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Professional Expectation Management: The Doctor as a Social Figure

Abstract: In this paper, I deal with the application and further development of the systems theory's insight into the sociology of professions, particularly the profession of medical doctors. I analyse doctoral professionalism from the perspective of a theory of society. The genesis and change of the social figure of the doctor are examined in the light of the changing societal expectations addressed to it. I show that the emergence and the continuing development of the doctor's profession are based not only on supposedly hard facts, such as expertise, the ability to cure ill people, a certain social status and so on, but equally on the professional image's social flexibility to adapt to and simultaneously shape an always changing society. Thereby, my paper contributes to explain the necessary breeding ground of a multitude of highly specific medical practices, and more generally, the mere existence and evolution of modern medicine.

Keywords: Doctoral professionalism, medicine, systems theory, qualitative social research, historical analysis

In this paper, I deal with the application and further development of the systems theory's insight into the sociology of professions, particularly the profession of medical doctors. The systems theory in the Luhmannian tradition basically starts with wondering how social order emerges and stabilizes. Instead of taking social order or social integration as a given and in need of preservation (as Parsons does), he is interested in observing the emergence of social structures (Luhmann, 1981/2009, p. 29-40). Usually, people take the practice of modern medicine for granted. This paper heads in the opposite direction. Despite a lot of criticism, seeking a doctor's help in case of illness or injury or for a check-up is unquestioned. Sociologically, this self-evident fact is challenging. I must explain why going to the doctor (and less likely to other medical specialists) is so obvious and why even a harsh critique or the discovery of scandalous behaviours of individual doctors or even entire medical branches does not fundamentally change this matter of fact. Initially, I, therefore, neglect the reasons that seem manifest and objective for the self-evidence of doctors' prominence in modern medicine at first glance. I do not examine the actual patient–doctor encounter but take a rather rough bird's eye view on how the self-evident societal image of the doctor is built. In this image, which is at the same time dynamic and stable, I perceive a central explanation for the potency and social meaning of doctoral professionalism.

By a comparative analysis of autobiographical self-images of doctors and sociology's outside view on doctors, I develop the central thesis of *professional expectation management*. Professional expectation management is the mechanism by which

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medicine is able to connect itself to a constantly changing society and is thus a requisite of modern medical practice. The central figure, around which this mechanism is construed, is the professional doctor. The professional doctor is a *polymorphic figure,* which is *generalized and specific* at the same time, causing its extreme elasticity and stability.

To elucidate my thesis, I present examples from a detailed analysis of the autobiographies of doctors born from 1821 until the 1980s and the sociological literature about doctors from its beginnings until now (Atzeni, 2016). To draw conclusions about doctoral professionalism from such a database, the first step is to explain the systems theory's premises, which lead to these results. Second, I discuss the systems theory's concept of professions and explain where the subsequent empirical findings either support or dissent from this concept. Third, I explain by means of two examples, drawn from the autobiographies of doctors, how the social figure of the professional doctor evolves and changes and why I consider societal expectation management as a central feature of doctoral professionalism. Finally, I sum up the empirically developed concept of doctoral professionalism and discuss it with respect to its social meaning.

Analytical strategy and theory

The central idea of Luhmann's systems theory is that society *is* communication (see Luhmann, 1984, 1997, p. 105). This is crucial for research because the definition of society as communication implies the autonomy of the social. Communication and thus society in this conception cannot be traced back to intentionally acting subjects. This has important implications for analysing autobiographical writings and sociological texts. The idea of society as operatively closed on communication leads to a hermeneutics of the social instead of that of the subject. From this perspective, autobiographies (and sociological texts) neither reveal nor hide the authors' motives but allow insights into the expectation structure of society. The concept of society based on communication implies the equality (not homogeneity!) of all forms of communication. For me, it is important that all forms of communication point to social expectations, which build social structures. In his systems theory, Luhmann (1980) emphasizes an insuperable interrelation between semantics (as forms of condensed meaning) and social structures. He conceives of structures as expectation structures. Therefore, communication practices can be analysed in terms of how the use of language and semantics influences the structuring of these practices. An analysis of semantics shows which forms of social (communicative) practices would be expectable, plausible and legitimized at a certain time. Thereby, they provide information about how doctoral professionalism could be narrated at that time and which forms of delivering medical service would be expected to be normal and normatively desirable or undesirable at that time.

In the primary study (Atzeni, 2016) on which this paper is based, I analysed 45 autobiographies of doctors born between the 1820s and the 1980s,[1] as well as the sociological reflection on professional doctors from the beginnings of sociology until now, using three circular analysis steps. First, I scanned both kinds of materials for descriptions of doctors. The leading questions in this step were as follows: How do doctors describe themselves? How does sociology conceive of doctors, professional practice and so on? What argumentative modes render these descriptions plausible? Second, these narratives were searched for and sorted by recurrent patterns. These patterns could clearly be distributed across the authors' birth cohorts. It became clear that not only how doctors described themselves but also how sociology viewed them were strongly bound to contexts of common experiences and historical

[1] The autobiographies were published between 1903 and 2014 in English or German.

locations (see Mannheim, 1970). This sorting of narrative patterns led to approximately 60-year time spans, in which the establishment of new expectations towards the doctors, their stabilization, normalization and beginning destabilization could be observed. Third, the two types of materials were paralleled in their historical sequences. This step allowed me to look for interdependencies and cross-references between them, as well as common references in organizational or societal contexts. By comparing autobiographies and sociological texts, I could picture the dynamics of self-description and external description. As systems are closed at the operational level but radically open at the informational level, self-descriptions are important as generators and representatives of systems identity. The function of self-descriptions for systems lies in their ability to handle, repel and balance external descriptions (see Nassehi, 2003, p. 102). This approach enabled me to carve out the societal concept of doctoral professionalism in its historical dynamic and simultaneously point to its astonishing stability, which is often overlooked.

Before I turn to some examples to illustrate the approach and the results, I refer to the systems theory's idea of (doctoral) professionalism and medicine.

The systems theory defines professions as occupations that deal with the problem of changing persons. In this regard, Luhmann (n.d.) adopts Hughes' (1971) idea of "people processing." What distinguishes professional occupations from other forms of expertise is that the former's tasks can only be achieved in interactions. The success of the professional intervention is as dependent on the client as on the professional (for convergences and differences in approaches, see Stichweh, 1997, p. 97).

Despite this focus on interactions, for me, the most interesting aspect is that thinking about professions and professionalism from a systems theory standpoint means focusing on their societal dimension as well. Probably the most important work from this perspective is Stichweh's (1996, 1997) research on the historical meaning of professions. He argues that because of their responsibility for the most existential conflicts of people, professions have been the first ones to gain social status attributed to merit instead of birth. The interesting point is that Stichweh addresses professions' transformational effect. Professions have legitimized the idea of orienting decisions and social order towards specific (rational) reasons instead of the conventional societal decision routines based on hierarchies of social status and traditional or religious patterns of conduct. The historical meaning of professions lies in their contribution to managing the transition from a pre-modern, socially differentiated society to a modern, functionally differentiated type.

In other words, this perspective is not so much about specific traits, which separate professions from other occupations (Carr-Saunders & Wilson, 1933/1964; Cogan, 1955; Goode, 1972; Greenwood, 1957), or about professions' social power in terms of status (Dezalay, 1995; Freidson, 1975; Larson, 1977). It is not interested in the *normative* prerequisites that form an important basis for social order (Carr-Saunders & Wilson, 1933/1964; Freidson, 2001/2004; Parsons, 1951; Swick, 2000), but it is about the effect of professions/professionalism on social structures.

While Stichweh (1996, 1997) and Luhmann (1980) focus on the dramatic sociohistorical transition from pre-modern (stratified) to modern (functionally differentiated) society, I suggest applying this perspective also to smaller and gradual historical changes.

After a short sketch of the systems theory's general conception of professionalism, I now turn to medicine's specialities. Medicine is understood as a social system amongst others, such as law, politics, religion, science and so on (for a current discussion of modern medicine and health care from a systems theory perspective, see Knudsen & Vogd, 2014). Given the definition of society as communication, systems are not substances or self-contained loci but communicatively constituted contexts of meaning. They can be differentiated only by the operative logic of their communication. While the system of economy is constituted by communication, which follows the leading distinction between paying and not paying, medicine's leading distinction is between ill and healthy. At the operative level of first-order observation,

systems are fluid and event based. At the level of second-order observation, there are mechanisms for systems' self-reflection and identity representation. Although the theory denies the notion of identity in the strong sense of a core essence, modes of self-reflection, as they offer the possibility of representing identity, are given great importance. This is crucial for stabilizing systems interiorly and exteriorly, thereby rendering the improbability of communication more probable (see Bohn & Petzke, 2013; Nassehi, 2003, pp. 160 ff.). The most important case that Luhmann (1987) discusses for this function of identity representation comprises the grand reflection theories that most systems have established. Examples include dogmatics in the system of religion, political theory in politics and so on. These grand reflection theories allow the systems' self-positioning in relation to their observation through other systems.

The crucial point is Luhmann's (1983, 2009) assertion that medicine has a deficit of reflection as it lacks such a grand reflection theory. In his rather few texts on medicine, the lack of a reflection theory in medicine, in contrast to other function systems, is one of the central issues. I briefly sum up this argument. He contends that this issue does not pose any problem for medicine yet since he assumes that the basic operation of the system is not dependent on communication (Luhmann, 1983, p. 172). However, his prognosis is that medicine will encounter issues in the future, when it has to deal with discussions about technically prolonging life, reproductive medicine, rationing and so on (see also Bauch, 2006). Against the background of his theory, which consequently conceives of communication (not action) as the smallest element of society, his argument about medicine is astonishing. He seems to describe medicine as a mere action system, where the professional doctors' task is "people processing" (see Kurtz, 2000, p. 176; Luhmann, 1983, 1968/2000, n.d.; Stichweh, 1997, p. 9) by skilled craftsmanship. For example, he states, "A communicative dentist and a less communicative dentist can do equally good jobs" (Luhmann, 1983, pp. 172 ff., translated by the author). Regarding everyday routine based on the level of interaction, Luhmann sees no problem for the functioning of modern medicine (at least not yet). Nonetheless, he expects that new technological possibilities, which are linked to public (ethical) debates in the context of larger societal changes and breaks, will challenge and overburden medicine since it lacks the possibility of theoretical self-reflection.

Undoubtedly, medicine has no grand reflection theories, in contrast to what we find in political theory, legal theory, epistemology and so on. However, I disagree with the diagnosis of the lack of reflection, which—in accordance with most contemporary theories of professionalism—banishes the system of medicine and doctoral professionalism to the level of interaction, while neglecting the societal level.

Instead of a reflection deficit, a different form of reflection exists in medicine, which is strongly bound to the social figure of the professional doctor. Perhaps I can add that this mode is so successful that it renders itself invisible—even to such a sharp observer as Luhmann. Medicine's self-reflection takes a *fragmented and polymorphic* form. One important form of medical self-reflection can be found in the self-descriptions provided by professional doctors.

To develop this argument, I give a definition of doctoral professionalism, which is the result of a semantic analysis of doctors' self-descriptions and of sociology's external view on doctors. By analysing the doctors' self-images and external images and how these have changed in modern times, I show that apart from professions' role in the transition from pre-modern to modern society, this transformational effect of the doctoral profession can still be observed, which plays an important role in medicine and society.

Empirical findings

To carve out the idea of my study, I present in depth only two examples taken from the autobiographical data. The results of the analysis of the sociology of professions are only summarized (for the whole analysis see Atzeni, 2016). The examples chosen are especially suitable; at first sight, they deal with nearly identical situations yet lead to very different narrative outcomes. The restriction to only two and admittedly very bold examples from a much richer pool of data bears the risk of giving a naïve impression of the complex interplay. Selecting their accounts does not imply that these two doctors' memoirs are true reflections of their professional lives or medical practice during their times or even truthful self-descriptions. However, they do offer excellent examples to compare the narrative possibilities of recounting themselves as doctors at two vastly different times with varying social expectation structures.

Ferdinand Sauerbruch, a German surgeon (1875-1951), and Christiaan Barnard, a South African heart surgeon (1922-2001), are probably two of the most prominent doctors in their respective eras. The similar settings of the two episodes involve two important clinical first attempts. Sauerbruch, who invented the hypobaric chamber, describes his first surgery inside a human's chest cavity. Barnard explains the circumstances of his first attempt to transplant a human heart. Both their patients die.

The examples give precise descriptions of the social framing in which their respective medical experiments take place. These descriptions allow conclusions about the establishment and change of social expectations. The analysis, therefore, focuses on the descriptions of the social references, which the authors consider important, and on the narrations of re-legitimation.

Self-evidence of doctoral professionalism in a rationalizing society

In Sauerbruch's autobiography, the invention and implementation of his hypobaric chamber are central. This invention has solved the problem of surgeons' inability to operate inside the chest cavity until then. He is well aware of the importance of his invention, not only for medicine but for society and humanity in general:

> There were more such possibilities, but there was always the danger for the lung and the like for humans. One had to find a means to operate in the thorax without the described dangers. This was a problem concerning humanity as a whole. (Sauerbruch, 1951/1971, p. 48, translated by the author)

Likewise, the motive of saving humanity and modern society is omnipresent in all self-testimonies of doctors in Sauerbruch's time. Similar motives can also be found in the *earliest sociological thoughts about professions* or special occupations. This offers the first hint about the importance of a special relationship between societal expectations towards doctors and professional forms of self-representation.

What unifies extremely different thinkers, such as Marx, Durkheim, Weber and Spencer, is that they all have a concept of professionalism or special occupations that is strongly bound to their concept of modern society. Society is analysed as differentiating itself, often also as disintegrating, and as something new, for which novel ways of dealing with it have to be found. The role of professions or special occupations is described as one of the possible remedies. Without denying the fundamental differences amongst the theories, it is striking that they all think of professions or special occupations mostly as positive concepts. They understand these as important elements of building up social order, whereas modern society, which differentiates and accelerates itself, is described as ambivalent at least. During this period of early sociology, professionalism is not thought of as an end in itself but always in relation to society. For the classic sociologists, professionalism is an instance

to make bearable the cruelties and impositions of modernity. In Spencer's functionalistic approach, professions, such as that of the doctor, have evolved and have been differentiated from the religious–political complexity of former times, and in developed societies, they perform the function of an "augmentation of life" (1885/1897, p. 218). In Marx's work, as brilliantly reconstructed by Stock (2003, 2005), the concept of professions plays a crucial and contradictory role. Without discussing these contradictions, it is stunning that professional occupations are considered possible barriers to an otherwise completely economized society (see Marx, 1863/1965). Max Weber's texts on politics (1919) and science as a profession (1919/1988) show a very strong belief in the "professional man." The professional man is by no means able to undo the fact that in modern society, the different spheres of life are detached from one another. Nonetheless, he is the only one capable of bearing this differentiation heroically, thereby contributing to society's well-being. Moreover, Emile Durkheim (1930/2012) recognizes the morally integrated and relatively autonomous professional groups as the breeding grounds for renewed social morals, serving as possible remedies for modern anomy.

It is not by chance that similar motives of healing and saving humanity or society as a whole can be observed in early sociological descriptions of professions, as well as in the doctors' professional self-descriptions. These are indicators of the mechanism of *social expectation management*, which I will explain later in detail. For the moment, I want to stress that such examples represent the genesis of the social figure of the doctor, which can (also) be described as a "textbirth," for which both sociological and self-descriptions cannot refuse parenthood. Social expectations about professions as special forms of occupations are set in this period of early modernity, a time of radical changes, challenges and uncertainties.

I return to Sauerbruch's autobiography to scrutinize this idea. The next sequence again clearly shows the social expectations towards the doctor who risks the first experimental use of his invention on a human after several attempts on dogs:

> As I passed the corridors of the clinic to reach the surgery room, everyone was excited and tense. People waved to me, similar to a soldier on his way to a battle, a battle that concerned everybody. They followed me, and as I came to the operating theatre, I found this picture: my chamber stood lonely in the middle; all the free doctors stood around it in a wide circle and waited for things to come.… I felt the expectant tension in the auditorium. (Sauerbruch, 1951/1971, p. 73, translated by the author)

He again describes himself as someone who faces people's expectations towards a saviour. The sketched image of a soldier who goes to war against an external aggressor is striking. If someone considers the utilitarian and rationalistic ideas, they perfectly match the expectations during the 20th-century wars. Those expectations were not exclusive to the medical sector but general at that time.

Sauerbruch describes the chief physician, privy counsellor von Mikulicz as the only one who reacts to the failure of the surgery and the death of the patient. He explains:

> When I came to the privy counsellor late at night, he explained to me what he thought: Any struggle for a new surgical field has claimed its victims; this will not be different in the field of thoracic surgery. The final aim, life for tens of thousands of patients struck by pulmonary tuberculosis, justifies our actions. (1951/1971, p. 76, translated by the author)

The patient's death is matter-of-factly addressed as the necessary oblation on the altar of scientific and medical progress. His boss is described as the only authority to interpret the situation. The patient's death is evaluated solely from this *inner medical perspective*.

On one hand, this incident points to a society with clear hierarchies in well-defined fields of responsibility. On the other hand, the chief physician's emphasis on the necessity of the experiment for scientific progress and the marginalization of the patient's death indicate a social environment where the collective welfare is clearly placed above individual fates. Medical science can only be described as shown in the quotes because these semantics perfectly go along with social expectations.

While rationality and science are the central semantics of the doctors' autobiographies in the late 19th and early 20th centuries, a scholar can also find strong semantics of the mystification of the doctor. For example, Sauerbruch calls the predecessor of his chair in Berlin, without any irony, "Berlin's healing god" (1951/1979, pp. 178 ff., translated by the author). Moreover, in most of the autobiographies of that time, doctors very naturally compare their medical actions to divine ones.

As a perfect match to a rationalizing society that orients itself towards general progress and simultaneously as completely different from that society by standing in a more or less direct line to pre-modern concepts of divine healing, this twofold self-description is striking and important. Another short side trip to the sociology of professions illustrates this point.

The combination of narrations of rationality and scientific medicine with narrations that point to the mystification of doctoral professionalism cannot only be traced back to very early sociological ideas on professionalism as proposed by the above-mentioned authors. Furthermore, these have remained important semantics to this day. Nonetheless, such semantics have undergone a logical turnaround. The normative validation of this mystification has been reversed. Today, the motive of the "demigod in white" is a precise indicator of the critique on doctoral professionalism or of jokes about doctors' hubris. It is exactly the subtle and the evident adjustments in the use of semantics that are interesting.

I illustrate this point with a little leap in time to Parsons' (1951) description of doctoral professionalism in his structural-functional approach. He conceives of the role of professions, particularly that of doctors in modern society, by means of his so-called "pattern variables." The doctor here—similar to the examples from the autobiographies—is shaped as a perfect match to rational modern society. Especially the pattern's achievement, universality and specificity conceive of the physician's occupation as genuinely modern. In contrast, the pattern of orientation towards the common good forms it as completely different from the usual action orientation in modern societies. Parsons' theory also considers professionalism as modern and pre-modern at the same time. Parsons' conception of (doctoral) professionalism touches on a crucial point in his theoretical efforts, which always deal with the problem of integrating modern society. Quite similar to the autobiographical self-descriptions from Sauerbruch's era, the proponents of the early sociology of professions think of professionalism always in relation to society as a whole. In narrating doctoral professionalism, it is not so much the individual patient who is the focal point but society, which is important and endangered in its entirety.

However, the motives used in Parsons' theoretical sketch of doctoral professionalism, already show the first slight hint of this fundamental change in the structure of expectations towards doctors. The semantic shift, which can be found there, hints about fundamental societal changes. Parsons' extremely normative conception of the doctors' role corresponds to a complementary conception of the sick people's role. Parsons identifies a mutual obligation of doctor and patient:

> This authority cannot be legitimized without reciprocal collectivity-orientation in the relationship. To the doctor's obligation to use his authority "responsibly" in the interest of the patient, corresponds the patient's obligation faithfully to accept the implications of the fact that he is "Dr X's patient" and so long as he remains in that status must 'do his part' in the common enterprise. (Parsons, 1951, p. 465)

This quote is an expression of an attitude that the later medical-critical sociology of

professions criticizes strongly. Its proponents condemn the fact that sociology takes the side of professions (e.g., Freidson, 1975, p. 32, 1983, p. 19; Larson, 1977, p. xi). I would still argue that a shift in the social expectation structure in general and towards doctoral professionalism, in particular, can already be traced there. The need to tell the patient what to do and to put him under a moral obligation vis-à-vis the doctor hints at the possibility that the patient—at least hypothetically—could do differently than ordered by the doctor! The need for a theoretical conception of the roles of doctors and sick people as complementary moral bonds would not have come into sight before. However, in 1951, when Parsons published the cited text on modern medicine, ideas of individual rights and criticisms of authorities slowly emerged as possible expectations in society's and thereby sociology's horizons. Only these shifts in the expectation structure can explain why the normative demand for patients' submission to doctors' control has to be mentioned, explained and even theoretically grounded.

A turning point: From society to interaction

I think it is not exaggerated to speak of a turning point in sociological thinking about professions from the 1960s onwards. By then, a vastly different sociological approach, which focuses more on the micro-sociological environment of professional practice, has become important. There, an interactionistic turn in the sociology of professions has taken place. The emphasis of the classics and the functionalistic approaches on professions' impacts on society now turns to the interactions, negotiations and boundary work of professional practices. One of the most prominent scholars in this context is probably Everett C. Hughes (1971). In his works on professions, the focus shifts from an interest in society to an interest in interaction. Hughes stresses the relational aspects of professionalism. To acknowledge this aspect properly, he gives the advice to step back from the schematic image that professions serve society. Instead, scholars should examine more closely how different professionals become professionals in various organizations by collaborating with other professions or occupations and different kinds of clients, and through this, be influenced by and affect society where all of these occur. This new perspective on professions has initiated many studies that take interest in the professionals' micro-climate.

Without this new sociological focus on the narrow range of professional practice instead of a broad societal frame of reference, the emergence of decidedly profession-critical approaches in sociology could not be explained. At least from the late 1960s onwards—and not coincidentally in parallel to different forms of civil rights movements—the sociology of professions establishes what can also be interpreted as a sort of emancipatory project. The most prominent names in the context of this so-called "power approach" are definitely Magali Sarfatti Larson and Eliott Freidson. In the beginning of the genuine autonomy of the sociology of professions, expert knowledge and the orientation towards serving the common welfare were considered central characteristics of professions. Now, the critical sociologists of professions refer to these approaches and somehow turn them upside down, for example:

> Profession appears to be one of the many "natural concepts," fraught with ideology, that social science abstracts from everyday life. The most common ideal type of profession combines heterogeneous elements and links them by implicit though untested propositions—such as the proposition that prestige and autonomy flow "naturally" from the cognitive and normative base of professional work. (Larson, 1977, p. xi)

Basically, the representatives of the power approach claim that until now, sociology has fallen for the tricks of professions, indeed even supported them in winding up

the public (see Freidson, 1975, p. 32; Larson, 1977, pp. xi-9). Instead, Larson (1977) takes autonomy (and prestige) not as the effect of the nature of professions but as their goal. The former idea of a legitimate autonomy of professions that naturally flows from the special requirements of their tasks turns into the idea of illegitimate autonomy. Based on this argument, the other criteria must be reassessed.

Even if they still attribute a vast amount of highly specialized knowledge to professions, this asset is no longer perceived as a guarantee for the delivery of the best possible services but as an ideological mask. Again, this viewpoint can be best observed in Larson's (1977) market model of professionalism. She believes that a profession's goal is to gain and maintain professional market power by monopolizing the reproduction of the producers. Therefore, and mainly so, professionals are interested in continually enlarging the base of the scientific knowledge required to join their ranks. Nonetheless, in different ways, all sociologists who criticize professions unmask scientific knowledge as an instrument of power.

The subordination of the patients under the professionals' dominance, which Parsons (1951) still conceives of as a functional requirement to integrate modern society, is denied by the proponents of profession-critical approaches. They criticize that the image of the doctor serving the common welfare and the patient who has to acknowledge this and do as he is told without questioning is pure professional ideology, supported by sociology.

As mentioned above, societal contexts cannot be considered independently from one another or located at different levels of reality. Semantics, which can be found in the doctors' autobiographies, can also be traced in sociology's reflection on doctoral professionalism and the other way around. Semantic shifts, which occur in theoretical conceptions of professionalism, do not just correspond to self-empowerment movements, for example; they can be perfectly found again in the shifts in the doctors' autobiographies.

To exemplify this point, I turn to Christiaan Barnard's autobiography. Born in 1922, he was a South African heart surgeon and the first person to perform a heart transplant on a human being in 1967. The medical importance of a heart transplant is often compared to Sauerbruch's invention of the hypobaric chamber. The self-descriptions of both Sauerbruch and Barnard show extremely similar narcissistic traits. Nonetheless, the differences in the descriptions of their first attempts in their respective surgical fields are striking despite the seemingly similar settings. Similar to Sauerbruch's first attempt, Barnard's also fails. Again, Barnard describes what follows his first heart transplant, when after a few days, the patient dies:

> The naked body of Louis Washkansky was lying on the white marble slab. The last beat of his heart in the early hours of the morning had transformed him from a deeply loved, meticulously cared-for patient, to a pathological specimen. The first human ever to receive a transplanted heart from a human cadaver was dead. The only interest left was what could be learned from this death. Where had I made a mistake? How could I improve the operation next time? I stood there in deep sorrow. A great sadness overwhelmed me and it was impossible to speak to my colleagues in the morgue—for fear that I would start crying. I have always easily been moved emotionally and I laugh or cry quite spontaneously. (Barnard, 1993, p. 7)

This framework resembles that of Sauerbruch's first attempt to use his hypobaric chamber. The first endeavour on a human fails, and again, the surgeon is interested in the technical or physiological reasons for this failure. The difference lies in the intensive thoughts given to the deceased patient. He is called by his name and introduced with his vita, his familiar and social background, and he is described as Barnard's serious partner during the preparations for this epochal surgery. Moreover, Barnard describes himself as deeply saddened and uncertain of himself after the patient's death.

The narrative figure of Louis Washkansky in the preceding quote has a completely different function from that of the anonymous female patient in Sauerbruch's memories. While the latter is but a requisite in the surgical play, which constitutes the professional self-description, the former is an integral part of the narrative constitution of medical professionalism. Apparently, the authoritative doctor is no longer the (only) legitimate source of medical decision-making. There are outside expectations by a critical public who questions the doctor's legitimation to decide on his own. Patients, relatives and other professional groups inside and outside the medical sector, as well as the media, join in the decision-making process by posing uncomfortable questions and articulating reasons from other perspectives, in short, by questioning the doctor's competence to decide:

> There were a lot of uncertainties about the ethical, moral and legal issues—as if they were different from kidney transplantation. The newspapers made the most of the suggestion by somebody that I should be tried for murder by the World courts as I had removed a heart from a human being. I was in the middle of crossfire from critics and accusers alike because the concept of brain death was not generally accepted and not clearly understood.… Everybody felt qualified to address these questions—especially theologians, lawyers and, of course, politicians. It was a sure way to get one's photograph in the newspapers.
> (Barnard, 1993, p. 13)

This description of the doctor's legitimation crisis could easily be interpreted (in fact, it often is) as hinting at the de-professionalization of doctors. I prefer a different interpretation, which focuses on not only the fundamental change in the doctors' status in the system of organized medicine but also on how they handle the modified expectations. The autobiographical style of this generation of doctors differs from that of their predecessors. The most obvious change is that the typical autobiographical narration is often broken with episodes, which are told out of sight of patients, relatives or neutral observers. These parts mark particularly significant events in the doctor's career or personal development. I interpret this not only as a stylistic device to produce a more exciting story but also as a new mode of professional legitimation. It is not that the doctor and medicine have changed alone, but society as a whole has been dramatically transformed since Sauerbruch's time.

As stated above, I follow Luhmann's (1980) definition, which assumes that social structures are structures of expectation. With this theoretical starting point, autobiographical material, as well as every other kind of material, mirrors these changed expectation structures and simultaneously influences them. Therefore, I would argue that de-professionalization is not a sufficiently differentiated diagnosis. It does not take into account that professionalism is not an objective quality of an occupation or a person but is a genuinely social fact. Thus, it would be naïve to assume that while society undergoes revolutionary changes, professionalism should stay as it is at the edge of modernity or vanish altogether. Instead, I think that the autobiographical material itself reveals a new form of professionalism. As in such situations, the empirical material illustrates the recovery and the articulation of the individual patient's will as the key element in how doctors themselves legitimize their actions. To illustrate this thought, below is another excerpt from Barnard's autobiography, where the first-person narrator is replaced by a "neutral outside observer":

> Afraid that future transplants might be stopped after the failure on Washkansky, Philip Blaiberg insisted, "Professor Barnard, I don't want to live the way I'm now. The quality of my life is worthless. So if there's any hope that, through this operation, my life can be improved then I'm prepared to take the chance. I want to go through with it more than ever now. I know that you're upset because Louis Washkansky died and you're probably unsure of yourself as well, but Professor, you gave him hope and, from what I've heard, he had a few wonderful days after

> the operation. I want that hope too, I also want those few days." Both men smiled. "I will operate on you," said Professor Barnard. "I will give you a new heart, and this time it's going to be successful." (Barnard, 1993, p. 12)

In Sauerbruch's memoirs, the only one to re-legitimate the surgeon's action after the failure of his first attempt to use the hypobaric chamber is his boss, privy counsellor von Mikulicz. Under the changed societal circumstances in which Barnard writes his autobiography, it is evidently impossible to just refer to utilitarian considerations about the common welfare and the authority of high-ranking medical experts. Nonetheless, in Barnard's and his contemporaries' autobiographies, the analysis reveals a new authority, which is able to re-legitimate the surgeon after a failure.

The individual patient serves as the catalyst for not only the crisis of professionalism but also for its recovery. It is the most important narrative resource after the fundamental criticism. My thesis is that the power of medical professionalism lies exactly in its capability to refer to and shape new social or organizational expectations *in the mode of these expectations*. This flexibility is the core of professionalism as a social phenomenon.

Results and outlook

I want to recapitulate the findings that in my opinion can be drawn from the empirical evidence for which I have given some examples in the previous section. One result of the study is that the lack of reflection, as claimed by the systems theorists' thoughts about doctoral professionalism, has to be qualified if not rejected. The material shows a strong interdependence between autobiographical writing and the sociological observation of doctors, which have to be described in similar terms, wherein Luhmann states the difference between self-description and external descriptions for other systems. In my opinion, the autobiographical self-descriptions not only react to but also powerfully shape social expectations, which are mirrored in the sociological reflection on the profession. In other words, the different, smaller forms of self-descriptions can be perceived as functionally equivalent to the grand reflection theories in other systems. In the empirical material, a constant back-coupling between the doctor's self-reflection, the societal opinion about doctors, and general, overarching social ideas and values can be observed as examples.

The earliest autobiographical self-descriptions drew the pictures of scientific iconoclasts who still had to fight for medicine's autonomy against irrational religious superstition (Atzeni, 2016, pp. 89 ff.; Atzeni & von Groddeck, 2015, pp. 30 ff.). As rationality and objectivity became increasingly socially accepted, the *social figure* of the heroic paternalistic doctor emerged, as shown in the examples from Sauerbruch's memoirs. The social figure, comprising motives of rationality and mystification, had been dominant from the end of the 19th century until at least the first half of the 20th century. The caricature of the "demigod in white" still uses it *ex negativo*. While society, in general, develops a more critical attitude towards authorities, that *social figure* also disintegrates, as a brief glance at the profession-critical sociology should have illustrated. However, the social figure soon adapts to new social expectations and changes and is narratively reborn as the compassionate partner of the patient. To exemplify this change, I have quoted from Barnard's autobiography.

The material shows that the genesis and change of the doctor's figure is strongly interwoven with the sociological reflections on doctoral professionalism and important time-specific values. Thereby, the autobiographical self-descriptions not only adapt to the external image of the doctor but also actively shape it. The socially powerful figure is the result of the strong link between doctoral self-descriptions and society's (external) view on the doctor.

Professional expectation management is what I would like to call the mechanism by which medicine adapts itself to and simultaneously shapes society. As a social

mechanism, professional expectation management is characterized by the concomitance of generality and specificity. It is driven by diverse, specific self-descriptions of doctors, which (despite all the differences amongst them) at the same time, are expressions of "the doctoral." Of course, the specific form of polymorphic and fragmented self-reflection is not that consistent and theoretically sophisticated as the grand reflection theories that Luhmann deals with. Nonetheless, it is precisely this quality that guarantees the specific function of the social figure of the doctor.

I interpret the changes in doctors' self-narrations, in close interdependence with the shifts in external expectations towards doctors and society in general, as important resources for medicine. Narratives constitute the doctor as a social figure. This social figure is the hinge with which medicine attaches itself to a permanently changing society. It is, therefore, vital for the existence of modern medicine. The absence of a grand reflection theory is not the issue. On the contrary, precisely because self-reflection is fragmented (which in its entirety still constitutes the social figure of the professional doctor), it renders the highly improbable reality of modern medicine self-evident and plays an important role in societal conflicts.

This systems theory-informed approach contributes to the sociology of professions by highlighting the societal dimension of doctoral professionalism. Zooming out of detailed observations of doctor–patient or doctor–third-party encounters or observations of the doctor's role in specific constellations (e.g., their changing practice in a rapidly changing technological and informational environment or under new forms of governance) obviously reveals a blind spot. Despite these restrictions, the systems theoretical approach is sociologically instructive as it points out the societal dimension of the constitution of doctoral professionalism. It can explain the necessary breeding ground without which the actual interactions, the multitude of highly specific medical communications, and more generally, the mere existence and evolution of modern medicine, cannot be explained.

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