostic and treatment decisions have to be negotiated, is becoming increasingly important.

If we broaden our view to include taking into account the problem of the patient's

reduced autonomy, a further reflexive relationship takes on a new importance. It is now no longer considered sufficient for doctors to respond to what their patients express explicitly. An unarticulated "Thou" perspective has also been placed under their responsibility, in the sense that they are called on to help patients achieve an autonomy or subjectivity of which they cannot be aware yet at the time of the interaction. Thus, the democratization of the doctor-patient relationship does not dissolve the asymmetry of the professional relationship. Rather, it adds a further contexture that should also be addressed. At this point, the doctor-patient relationship takes on a new complexity since it is no longer possible to rely on a predefined rationale or a technically formalizable routine that could serve as the basis for establishing the optimal balance between symmetry and asymmetry. The true professional is constituted by this arrangement. From this point on, doctors have come to be regarded as not only executors of (scientific) evidence-based and thus apparently objective expert knowledge. They are also required to be subjects themselves so that they can pass decisions on the "in principle undecidable questions" that repeatedly arise (Foerster, 1981). There is rarely a simple "right" or "wrong" answer, with no single correct course of action, but something should be done.

This arrangement is stabilized on the one hand by science and law and on the other, by the doctor-patient interaction, which is gaining in importance and is now viewed both as a democratic negotiation (i.e., a symmetrical process) and an asymmetrical process marked by power and empowerment. Both the policies of the welfare state and the economy that continues to fund these processes remain in the background as the technical and the organizational processes that make medical treatment possible.

## *Second crisis of modern medicine*

The second, more profound crisis of modern medicine comprises a series of shocks to organized medical treatment. They share in common the fact that the processes and the functional relationships integral to them are themselves reflective and thus problematic.

Beck, Giddens, and Lash (1994) refer to the societal development phase in which these processes also become part of the semantic fabric of society as "reflexive modernity." From this perspective, the world, society, technology—and thus also medicine—no longer appear as spheres that can be understood through linear logical reasoning and cannot, therefore, be ruled by objective rationales.

In the following subsections, I focus more systematically on the perspectives in contemporary medical treatment, which require perspectives of reflection that seem increasingly irreconcilable.

### The body as a non-trivial machine

The biological body is the starting point of the uncertainties that have now become conscious. Bodies that are affected by multiple diseases can hardly be considered trivial machines that adhere to linear input-output relations. For example, think of unexpected immunological responses, paradoxical reactions to medications and the difficulty of assigning symptoms unequivocally to a diagnosis. In practice, the doctor's search for the correct diagnosis and suitable treatment can often be likened more to a hermeneutic approach than to logically deductive thought processes. The doctor starts with a certain prior understanding, which gives him or her the reason to carry out a diagnostic or therapeutic intervention, with a view to obtaining a response from the body. This response then needs further interpretation. For the body under treatment, there is also the problem of which symptoms are attributable to the treatment and which ones to the illness itself.

## Technology

As a rule, technological processes are understood as automatized ends-means relationships. However, as demonstrated by the "science studies" (Latour, 2013), this particularly under-estimates the complexity of the processes and the transformational procedures that have to be carried out at the various interfaces involved. Thus, a diagnostic procedure mediated by technology must now always also be conceived of as a *black box* that produces a result. However, it is uncertain whether this result is an artefact of the technical procedure or an adequate representation of a medical problem.

Since diagnostic procedures can also lead to false positive results that indicate the presence of a disease where there is none, expanding their use is also associated with the risk of false diagnoses. Conversely, a negative finding is not evidence of the absence of a disease. Moreover, many diagnostic and therapeutic procedures are invasive and may have harmful effects on the body, cancelling the expected therapeutic benefits or the early diagnosis.[6] Technical procedures are themselves also susceptible to interference, making it necessary to employ further techniques to monitor them. Today, in contrast to the medical arrangements in historical times, these uncertainties are present within the horizon of societal semantics and are thus inevitably also involved in professional relationships. In this sense, it is correct to speak of reflexive modernity. The more the information provided by (laboratory) techniques is based on complex processing, the greater the need is for a critical recontextualization by an experienced expert.

## Functional systems of society

Let us now closely study the functional systems of society under the conditions of reflexive modernity.

Since the rise of the evidence-based medicine movement at the end of the 1980s, reflection has also become an integral part of the relationship between science and medicine in such a way that medical knowledge is now no longer deemed unproblematic. What in the past seemed (for physiological, scientific reasons) a rational diagnosis or choice of treatment because it had been scientifically proven is now subjected to a second examination using biostatic methods. However, from this new, altered perspective, many of the procedures used in medicine have now been shown as lacking "evidence" to support them or even being harmful. Nonetheless, evidence-based medicine does not permit absolute statements since it is not possible to draw conclusions about an individual case from the statistical mean.

Accordingly, in the everyday practice of medicine, a complex mental operation is required to decide which scientific statements must be understood in what way and in which context.

The same applies to the functional relationships of treatment funding. With good reason, doctors are no longer accorded the sole responsibility for the management of healthcare institutions. There is now increasing insistence that their management and monitoring should be in the hands of qualified staff. However, since the financial crisis of 2008, it has become clear that the bases of these expectations of economic and managerial efficiency are also shaky (see Latour, 2013, pp. 433 ff.).

Two other functional systems of society are also gaining increasing influence on medical treatment. First, medical treatment is—simply because of the heavy burden of documentation—increasingly coming under legal scrutiny. Second, it is exposed to the critical eye of mass media that home in on the problems and the consequences of the above-mentioned areas of uncertainty and publish them in scandal reports.

---

[6] For more information, see Fisher and Welsh (1999).

## Organizations as constituting the problem and the solution

One of the most important advantages of organizations lies in their ability to use decision-making to align irreconcilable orientations into a workable arrangement. This can be done by decoupling processes from one another and having some tasks processed in an as-if mode. This makes it possible in given situations to accord less weight to prescribed statutory, economic and sometimes medical action priorities (Weick, 1995). However, because the different organizational routines can cause treatment processes to disintegrate, organizations also create a number of additional problems since as a rule, the routines are not sufficiently integrated with their respective interfaces.

Another aspect that I can consider briefly is that organizations cope with the uncertainty about hierarchy. At the top of the hierarchy, decisions tend to be made on the basis of abstract criteria, whereas interventions at the patient level need to be made on the basis of the concrete problems of each case. This is again an area where professionals deciding on interventions find themselves beset by differing, sometimes conflicting exigencies. Accordingly, the individual doctor has to decide *how* instructions from above are to be interpreted and implemented.

While modern organizations such as hospitals may transform spheres of professional autonomy into expert routines, this does not mean that the special position that professionals are required to fill in the organizational structure disappears. They are still needed to push through complex decisions.

## The professional as a polycontextural lived body

The subjectivity of professionals and the associated professional charisma arise from the felt situation of tension (i.e., they personally experience and embody all the dilemmas associated with their professional status). Medical training must thus always include an element of "training for uncertainty" (Fox, 1969) in which students experience first-hand what it means to make mistakes, be blamed for something, have to act in uncertain circumstances and be accountable. Of course, not all doctors are able to endure the physical burden and the tensions resulting from these processes. However, this does not eliminate the expectation inherent in the logic of the professional identity that a "good" doctor must simply be able to withstand all this pressure.

## Preliminary conclusion

From the above discussion, it is clear that while the work of doctors may change, along with the transformations of society, this does not mean that the central dynamic of what constitutes the professional's role disappears. On the contrary, there are several partly contradictory results both within medical research and between it and the economic orientation and the more complex organizational and technological demands. There is thus a greater need for actors who have both institutional legitimacy and the personal capacity to cut the Gordian knot of complexity and uncertainty.

In sum, professions have arisen as a consequence of a specific configuration of problems in the modern era. While the arrangements that professionals produce as autonomous actors change, the difficulties they face in reconciling different perspectives remain constant. Thus, insofar as society is unwilling to relinquish the primacy of autonomous acts and the acting subject, which is constitutive of modernity, we can assume that there is a need for autonomous actors who are able to process all the irreconcilable demands arising from the required respect for patient autonomy and from medicine, technology, the functional systems of society and organizations, without causing people to lose their trust in medicine (as a system).

## The future of professions?

The issue of sustaining trust despite the difficulty of not knowing what really is the case will continue to be one of the central problems of the medical profession, which will, in turn, maintain its special role. Medical treatment can only be provided permanently as a social system if patients can rely on the fact that the treatment is concerned about their health, not money, politics, scientific experiments or anything else (i.e., medicine is the "primary frame").

This situation will also not change in the society of the future but will be further complicated by several factors since now, not only the subjectivity of the other appears inaccessible, but the spheres of knowledge that are assumed to be evident will seem increasingly permeated by uncertainty and the state of not knowing. We now know that reading and interpreting the body is anything but a trivial undertaking and itself beset by uncertainty. We also understand that bodily changes are options that can be associated with problematic side effects. Moreover, we are becoming increasingly aware that economic, legal and organizational complexities are also involved in the medical treatment process. In other words, the corresponding system and instrumental rationalities enter into the arrangements of medical treatment in such a way that the primary and the secondary frames are often no longer easy to distinguish.

The politically backed infiltration of austerity thinking into medical treatment, organized by the welfare states, is particularly responsible for softening the boundaries between the individual spheres and thus for eroding confidence and trust in the existing arrangements. This is illustrated well by the following example.

Since 2003, hospital services in the Federal Republic of Germany have used a system of lump sums paid for cases (diagnosis related groups, DRGs). It is based on the assumption that health policy has put a price on a statistical construct that was originally developed by epidemiologists for quality assurance purposes. Based on the virtual products that have thus been created, health economists have then been able to calculate the value of medical services as goods (Samuel, Dirsmith, & McElroy, 2005, p. 269).

Because of the new payment system in Germany, hospitals now have a strong incentive to uncouple medical indications from the benefits paid for by health insurance companies. As a result, whether or not intentionally willed, doubts slip into the doctor-patient relationship if a medical intervention was not decided for financial rather than therapeutic reasons.

Whereas until recently, the belief in the political and economic independence of medicine has had a calming effect on the precarious relationship between knowing and not knowing, this relationship is now becoming fragile. It can be assumed that the period when human beings could at least believe[7] that what constituted a medical service was defined primarily by medical considerations alone is therefore over, even in Western Europe, and that people will thus become increasingly aware that they cannot trust medical institutions unconditionally. The doctor's role as a mediator in managing one's own (his or her patient's) not knowing, therefore, appears problematic yet still indispensable.

Regarding the peculiar features of the problem of "trust," all these give reason to suppose that in the future, professionals will become more important than ever as actors in the above-mentioned scenarios. The only way we can cope with our old uncertainties about our bodies and worries about systemic aspects of future medical treatment is by relying on the competence of individuals whom we consider equipped with the necessary abilities and moral integrity. In this context, the issue

[7] From a sociological perspective, a scholar can of course argue that medical treatment was also controlled by several rationalities that were foreign to medicine itself in the past. However, in the past, this at least did not prevent people from "believing" that it was possible to undergo medical treatment without risking being confronted with too many problems.

of transference and countertransference particularly assumes a new, greater significance, since how else can we assess whether and how we can trust another person other than in a concrete interactive relationship?

Although the medical profession has undergone a marked loss of power and influence in terms of managing and organizing medical treatment and dealing with health policy issues, their position in the medical decision-making process is stabilizing. As professionals, doctors remain the decisive nodal points since their ability to switch between the different institutional logics and constantly redefine the subject-object relationship remains indispensable.

However, it is important to keep in mind that this situation requires people who are prepared to endure the heavy demands that it imposes. Empowerment as a professional subject depends on the effects on the lived body that arise from all these situations of tension, which the professional must then—facing the emotional demands—manage autonomously.[8] How great and complex can the tensions then become for a person assigned a professional's role yet still allow himself or herself to be affected in a productive way?

Finally, some questions emerge regarding the recruitment of such professionals. Are the potential elites who aspire to a profession in which they can make decisions autonomously still willing, under the current conditions, to venture into the fields of professional action? Are there thresholds at which the empowerment ceases to be productive and degenerates into cynicism or resignation?

In other words, what would happen if, in the future, a decreasing number of people would be willing to rise to the challenge of allowing their lived bodies to be affected by these complex demands? This would result, above all, in the risk of the loss of trust in the system. Consequently, modern society would no longer appear modern since the rationality of its functional relationships could no longer be rendered plausible if no actors were prepared both to recognize and to negotiate the different "modes of existence" (Latour, 2013) with each other dialogically in such a way that autonomy and subjectivity would be promoted in both the doctor and the patient. The arrangement of medical treatment would then be radically changed.

What I have shown here for the medical profession also applies to other professions, which are equally called on to reflect on what autonomy means and how it can be lived and reproduced under the given circumstances. There are of course specific structural differences (e.g., the special characteristics of the conditioning of professionals in law, education and the sciences) arising from the respective influences of society and organizations, as well as dynamics typical of different countries. We can, therefore, expect various arrangements associated with these differences. Thus, each case requires detailed analyses, which can in turn benefit from the analytical, contextural approach. Again, in each case, complex logical spaces need to be related to one another in an arrangement, in turn leading to the development (emergence) of specific configurations of autonomy and subjectivity.

## References

Abbott, A. (1988). *The system of professions. An essay on the division of expert labor.* Chicago and London: University of Chicago Press.

Ackerknecht, E. H. (1982). *Short history of medicine.* Baltimore: Johns Hopkins University Press.

[8] The approach proposed here follows that of Parsons (1951) insofar as the affective processes are included in the sociological analysis. However, my model is not based on psychoanalysis but on Merleau-Ponty's (2012) phenomenology, which is oriented towards the lived body and views alterity and sociality as constituted by the lived body.

Beck, U., Giddens, A., &. Lash, S. (1994). *Reflexive modernization. Politics, tradition and aesthetics in the modern social order.* Stanford: Stanford University Press.

Dent, M., Bourgeault, I. L., Denis, J.-L., & Kuhlmann, E. E. (2016). *The Routledge companion to the professions and professionalism*. London and New York: Routledge.

Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology Review, 61*(5-6), 778-796. https://doi.org/10.1177/0011392113479316

Filc, D. (2006). Physicians as "organic intellectuals": A contribution to the stratification versus deprofessionalization debate. *Acta Sociologica, 49*(3), 273-285. https://doi.org/10.1177/0001699306067709

Fisher, E. S., & Welsh, G. H. (1999). Avoiding the unintended consequences of growth in medical care: How might more be worse? *Journal of American Medical Association, 281*(5), 446-453. https://doi.org/10.1001/jama.281.5.446

Foerster, H. V. (1981). *Observing systems: Selected papers of Heinz von Foerster.* Seaside, CA: Intersystems Publications.

Foucault, M. (2003). *The birth of the clinic: An archeology of medical perception.* London: Routledge.

Fox, R. (1969). Training for uncertainty. In R. K. Merton, G. G. Reader & P. L. Kendall (Eds.), *The student physician: Introductory studies in the sociology of medical education* (pp. 207-241). Cambridge, MA: Harvard University Press.

Freidson, E. (1970). *Professional dominance – the social structure of medical care.* New York: Atherton Press.

Freidson, E. (2001). *Professionalism: The third logic.* Cambridge, MA: Polity Press.

Günther, G. (1976). Cybernetic ontology and transjunctional operations. In G. Günther (Ed.), Beiträge zur Grundlegung einer operationsfähigen Dialektik, Band 1 [Contributions to the foundation of operationalisable dialectics, Vol. 1] (pp. 249-328). Hamburg: Meiner.

Günther, G. (1978). *Idee und Grundriss einer nicht-Aristotelischen Logik* [Idea and outline of a non-Aristotelian logic]. Hamburg: Felix Meiner.

Günther, G. (1979). Die Theorie der "mehrwertigen" Logik [The theory of multi-value logic]. In: G. Günther (Ed.), *Beiträge zur Grundlegung einer operationsfähigen Dialektik. Zweiter Band: Wirklichkeit als Poly-Kontexturalität* [Contributions of the foundation of operationalisable dialectics, Vol. 2: Reality as poly-contexturality]. Hamburg: Meiner.

Hesse, H. (1949). *The glass-bead game.* New York: Holt, Rhinehart & Winston.

Jansen, T., von Schlippe, A., & Vogd, W. (2015). Contextural analysis – a proposal for reconstructive social research in organisational contexts. *Forum: Qualitative Social Research/Sozialforschung, 16*(1).

Knudsen, M., & Vogd, W. E. (2015). *Systems theory and the sociology of health and illness. Observing healthcare.* London and New York: Routledge.

Latour, B. (2013). *An inquiry into modes of existence.* Cambridge, MA: Harvard University Press.

McDonalds, K. M. (1999). *The sociology of professions.* London, Thousand Oaks, and New Delhi: Sage Publications.

Merleau-Ponty, M. (2012). *Phenomenology of perception*. New York: Routledge.

Oevermann, U. (2000). Mediziner in SS-Uniformen: Professionalisierungstheoretische Deutung des Falles Münch [Doctors in SS-uniforms: An interpretation of the Münch case based on the theory of professionalisation]. In H. Kramer (Ed.), *Die Gegenwart der NS-Vergangenheit* [The present of the national socialist past] (pp. 18-76). Berlin and Vienna: Philo Verlagsgesellschaft.

Parsons, T. (1951). *The social system.* London: Routledge and Kegan.

Samuel, S., Dirsmith, M. W., & McElroy, B. (2005). Monetized medicine: From physical to the fiscal. *Accounting Organizations and Society, 30*(3), 249-278. https://doi.org/10.1016/j.aos.2004.02.001

Stichweh, R. (1997). Professions in modern society. *International Review of Sociology, 7*(1), 95-102. https://doi.org/10.1080/03906701.1997.9971225

Thornton, P. H., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure and process.* Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199601936.001.0001

Vollmann, J., & Winau, R. (1996). History of informed medical consent. *Lancet, 347*, No. 8998, 410. https://doi.org/10.1016/S0140-6736(96)90597-8

Weick, K. E. (1995). *Sensemaking in organizations.* Thousand Oaks: Sage.