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Introduction to Special Issue: Professional-Citizen Relations

Whether in the form of patients, clients, students, customers or inmates, professionals constantly interact with citizens and thereby exercise their professionalism through citizen relations. These relations between professionals and citizens are important in many ways for professions and professionalism. Professionals develop and maintain relations and boundaries not only vis-à-vis the state or competing occupations, but also vis-à-vis citizens. The use of expertise and specialized knowledge to solve problems among citizens and clients is thus a key aspect of how we oftentimes characterize professionalism and professional work:

The tasks of professions are human problems amenable to expert service. They may be problems for individuals, like sickness and salvation, or for groups, like fundraising and auditing. They may be disturbing problems to be cured, like vandalism or neurosis, or they may be creative problems to be solved, like a building design or a legislative program. (Abbott, 1988, p. 35)

More precisely, relations between professions and citizens are both structural and interactional in character. Structurally, citizens play an important role in how professions are able to constitute boundaries and claim authority, legitimacy, autonomy or status for their expertise. At the same time, the relationship between professionals and citizens is also defined in the context of the daily work tasks in which professionals interact with citizens. Professional expertise is thus understood and implemented through citizen interactions—a process that often involves the exchange of intimate details or an attempt to handle people's inner fears and emotions on a daily basis.

Even so, the relations between professionals and citizens do not play a prominent role in existing scholarship on professions and professionalism. Especially in recent years, the focus has rather been on the link between organizations and professions as well as the possible hybrids between professionalism and managerialism. Discussions about the constitution of professions similarly tend to ignore citizens, because the main focus is on how the boundaries of professions are constituted by social institutions like science or the state, or by power and social values.

Relations between professionals and citizens are mainly discussed as a matter of professional ethics, disinterestedness or the special fiduciary relationship that exists between professionals and citizens (e.g., Parsons, 1939; Abbott, 1983). Citizens' impact on the legitimacy of professional knowledge or on the development of professionalism is, to a large extent, typically not recognized. There are nonetheless good reasons to believe that citizens do in fact play an important and even constitutive role for professions and professionals, not least in the context of late modernity and individualization.

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The democratizations of knowledge and the presumed eroded authority of expertise (e.g., Beck, Giddens, & Lash, 1994; Giddens, 1990) may lead to more questioning of professional knowledge and expertise, and may lead to increased competition for professions from other occupations or alternative solutions: Who needs an architect when you can design your own house? And why use a physiotherapist when you can watch free videos on YouTube with advice on training and treatment?

Furthermore, new societal problems such as aging populations, migration, and global warming may also result in the development of new professions and new professional work tasks, including new forms of interactions with citizens. For example, social workers and teachers are increasingly involved in the integration of immigrants into their new host societies, but these professionals may at the same time be involved in surveillance, control, and the prevention of radicalization among citizens. Recent decades have also seen a progressive professionalization of care and intensification of emotional labor due to changes in labor markets and new ways of organizing family life (Hochschild, 1983). This also intensifies the involvement of professionals in the emotional and mental aspects of citizens' lives, and it may result in new forms of professionalism with close and emotional relationships to citizens.

We believe these developments call for a new reflection on the relations between professionals and citizens, both as a structural and an interactional phenomenon, and both theoretically and empirically. This special issue of *Professions and Professionalism* seeks to take further steps in the development of new scholarship on professionals and citizen relations. We present four articles that approach the relations between citizens and professionals in different ways.

First, Lars Thorup Larsen's article "No Third Parties: The Medical Profession Reclaims Authority in Doctor-Patient Relationships" tackles the issue of professional authority and the ways in which this may be challenged by citizens and reclaimed by professions. Analysing editorials in journals published by the medical profession since 1950 in the United States, the United Kingdom, and Denmark, Larsen compares how the medical profession in these three countries perceives and reacts to challenges to authority by citizens. Among other things, he finds that in general, medical doctors do not find themselves challenged in any great measure by citizens who contest their knowledge authority or diagnose themselves. Even so, American and Danish medical doctors continuously establish a hard boundary towards citizens, whereas British medical doctors are more reflective upon and open to new ways to interact with patients.

Second, in the article "Patient-Centred Professionalism? Patient Participation in Dutch Mental Health Professional Frameworks," Aukje Leemeijer and Margo Trapenburg explore how the Dutch policy goal of patient inclusion in mental health care involves four different professions. The article suggests that the degree of professionalization will influence how professional frameworks describe and regulate professional-citizen relations. Exploring such professional frameworks (e.g., professional profiles and codes of conduct) from psychiatrists, psychologists, mental health nurses and social workers, this suggestion is partly confirmed. The article demonstrates how social workers seem the most accommodating towards the inclusion of patients in planning and executing mental health treatments, whereas psychologists are the least open to such inclusions since they more heavily emphasize professional autonomy and expertise.

Third, the article "Welfare Service Professionals, Migrants and the Question of Trust: A Danish Case," written by Barbara Fersch, reverses the viewpoint from professionals to citizens. Building on theories of welfare institutions and social trust as well as interview data with migrants in the Danish welfare system, Fersch explores how the frontline encounters between welfare service professionals and migrants are important to the establishment of trust in public institutions. Among other things, Fersch, therefore, points to the integrative potential of such encounters.

Finally, Gitte Sommer Harrits' article "Being Professional and Being Human: Professional's Sensemaking in the Context of Close and Frequent Interactions with Citizens" explores how welfare professionals make sense of their own professionalism and their relationship to clients. Building on theories on professionalism, professional identities and role conceptions, as well as on 58 semi-structured interviews with Danish health nurses, child care workers and primary school teachers, Harrits demonstrates how most professionals seem to blend a logic based on formal and practical knowledge with a logic based on emotions, intuitions, and relations to citizens. This raises questions for the traditional narrow understanding of professionalism as based solely on formal knowledge, but it also raises the issue of how to normatively legitimize professional authority.

Building on different theories, data, and angles, all four articles contribute to our understanding of the meaning and importance of professional-citizen relations. The articles were originally presented and discussed in two panels titled "Professionals and Citizen Relations" chaired by Lars Thorup Larsen at the 2015 Interim meeting of the International Sociological Association's Research Committee 52 on Professional Groups in Milan. We thank all participants in this panel for fruitful comments and discussions.

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Lars Thorup Larsen

No Third Parties. The Medical Profession Reclaims Authority in Doctor-Patient Relationships

Abstract: A key aspect of the classic doctor-patient relationship is the idea that doctors exert a professional authority through medical expertise while also taking care of the patient. Some professional organizations have held that “no third parties” should come between doctor and patient, be it governments or corporations. The sanctity of medical authority has also met resistance, and doctors are often said to face more demanding patients today with their own information about diagnoses. This article concerns how the medical profession reacts faced with challenged authority. Do they seek to reestablish a classic authority position or develop an alternative relationship with citizens? The analysis compares approximately 1.000 editorials in American, British and Danish medical journals from 1950 to the present. The analysis shows that all medical professions see their authority challenged by third parties, but some react defensively while others try to rethink the authority relation between professionals and citizens.

Keywords: Authority, doctor-patient relationship, document analysis, health care system, critique of medicine, social authority, cultural authority, self-diagnosis

A common assumption in studies of cultural history holds that we live in a society where authorities have fallen off the pedestal (Jensen, 2006). Similar assumptions are also found in the sociological literature on reflexive modernization, for instance in Giddens’ claim that a “non-traditional culture dispenses with final authorities” (1994, p. 87). In understandings such as these, what undermines authority are not particular actors nor their overt resistance to power. The previous obedience to religion, science, political institutions and father figures simply erodes through modernization (Inglehart, 1997). Narratives of a broadside erosion of authority are problematic for a number of reasons. They may easily lead us to the mistaken assumption that authority was somehow uncontested before modernity, and they may also lead contemporary sociologists to treat the problem of authority as more or less overcome in the present (Furedi, 2013, p. 3). Both of these sets of assumptions are problematic. Even if some authorities do of course change, it is important to maintain the analytical starting point that authority relations were never uncontested nor are contestations in the present necessarily signs of a general loss of authority.

If we consider doctors’ professional authority towards patients specifically, there are also dominant narratives about why doctor authority is not what it used to be. One narrative typical claims that medical authority has been overrun from above so to speak, that is undermined by managerialism and political controls (Freidson,

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2001; Dent & Whitehead, 2002; Pedersen, 2011; Togeby, Andersen, Christiansen, Jørgensen, & Vallgård, 2003, p. 145). Another common story is that medical authority has been undercut by patients who google their own diagnoses or in other ways refuse to respect the doctor's superior medical expertise (Furedi, 2006; Hughes, McElnay, & Fleming, 2001; Scott, Deary, & Pelosi, 1995; Stevenson, Kerr, Murray, & Nazareth, 2007). All of these narratives may have some merit, but there may also be developments in another direction. For example, reflexive modernization can undermine our belief in authority, but at the same time increase the number and complexity of situations in which individuals need to depend upon specialized expertise (Beck, Giddens, & Lash, 1994). Further, by focusing on the decline of authority, one can easily naturalize the "before" as being a classic, uncontested relationship between doctor and patient.

Bearing these problems in mind, this article seeks to analyze how the medical professions in three different countries try to reclaim professional authority faced with various threats or challenges. Whether or not professional authority has indeed eroded, it is possible to compare how the profession perceives changes to doctor-patient relations and which solutions are proposed. The analysis here focuses specifically on how the medical profession characterizes the doctor-patient relationship and possible challenges to this relationship posed by external actors or by new developments in either science or society. The analysis also compares which courses of action the profession proposes as means to overcome the perceived challenges and reinstall authority. Who should do or understand what differently according to the profession? For example, does the challenge force the profession to act or should the problem be resolved by others? Or, as another alternative, does the profession present the case as if no changes are needed to restore authority?

Finally, it is important to underline the article's comparative ambition and explain the underlying case selection. Aside from comparison over time, the analysis also compares the medical profession in three countries, the United Kingdom, the United States and Denmark. These countries vary significantly with respect to the proximity of the medical profession to the state including variation in the health policy contexts in which doctor-patient relations are inscribed. The United States represents a market-based health care system with partial public funding (Medicare and Medicaid) and most doctors employed privately. The United Kingdom and Denmark both represent state-centered single-payer health care systems with a large proportion of doctors in public employment. In contrast to Denmark, however, the British medical profession has perhaps a stronger historical tradition of independence from the state, for instance through its autonomous scientific societies. These differences are not used for a parsimonious test of the general effect of health care systems on professional authority nor is the expectation that authority claims diverge completely between the cases. Nonetheless, the three different combinations of health care contexts and professions offer a variety of possible authority positions and threats from "third parties."

The article is structured into four parts. The first section develops a historical and theoretical background for the study of doctor-patient authority. This involves a clarification of the key concepts such as professional authority, but also a discussion about why the relationship between professionals and citizens, here patients, cannot be entirely separated from the policy context in which the professional work is embedded, here the organization of medicine and health care. The second section presents the empirical basis for the analysis and explains the essential methodological choices. Third is the analysis, which is structured by country, that is a country-by-country analysis of the dominant challenges to medical authority and the solutions or actions prescribed by the profession. Finally, the fourth section offers a comparative discussion about differences and similarities across the three countries. First, however, it is necessary to place the analysis within a broader theoretical literature on medical, and more generally, professional authority.

Scholarship on doctor-patient authority

The relationship between professionals and clients is not an entirely new field of study. In some situations, however, the connection to clients is mostly used to simply classify and separate professional knowledge from other types of abstract knowledge without discretionary or practical application (Brante, 2011; Freidson, 2001, p. 34), and thus not given detailed consideration in its own right. Other scholars explore the client relation more in detail, but typically limited to a single profession. One example here is Bourdieu's discussion of the ideal-typical relationship between lawyers and legal clients, although this is illustrated through a relational field perspective rather than a profession-centered perspective as such (Bourdieu, 1987). Besides classical works on the role of doctors and patients (Merton, 1957; Parsons, 1951), there is limited literature on the current status of doctor authority toward patients. One study investigates General Practitioners' perceptions of changing patient relations (Brown, Elston, & Gabe, 2015) while another study examines the reverse relationship, that is patients' ability to control doctors' orders (Menchik & Jin, 2013). Before analyzing whether the profession perceives its authority as being intact, it is useful to specify a yardstick of what medical authority could look like, even if it is merely the profession's wishful thinking.

The main title "no third parties" designates a key aspect of this yardstick, which is the idea of an unmediated relationship between doctor and patient. The expression itself comes from a famous declaration made by the American Medical Association in 1934. As the second out of ten "commandments" on health insurance, the declaration simply stated that "[n]o third parties must be permitted to come between the patient and his physician in any medical relation" (American Medical Association, 1934, p. 2200). The professional organization definitely had the federal government in mind when they drafted this New Deal era document, but it is important to remember that the medical profession also opposed the entry of corporations and private insurance companies into the organization of medicine during this period (Starr, 1982). The declaration also specifies that doctor-patient relations should be permanent and confidential, but although the patient should be free to choose his or her doctor, the relationship between doctor and patient is by no means equal in this understanding. This archetypical understanding of a "pure" doctor-patient relationship without the interference from third parties is still based on the doctor's superior authority position. No matter how benevolent a doctor is, the patient is subject to and dependent upon the doctor's superior medical competence, a significant dependence given the simultaneous exclusion of third parties.

The principle of no third parties is a good starting point for an ideal type of pure professional authority as seen from the point of view of the profession itself. It is, however, not an empirical characterization of how medical authority actually worked in the 1930s nor is it in any way a "natural" or normatively superior state of affairs. Most importantly, what presents itself as a doctor-patient relationship entirely free from political interference has immense implications for the organization and financing of health care. For instance, a later passage in the same document states that "[t]here should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession" (American Medical Association, 1934, p. 2201). The principle clearly limits the scope of health policy decision-making, which means that a ban on third parties between doctor and patient implies a sort of "shadow" political conflict about health economy and resources. Few scholars of professional studies would be surprised to find that professional organizations argue in their members' interests. Nevertheless, it is a healthy reminder that an uncontested authority position with no intervening third party is not the same as an interest-free or equal relationship. By excluding third parties, doctors also monopolize access to the patient with significant policy implications even when it is presented as being entirely apolitical.

If we turn to the generic theoretical notion of authority, it is built on a Weberian

tradition. Weber famously defined authority as “the probability that certain specific commands ... will be obeyed by a given group of persons” (1978, p. 212). By implication, professional authority is not intrinsic to a profession nor to its members and therefore cannot be studied solely through them. Ultimately, it is a question of whether or not professionals are able to command authority in the eyes of outsiders, here mainly patients, but also their command on having exclusive control with patient interaction. Weber’s focus on obeying commands and his three “pure types of authority” (1978, p. 215) do, however, seem too rigid to analyze what it means to accept a professional’s authority today. Instead, this article draws on Starr’s modernized Weberian definition of professional authority as a relation of “dependence on the professional’s superior competence” (1982, p. 15). Do citizens feel compelled to depend on the professional’s competence, and which factors explain their willingness to do so are thus the essential questions for a Weberian study of professional authority. As the methods section below clarifies, this article does not have any direct evidence of citizens’ acceptance of authority, since the data analyzed here only shows how the professional organization perceives and discusses possible threats and solutions to doctor-patient authority.

To adapt the general notion of authority more clearly to professions, the article uses Starr’s distinction between social and cultural authority as two conditions of a strong professional authority. Social authority concerns people’s willingness to follow the professional’s prescribed course of action. Cultural authority concerns whether people see the professional’s specialized knowledge as being necessary to interpret a given problem. In both cases, “people” should be understood simply as outsiders, which can include political authorities or, as here, individual citizens in their capacity as patients seeking medical advice. A profession’s lack of social authority would thus make citizens contest their recommended actions, and a lack of cultural authority would make them doubt the need for professional expertise. Previous studies have exemplified that while social and cultural authority can in some cases be separated historically because a profession may develop them in stages (Haber, 1991; Starr, 1982), the two categories are difficult to separate empirically in a present setting (Harrits & Larsen, 2016). It is rarely possible to code empirical sources as being solely about either social or cultural authority, but this is not necessary for the concepts to be analytically relevant.

It is a theoretical distinction between two necessary conditions for a strong professional authority. In empirical settings, however, a given profession at a given time and place may be more challenged on one of these dimensions, and therefore the professional organization’s authority claims will most likely reflect the status of their authority. In the case of a doctor-patient authority, some patients may accept or contest it out of habit, whereas others may do so because of how they understand the need for medical expertise. Similarly, the medical profession may see their authority as being challenged on some dimensions or in some types of situations interacting with the patient, or the profession may identify given social or political developments as the causes of the loss of authority. There are several conceivable outcomes of a broken or compromised authority relation, for instance, patients trying to control the outcome of professional decisions (Menchik & Jin, 2013).

Irrespective of what actually happens in doctor-patient encounters, this article focuses on the medical profession’s perception and the claims it puts forward to reestablished a compromised authority position. Does the professional organization go on the defensive and simply refuse to recognize third parties that pose a threat or challenge to their authority? Or do they choose to comply with the external demands, either willingly if the challenge is understood as being reasonable, or unwillingly if the challenge is somehow overwhelming or unavoidable? Key here is that there is a wide scope of possible strategies and responses, which calls for a qualitative exploration of the specific argumentation used by each professional organization.

Based on this overview of scholarship on professional authority, the following

three-legged research question can be formulated for this study: 1) What, if anything, does the medical profession (in Denmark, the United States, and the United Kingdom) identify as intervening “third parties” in their authority relation towards patients; 2) Which aspects of authority do they see as being contested, and 3) Which courses of action do they propose as solutions to reclaim authority?

Methods, data, and coding

The first methodological problem in the study of professional authority is to find credible sources to indicate whether or not—and perhaps also why—a profession commands authority over citizens in a given relation or capacity. The choice of research strategy easily becomes a dilemma between on the one hand a type of experimental setup designed to measure citizens’ willingness to comply with hypothetical authority “tests,” and on the other hand studies of real-life situations where the citizen’s compliance with authority is more difficult to measure and isolate. This study does not presume to be able to measure citizens’ willingness to comply with professional authority because there is no available empirical material from which to evaluate this willingness, and certainly not back in time. The material here can only show the professional organizations’ perception of professional authority, and it can only describe and explore these perceptions of authority, but not explain authority or its effect in practice.

The analysis uses editorials from professional journals as a proxy “voice” of the medical profession, although of course not all doctors are members of the underlying professional organizations. This material has the advantage of being published text, which can reasonably be said to represent the opinion of the professional organization. Even if editorials have different authors, they are subject to some sort of scrutiny by an editor appointed by the professional organization, and the texts can thus be said to speak for the profession. The journals selected for the analysis are the professional organization’s main general medical journal in each country, specifically the British Medical Journal (BMJ, 1840-present), the Journal of the American Medical Association (JAMA, 1883-present) and *Ugeskrift for Læger* (UfL, the Journal of the Danish Medical Association, 1839-present). Because these journals are aimed at a broader audience than just members of the profession, their editorials give a sort of window into how the profession portrays itself to the outer world. They are of course also aimed at doctors and can thus be read as instructions to doctors on how to act or react when faced with challenges from patients or from society. As mentioned before, the material is clearly limited in depth and does not claim to uncover an underlying “real” mechanism of authority. It is, however, quite well-suited to the specific task here, that is to describe how professions perceive threats to their authority and which authority claims and actions they prescribe as solutions.

The material further has the advantage that it facilitates comparison because editorials have similar length and scope across time and space. The data set here comprises a sample of 25 randomly selected editorials from every fifth volume since 1950 giving 13 volumes in each country and a total of 975 editorials. The analysis starts in 1950 because professional power and authority is often assumed to be at a high point during this period of professional “sovereignty” (Starr, 1982). There is, of course, a risk that the sampling will overlook relevant discussions in between the sampling points. If a perceived threat to professional authority carries great weight, it would most likely be discussed several times and thus still appear in the broad patterns of authority claims described here.

The data set allows for comparison across time and country, but the temporal dimension is mainly included to provide a variety of possible challenges to professional authority over the analyzed period. The following analysis is structured by countries because professional organizations, as well as the social organization of

professions typically, follow national boundaries. As mentioned before, the three countries represent three different medical professions in three different health policy contexts, since for example Danish doctors have probably never been able to keep third parties out of patient relations to the same extent as American doctors. The British medical profession has a longer history of independence (Saks, 2003, p. 37), but nevertheless, work within a health care system much like the Danish.

Finally, a few words on the coding and interpretation of the sources. It is unlikely that profession will explicitly label its authority claims as such because having or exerting authority sounds less legitimate than promoting health based on scientific knowledge. As a consequence, the analysis must be able to interpret how an editorial—besides perhaps conveying a more specific piece of news or opinion—also entails an authority claim about doctor-patient relations. Since the editorials typically focus on problem areas or challenges, the claims typically identify how someone—could be patients, the state or other social organizations—should act differently in order to respect medical expertise. As an initial coding, the sources were first separated depending on whether their embedded authority claims—provided there were any—could be said to involve the doctor-patient relationship, or whether they mainly concerned conflicts with the state or simply contained news about recent developments in medical research. Only editorials on or with implications for doctor-patient relations were included in the analysis. The remaining sources (216) were finally subjected to a second coding process in order to identify for each editorial 1) what constituted a challenge or threat to doctor-patient authority, for instance, a perceived third party, and 2) who should do what differently according to the editorial. Although the tables do not specify the underlying source text for each individual source, which would expand the text significantly, the analysis exemplifies the dominant themes with key examples¹.

Another issue in coding the material concerns the built-in ambivalences of medical discourse, which the analysis automatically inherits. For example, the editorials often refer to “doctors” without specifying whether the text mainly concerns general practitioners, specialists or rather the whole profession. Many sources appear to talk about issues in general practice, but the authority question is no less relevant for specialists or hospital doctors who more often interact with patients whom they do not know in advance. This is precisely why a generic understanding of doctor authority is relevant, even if it is imprecise, as it concerns the authority ascribed to a doctor simply because he or she belongs to the profession.

Danish doctors’ authority toward patients

The first thing to notice in the Danish case is what is not there, and what is, in fact, missing in all three countries. One topic that many would perhaps intuitively associate with the change in doctor-patient relations over time is the effect of individualization, for instance, if patients in large numbers begin to google their diagnoses or preferred treatments instead of relying on the doctor’s advice. Whether or not this phenomenon is real in practice, it does not register in the material analyzed here. The individualization of patients may be an undercurrent in some of the typical authority claims that do appear here, but it is always mediated through other perceived challenges to medical authority, for instance, the increase in media attention and legal regulation in the area of doctor-patient relations.

¹ To facilitate transparency, the coding list can be obtained by contacting the author. References to the sources are not entirely uniform, because the three journals subdivide volumes in different ways. The Danish references indicate issue number within one singular volume per year whereas the US and UK references tend to have more volumes per year, but with continuous pagination.

One theme that receives considerable attention already in the 1960s and onwards is the question of medical malpractice or side effects emerging from treatment prescribed by doctors. This challenges the cultural authority of medicine because it may hurt the belief in medicine as a necessary means to achieve health. The editorials do not explicitly reference the ongoing international debates about anti-medicine, such as Illich's "Medical Nemesis" (1975), but they appear to refer implicitly to these broader debates. For instance, a 1965 editorial discusses the issue of iatrogenetic effects, that is medical problems caused by treatment, rather than the underlying disease, while another discusses the issue of side effects in broad terms (UfL, 1965, 05). In both cases, the editorials ward off the critique by saying that members of the public tend to misunderstand these problems as doctors' mistakes, but that they are really just indications of how complex diseases are. In consequence, the editorials see no need for doctors to act differently to overcome this challenge to cultural authority, except perhaps try to educate the public on the complexity of medical situations. Later editorials under the same theme, for example, a 1990 editorial on whether doctors' mistakes are really mistakes, tend to focus less on denying the existence of medical malpractice as the earlier texts did. Instead, focus is on the formal system of medical supervision, which should be controlled by doctors and not the state (UfL, 1990, 33).

A large number of the authority claims are the profession's reactions to contemporary discussions and proposals that seek to formalize or otherwise advance patient rights. In these situations, the formalization of patient rights works as a third party that comes between doctor and patient and threatens the social authority of the former. The editorials clearly warn against this development. The standard response to these types of proposals—for instance proposals about a patient ombudsman (UfL, 1995, 13), formalized medical ethics, patient complaints system, etc.—is that the previous unmediated relationship between doctor and patient were preferable. Not just preferable for doctors, but rather that the immediate needs of the patients were better served without formal regulation entering the social authority relation. Some patient rights such as the "waiting time guarantee" (Larsen & Stone, 2015) are not actually designed to empower patients in relations with individual doctors, but toward the public health insurance and public hospitals. Again, the reaction of the medical profession is to defend the status quo, a less regulated social authority relation toward patients (UfL, 2000, 35; 2005, 25-31). The threatening third party in these discussions is a new policy proposal that formalizes doctor-patient relations, which the profession clearly warns against. The profession presents itself as a sort of guardian of the patient's interests, for example, in protecting patients against marketization in the health care sector (UfL, 1995, 51), employers seeking access to health information on individual patients (UfL, 1995, 15), or the state seeking a doctor's evaluation of individual patients' fitness to be a parent (UfL, 2010, 45).

The editorials are particularly defensive against new transparency policies. For example, regulations that give patients and the public access to transparent records are fiercely opposed, for instance, transparency regarding possible competing interests (e.g. pharmaceutical sponsorship of doctors or research) or regarding complaints records on individual doctors. Almost all of these transparency regulations are criticized as being an unnecessary "public pillory" (Danish: *gabestok*) for doctors (UfL, 2005, 23, 35). These later period editorials do not go as far as to deny the existence of malpractice, competing interests or other compromising actions performed by doctors. They characterize the allegations against doctors as being overblown, but mainly they systematically favor solutions that intervene as little as possible into medical practice, for instance promoting an "open culture" where mistakes can be admitted without the need for whistleblower protection systems and similar formalized legal arrangements (UfL 2000, 19). The best remedy to doctors being in the pocket of the pharmaceutical industry is allegedly to promote an ideal of "openness,"

which on one hand does recognize competing interests as an actual problem for doctors' authority, but nonetheless, opposes all intervening third parties into the relation.

Finally, another perceived threat to medical authority comes from the media whose attention to problems in doctor-patient relations is also presented in the editorials as an unnecessary third party. Similar to the reactions against politically induced transparency measures, the editorials here are equally furious against media "scares" and "witch hunts" against doctors and medicine. This discussion concerns cultural authority because the public reputation of medicine is on the line, but indirectly also social authority if patients act on information from the media rather than relying on the doctor's traditional knowledge monopoly.

Table 1 summarizes the dominant themes in the Danish editorials. At least three characteristics stand out. First, the Danish editorials do not present an explicit ideal of how doctor-patient should work, but indirectly they oppose all potential changes to the existing, unmediated authority relation. This fits with the thematic discussion of "no third parties" in the introduction, but only rarely do the discussions concern actual interactions with patients. The perceived threats to both cultural and social authority are not seen as coming from patients themselves, but from other intervening third parties who claim, wrongfully in the eyes of the medical profession, to take care of the patient. Second, the Danish editorials are not particularly clear on solutions, that is who should do what differently than now. A large number of editorials simply identify a problem without any clear indication of who should do what differently. Third and finally, when there are suggested courses of action, they usually defend the status quo. To the extent that a need for change is even recognized, the Danish editorials mostly suggest that outsiders should understand them better or that problems can be solved within the status quo. In other words, the Danish medical profession reclaims authority in a quite defensive manner and without any real attempts to find a new foundation for the profession's social or cultural authority.

Table 1

Danish doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Malpractice/side effects/iatrogenetic effects	Educate the public on complexity of medical situations
Regulation of medical ethics	Remain unregulated patient interaction
Patient rights (legal, ombudsman and choice)	Avoid regulation, but protect patients against marketization
Media scares	Resist witch hunts
Transparency policies (competing for interests/complaints)	Resist public "pillory"

American Doctors' Authority Toward Patients

The American editorials are surprisingly similar to the Danish in terms of their defensive tone and their clear preference for status quo solutions with as little formalization of doctor-patient relations as possible. The similarity is surprising, given how different political and social circumstances American doctors' work under compared to the Danish, although parts of the material reflect the diverging health care systems.

The first area where the US editorials resemble the Danish is in their reactions to

broader social critiques of medicine such as anti-medicine. These critiques are especially relevant for the profession's cultural authority because the public's willingness to accept professional decisions and various privileges may depend on whether or not they believe medicine to be a necessary means to achieve health. While the editorials do not say explicitly that patients increasingly challenge their authority, there is nevertheless a clear recognition in JAMA that the public image of doctors influences patient relations. One editorial from 1965 references the "Dr. Jekyll image" of doctors, but finds comfort in a report showing that doctors still rank highly on occupational prestige (JAMA, 1965, 194(11), p. 22). Similarly, other editorials address various media critiques or panics, typically by stating that the public should stop blaming doctors, but without any suggestions that either doctors or patients should act any differently than they did before. In other words, the editorials try to defend doctors' honor and demand respect from the public, but without any suggestions for actions to improve the cultural authority of doctors.

The American editorials also resemble the Danish when it comes to the later discussions about transparency policies, typically fueled by proposals about the disclosure of competing (financial) interests, industry funding and complaints records. The similarity is perhaps surprising, considering that a larger proportion of American doctors compared to Danish work in privately owned, profit-seeking or even outright capitalist organizations. The proposed alternatives offered in the US editorials are similarly devoid of real changes in authority relations, and they generally just propose that conflicts of interest should be addressed through informal appeals to 'balance and openness.

The social authority of American doctors is clearly more challenged by the introduction of "managed care," DRG systems and other economizing instruments in the health care sector. These developments are generally viewed as disruptive, because incentives work "differently" in medicine, as one editorial says (JAMA, 2005, 294(14), p. 1821). JAMA stays very close to the original no third party argument here, which is to oppose any development that interferes with an imagined, "pure" fee-for-service interaction with the patient. When I say imagined, it is not to suggest that there is no real threat to the social authority of doctors in policy tools like managed care and health economy. Imagined, however, is the absence of economic incentives in unregulated fee-for-service medicine, both in these editorials and in the original 1934 AMA declaration. The editorials do not say that authority is threatened, but instead, it is argued that patients' access to medical services will be limited by these policy reforms. Again, the profession's preferred solution is to maintain the status quo. Ironically, the JAMA editorials also criticize the opposite development, such as reforms seeking to expand access to health care, either through a new single-payer health care system (JAMA, 1975, 234(9), p. 25) or through expansions of Medicaid coverage for uninsured children (JAMA, 1995, 274(18), p. 33). The editorials clearly oppose such expansions of access to health care, for instance, arguing that any single-payer health care system would interfere as a third party between doctor and patient (JAMA, 1975, 234(9), p. 25).

End-of-life decisions constitute another threat to the unmediated social authority of doctors. From 1990 and onwards, there are several discussions about do-not-resuscitate-orders and other related proposals for formalization (JAMA, 1990, p. 264(10), p. 33). These are situations where the patient is—either temporarily or permanently—unable to consent to the doctor's proposed treatment. The profession again prefers the unregulated status quo where a doctor exerts social authority and decides on a case-by-case basis. This means opposition not only towards policies that would regulate end-of-life decisions, but also legal action or general juridical models that would also act as a sort of a third party between doctor and patient. The editorials do not really seem to consider that some of these court decisions or proposals may come from patients' wishes, or at least the profession prefers to remain

the sole interpreter of patients' wishes and thus to preserve an authority relation toward patients.

Unlike the Danish editorials, an increasing number of the American documents in the past few decades do actually point to doctors as the agents responsible for taking action in the given situation. For instance, there are discussions about how doctors should work to avoid social exclusion among the elderly (JAMA, 2010, 304(17), p. 1955), how they should handle informed consent in interactions with patients from multicultural backgrounds (JAMA, 1995, 274(10), p. 39), or doctors' role in the prevention of opium addiction (JAMA, 2010, 304(14), p. 1612). These editorials do not refer to a clear and identifiable challenge to professional authority, and no unifying third parties are involved. It is, however, an increase in the number of situations where JAMA calls on doctors to act instead of only pointing fingers at others, even if it is not a fundamental change from how they worked before. There are also a few editorials in the most recent volume that call on doctors to cooperate when faced with crisis over surgical mortality or questions about financial impartiality (JAMA, 2010, 304(15), p. 1721; 303(1), p. 75). These types of situations would previously have been brushed off as witch hunts against doctors. So, while the American medical profession's standard response to perceived challenges is to avoid general regulation models and maintain a largely unregulated social authority relation towards patients, there may be small steps towards cooperating with these systems that regulate the doctor's professional work.

Table 2

US doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Doctors' image as Dr. Jekyll, critique of medicalization	Demand respect for patient guardianship, defend honor in public
Transparency policies (competing for interests/industry funding/complaints)	Resist regulation, call for "balanced" policy or culture of openness
Managed care/health economy/incentives in doc-patient relations	Resist incentives and bureaucratic third parties, maintain fee-for-service remain.
Uninsured patients/children	Avoid Medicaid solution, avoid third parties
End-of-life decisions, "do not resuscitate"—orders, etc.	Avoid general or legally formalized model, preserve discretionary judgment

British Doctors' Authority Toward Patients

The British editorials reflect some of the same themes as in the US and Denmark, such as challenges to their work situation brought on by managerialism as a third party coming between doctor and patient. For example, there are complaints about "hamster health care" with doctors running like hamsters in a wheel while seeing patients less (BMJ, 2000, 321, pp. 1541-2). Another editorial criticizes the adoption of "personal medical systems" for each individual patient because the system is managerially and not professionally driven (BMJ, 2000, 321, p. 1359-60). We see other topics that could just as easily have been written in JAMA or UfL, for instance, about

the need for doctors to maintain the social authority position as gatekeeper to specialist referrals (BMJ, 1995, 311, p. 1447), or the public being “totally misguided” in its perception of facial transplants (BMJ, 2005, 331, p. 1349).

There are also situations, however, where the perceived challenges to medical authority prompt new types of responses and solutions compared with the other countries. One editorial, for example, reminds doctors that problems in the NHS are no excuse for “cavalier” treatment of patients and their relatives (BMJ, 1990, 301, p. 1407-8). This editorial exemplifies a common characteristic in many if not most British editorials, which also set them apart from the Danish and the American: The agents responsible for acting differently are doctors themselves, either with the aim to make the threatening third party go away or to reconstitute doctor-patient authority in light of the given challenge. The authority claims made by Danish and American doctors were almost exclusively met with calls for someone else—patients, the public, the state, the media, or other perceived third parties—to act differently. The British editorials are different here. The implications for action they derive from challenges to existing authority positions typically say what doctors can or should do differently. Also, while a few editorials in BMJ also ward off critique, they do not automatically defend the status quo as fiercely as the other journals do.

When the BMJ calls for doctors to act differently in light of a given situation or challenge, it does not mean that the profession does not assert its social or cultural authority toward third parties. It is perhaps more accurate to say that the authority relation towards patients is reconfigured according to the given challenge. A large proportion of the British editorials describes a specific type of delicate situation—supposedly one that many doctors face in encounters with patients—that requires the doctor to handle the interaction differently than hitherto and to do this with some professional diligence. For example, there are editorials about how doctors should handle patients seeing prostitutes (BMJ, 1960, 2, p. 1974), how to handle addicts who try to trick the GP for prescriptions (BMJ, 1975, p. 541), when to go against patients’ wishes with electroshock treatment (BMJ, 1980, 281, p. 1588), how doctors can be sensitive while still treating male rape victims (BMJ, 1990, 301, p. 1345), how to act on seizure patients’ access to driving again (BMJ, 2010, 341, p. 1260), or how to prevent heart disease with binge drinkers (BMJ, 2010, 341, p. 1146).

There are numerous situations like these in the material. What binds them together is that although some of them may be related to new diagnoses or treatments in medicine, the editorials’ key message is not about new scientific evidence. It is about how the doctor should take care for and handle a potentially difficult situation with a specific group of patients. In this sense, what challenges the normal doctor-patient relationship in these situations is usually not new medical knowledge, but rather the part of the doctor-patient relationship that is not simply an exchange of purely scientific expertise. It can be situations that may be potentially embarrassing for the patient, or where the doctor has regulatory functions, such as giving or taking away a driver’s license.

What makes this group of authority claims interesting here is on one hand that the British medical profession appears more willing to take responsibility for new developments in doctor-patient relations, and thereby to offer a more genuine form of patient guardianship. On the other hand, these types of authority claims are also particularly interesting because while doctors appear much more willing to change here, this is not an end to the authority between a doctor and a patient. The new type of doctor-patient relationship described in these editorials is still an authority relation. It is precisely the doctor’s responsibility—not the state’s nor the patient’s—to handle or take care of a potentially difficult situation for the patient, even when the delicate nature of the encounter is prompted by the patients’ actions, special problems or social circumstances. The social authority of the doctor is reconfigured as a type of guardianship here, which is not necessarily completely new because many doctor-patient encounters were of course also difficult before this period. Nevertheless, one

could potentially see this as a medical profession that has taken the critique of medicalization and medical domination seriously and pursued a reconfigured form of professionalism and authority. Conceptually, this change mainly refers to social authority because of its orientation towards action, but indirectly it may also seek to rehabilitate belief in the benefits of medicine more broadly, i.e. cultural authority.

Table 3

UK doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Complex medical/social situations with patients (mental health, prostitution, obesity, elderly, pregnancy, male rape)	Doctors should manage situation with care, take responsibility for handling patient relations diligently given difficult situation (topical or new knowledge)
NHS limitations hurt patients and doctors	Treat them well despite limitations
Patient demanding direct access to specialists	Maintain GP gatekeeper function (referrals)

Comparative Challenges to Medical Authority

If we look across the medical professions in the three countries, they often identify some of the same developments as possible third parties threatening their authority towards patients, such as managerialism, formalized patient rights or critical media attention. Nevertheless, there does not appear to be any direct relationship between what threatens professional authority and the responses it provokes. There seems to be a range of possible ways that doctors can react to having their authority—cultural as well as social—questioned in public. The profession may choose to push back hard as Danish, and American doctors do against all challenges and simply argue that the public scrutiny of medicine is unreasonable and that no formal, legal or policy changes are necessary. It can also be less defensive and come up with more constructive ways to rethink the authority of doctors in light of how external conditions change or given that the public's trust can no longer be taken for granted. The range of possible responses may reflect that we are talking about a profession with a well-established professional monopoly, a status quo to defend. In any case, it is remarkable that Danish and American doctors are more similar than their British counterparts in this analysis. This pattern suggests that authority relations between doctors and patients are not determined solely by the policy subsystem on a macro level, which means being in either a market- or state-centered health care system.

If we ask more generally what challenges professional authority, there is no real evidence in this material to support the initial idea that doctors see their authority as being undermined by individualization or the spread of medical information on the internet. The topic simply receives very little attention and more broadly one could argue that patients have relatively little impact on the content of these editorials. The exception here are the specific debates in the BMJ on how doctors should address a potentially difficult situation prompted by the patient's situation or by some other social development. Even in these cases, the argument rarely calls for doctors to enter into a dialogue with patients on equal footing. The doctor should, both as cultural and social authority, take responsibility as guardian for the patient in a given situation, but few situations call for doctors to involve the patients in medical decisions.

The limited attention devoted to patients indirectly says something about the state of medical authority. It appears that the medical profession in all three countries sees little need to legitimize their authority position towards patients, perhaps because they see this relationship as being primarily defined by the exclusion of third parties. They do see professional authority as being contested, however, but mainly from external third parties such as political institutions, managerialism, negative media attention or the opening up of medicine to systematic scrutiny, for instance on medical malpractice, competing interests or medical decision-making in broad terms. Here, we also see how both dimensions of doctors' professional authority—social and cultural—are in play at once. It is difficult to expose medical decision-making to public transparency without a perceived threat to the profession's general reputation, and the protection of doctors' reputation against skepticism in public is often presented as an argument against change. So, while all medical professions continually try to command authority, they may do so either through action and change or, on the contrary, through a defensive refusal to make any changes to the status quo.

As a final note, it is worth to underline how this article answers the research question as well as reflect upon the reliability of the answer. The article argues that the medical profession continuously identifies external parties as intervening third parties that disrupt the idealized, unmediated authority relation between doctor and patient. The third parties are not simply actors, however, but also developments such as increased media attention, patient rights or marketization. The analysis points to challenges against both the social and cultural authority of doctors, but the two have proven difficult to separate. This is no surprise given Starr's original use of the terms but nevertheless, points to a limitation in the analytical setup. It is also essential to consider the possibility that when the study finds no major erosion in doctor-patient relationships, it is simply because the selected material and selected type of material is unable to show such a development. This is possible, and as the methods section argues, the study only provides a broad overview of what the profession says about authority. It would require other sources and another depth of analysis to determine the status of authority in practice, and it would most definitely require a combination of different methods.

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Aukje Leemeijer and Margo Trappenburg

Patient Centered Professionalism? Patient Participation in Dutch Mental Health Professional Frameworks

Abstract: Patient participation is an important development in Dutch mental health care. Notwithstanding a generally positive attitude towards patient participation, mental health professionals show ambivalent responses to it due to tensions that may occur between professional values and societal values like (more) patient participation. Professionals vary in their degree of professionalization which is translated to their formal professional frameworks like professional profiles and codes of conduct. To explore how formal professional frameworks of mental health professionals mirror how and to what degree they accommodate patient participation the professional frameworks of four types of mental health care professionals were studied: psychiatrists, psychologists, nurses, and social workers. We hypothesized that the higher professionalized professions were less open to patient participation. The results partly support this hypothesis. Professional frameworks of social workers and nurses indeed show more openness to patient participation, but the picture for psychiatrists and psychologists is ambiguous—more professionalized psychiatrists being more inclined to incorporate patient participation than less professionalized psychologists.

Keywords: Mental health care, professionalization, occupational attitude, patient participation, Netherlands

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Professions are sometimes seen as beacons of stability who will adhere to their professional values no matter the circumstances. Crime may rise and fall, but defense lawyers will take an oath to defend their clients to the best of their abilities. Health care costs may rise to an all-time high, but doctors will devote themselves to their patients' health no matter what. Nevertheless, authors also sometimes argue that professions should become more flexible, acknowledge the contradictory values in their surrounding environment and adapt their professional habitus to accommodate them. They should, for example, help the government fight crime or cut health care costs. Such contradictory values, however, can cause tensions for professions, having to accommodate societal demands and to balance these with their professional norms and values. In the beautiful words of the oncologist Lucien Israel (1982, pp. 99-100):

As a private citizen, I am aware of the pressing economic issues connected to finite resources.... Apparently, contradictory values do exist, and balancing them is the art of governing. As a citizen, I use my vote to express my choice, and as a witness to history, I deplore human society's orientation toward the welfare state.

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As a doctor, however, I am lock, stock, and barrel behind those who want a longer life.... In the future, some politicians or administrators may have the power to reduce my clinical budget. But they will never get me to do it for them. I hope that all physicians will do the same, to preserve what is essential, their status as a human resource against sickness, the avatar of fate.

In this article, we will look at the way different health care professions balance societal demands with their professional values. We have chosen one specific and important societal development in health care—enhanced patient participation, which will be introduced in the next section. Our research was done in the Netherlands, and we have chosen four professions in the field of mental health varying from strongly professionalized psychiatry to far less professionalized social work to answer the following research question: How do professions in mental health care with different degrees of professionalization accommodate patient participation?

We introduce existing theory about professions and professionalism and discuss what is known about the way in which different professions respond to societal demands. Following that, we introduce patient participation and professionalism in our chosen case—mental health care in the Netherlands. In the next two sections we explain our chosen methodology and present our findings. In the final section we answer our research question and discuss the merits and limitations of our research.

Patient participation

As in most Western countries, patient participation and user involvement have become very fashionable in Dutch health care (Dedding & Slager, 2013; Lang, Gühne, Riedel-Heller & Becker, 2015; Raad voor de Volksgezondheid en Zorg [RVZ], 2013; Vennik, Van de Bovenkamp, Grit & Putters, 2015; Vollaard, Van de Bovenkamp & Vrangbaek, 2013). Patient participation is sought at various levels in the health care domain. Patients (or patient representatives) are asked to co-design policy at the macro level (Van de Bovenkamp, Vollaard, Trappenburg & Grit, 2013), to co-create medical guidelines and hospital policy at the meso level of organizations (Van de Bovenkamp & Trappenburg, 2009; Van de Bovenkamp & Zuiderent-Jerak, 2015; Vennik et al., 2015) and to engage in shared decision making at the micro level of doctor-patient contacts. Patient participation is taken to improve the quality of care and to be just from a democratic perspective.

Research has shown that patient participation in practice is far from ideal and continues to be a subject of debate. Participation requires time and energy both of which are scarce for people with serious health problems (Trappenburg, 2008; Van Staa, 2012). Including patients' preferences based on anecdotes and personal impressions in medical guidelines sits uneasily with evidence-based medicine (Van de Bovenkamp & Trappenburg, 2009; Van de Bovenkamp & Zuiderent-Jerak, 2015). Patient-representatives experience a marked tension between being taken seriously by other stakeholders and resembling ordinary patients. Following courses in research or "expert participation" contributes to the first aspect while diminishing the latter (Trappenburg, 2008). In addition, authors sometimes find that patients are being used by policy makers, health insurers or pharmaceutical companies who "play the user card," announcing that their chosen course of action is right because it has been approved by patients. Professionals sometimes argue that putting the patient's interest first has always been a guiding principle in their work (Trappenburg, 2008). Thus, while there are good reasons to strive for patient participation, there are also valid reasons to be much more reluctant to accommodate this trend. In this article we take a neutral position towards the enhanced demand for patient participation,

considering it a given phenomenon in health care, and we focus on the way professions handle it.

Professions and societal pressures

Defining professionalism

Professions are generally assumed to possess three defining characteristics: specialized knowledge, a service ideal, and professional autonomy (Evetts, 2003; Freidson, 2001; Wilensky, 1964). The work of professionals is based on highly specialized knowledge, achieved after years of higher education and vocational training. The goal of the profession is always a (public) service ideal—educating young people, providing fair justice, curing the sick. There is a set of professional institutions such as a professional association with its “esprit de corps,” professional profile, professional code, and disciplinary board. Access to the profession is legally protected and regulated through formal registration and membership of the professional association. There is, in other words, professional control, including both content and institutional control (Noordegraaf, 2007). Finally, in daily practice, professionals have considerable discretion in the execution of their jobs. This discretionary authority implies a moral responsibility, hence the importance of professional codes of conduct.

Changes in health care professionalism

These defining characteristics of professions may be challenged due to social developments like increasing managerialism in public services, growing bureaucracy, new technologies, distribution of knowledge, and democratization (Evetts, 2003; Noordegraaf & Steijn, 2013). Dwarswaard, Hilhorst and Trappenburg (2009) studied the way general practitioners and surgeons respond to changing patient demands as a result of patients’ higher education and better access to information. They conclude that, in the Netherlands, general practitioners adapted much more quickly to patients’ demands than surgeons.

Rogowski (2011), Younghusband (1973) and Spierts (2014) studied social work as a profession. All of them argue that social work is much less professionalized than medicine, first and foremost because it lacks a specialized body of knowledge. Hence social work is more inclined to accommodate societal demands. Social workers in the nineteen fifties tried to help clients adjust to societal norms whereas their colleagues in the late sixties and seventies climbed the barricades to change society rather than their clients. The new public management era thereafter forced social workers to register their every move and find business models for their tasks. Social workers adjusted to each of these new demands.

From these studies we may carefully conclude that the more professionalized a profession is—surgery is generally seen as a profession *par excellence* whilst general practitioners struggled for years to find their own niche once more medical specialties developed—the more it will be inclined to adhere to its traditional professional autonomy and moral code.

Adapting to societal demands

Scientists differ in their opinions on how and to what degree professions should accommodate societal demands. Researchers studied the effects of a market ideology on professions, arguing that having to face market competition might make profes-

sionals give up their service ideal (e.g. patient's health) trading it for consumer preferences. Krizova (2008) theorizes about a decline of professional autonomy due to marketization. Professional autonomy used to be in the patient's best interest; hence a decline might cause "a decrease in altruistic or service-oriented attitudes toward patients" (Groenewoud & Dwarswaard, 2007; Krizova, 2008, p. 111). Inspired by the late Elliott Freidson, these authors feel that professions should be careful to adapt to political or societal demands for fear that supreme professional values might get lost in the process.

On the other hand, there are also authors who argue that professions and professionals should not see themselves as isolated from society and its ever changing and developing values and demands (Allsop et al., 2009; Evetts, 2011; Noordegraaf, 2007; Noordegraaf & Steijn, 2013; Trommel, 2006). They state that professions should develop their professional skills and standards in ways that maintain certain occupational autonomies and values but at the same time adapt to societal expectations and changing values (Noordegraaf & Steijn, 2013). Subsequently, these authors observe that there are many societal changes: People are becoming more highly educated, society is more individualized, computer technology is expanding, women's participation in the labor market is growing, state authorities are in transition from government to governance. New societal demands cannot be ignored, so the best way forward is to adjust. Professional services need to be "reconfigured" and "reshaped" (Noordegraaf & Steijn, 2013, p. 235).

The above-mentioned studies and discussions demonstrate that accommodation to societal demands may cause tensions and dilemmas for professions because it may force them to handle competing or conflicting values. In this article, we focus on the tensions that may rise from accommodating patient participation, for example, the tension between patient autonomy and professional autonomy. We present a comparative study of four professions in mental health care varying from psychiatry (highly professionalized medical doctors) to psychology, to mental health nursing and social work (semi-professionalized). Following up on the findings of Dwarswaard et al. (2009), Rogowski (2011), Younghusband (1973) and Spierts (2014), we hypothesize that the more professionalized of these professions will be more adherent to classic professional values like professional autonomy than the less professionalized ones, and thus give less room to patient participation.

We studied formal professional frameworks¹ of four mental health care professions. These frameworks mirror the professional norms and values of a given profession and therefore can be used as an indication how these different professional groups respond to patient participation.

Patient participation and mental health professionals

Patient participation in (Dutch) mental health care

Patient involvement in mental health care is rooted in the widespread anti-psychiatry movement in the nineteen seventies (Hunt & Resnick, 2015; Oosterhuis & Gijswijt-Hofstra, 2008; Van Dijkum & Henkelman, 2010). The influence of this movement is still visible in patient organizations nowadays, especially in the plea for patient empowerment, recovery-oriented care, and the direct use of patient experience in mental health care. Many Dutch mental health care organizations have an explicit policy to involve "experience experts" in treatment and care, a booming

¹ Formal documents, drafted by professional associations that describe and prescribe goals, responsibilities, values, and rules of conduct of professions such as professional profiles and codes of conduct.

development during the last 20 years (Boertien & Van Bakel, 2012; Karbouniaris & Brettschneider, 2008; Storm & Edwards, 2013; Van Haaster, Hidajatoellah, Knooren & Wilken, 2009). (Ex)patients are actively involved in the development of care programs, in the practical execution of care and in training mental health professionals. Patient organizations are involved in developing and evaluating health care policy and research (Dedding & Slager, 2013; RVZ, 2013; Van Dijkum & Henkelman, 2010). At the organizational level, legally based patient councils have advisory rights on issues that relate to patient care and patients increasingly have an active role in measuring and evaluating the quality of care.

By contrast, at the level of individual treatment relationships patient participation is not widely practiced in mental health care (Angell & Bolden, 2015; De las Cuevas & Peñate, 2014). Shared Decision Making² in psychiatric care has led to discussions, specifically considering the decisional capacity of patients in view of their mental disease (Angell & Bolden, 2015; Haman et al., 2009; Zijlstra & Goossensen, 2007).

Responses of mental health professionals

Professionals in mental health care have ambivalent responses toward patient participation. Oosterhuis and Gijswijt-Hofstra (2008, p. 754) point out that the Dutch professional association of psychiatrists (Nederlandse Vereniging voor Psychiatrie [NVvP]) in the nineteen sixties and seventies, when psychiatrists were confronted with assertiveness and even resistance of patients, did not take a clear stance towards the issue because of different opinions among its members. Angell and Bolden (2015) found that psychiatrists in the US find it difficult to combine their professional considerations and patients' wishes in decisions on medication. Storm and Edwards (2013) collected empirical research on patient-centered care in the US, the UK, and Scandinavian countries and conclude that notwithstanding the general enthusiasm for user involvement, there are concerns regarding the implementation, sometimes directly related to the capacities or attitudes of professionals:

What evidence there is indicates tensions between patients' and providers' perspectives on treatment and care.... Lack of competence and awareness among providers are further issues ... difficulties when patients' views are different and challenge staff judgments of proper aims. (Storm & Edwards, 2013, pp. 313, 322)

They refer to Larsen (2009) who suggests that mental health professionals face an ambiguous role; while policies call for more user involvement, their daily work seems to be influenced by the understanding that professionals have the expertise and know what patients' best interests are (Storm & Edwards, 2013, p. 322).

Four types of mental health professionals

Mental health care professionals come in varieties, with different levels of education and different degrees of professionalization. We try to link openness to the development of patient participation to the degree of professionalization of four professions in mental health care as mentioned above.

Based on the criteria discussed before *psychiatrists* can be ranked as having the highest degree of professionalization, being medical doctors and therefore belonging to one of the classical professions. It takes more than ten years of academic education and vocational training to become a psychiatrist. To exercise the profession one has

² A methodical approach that enables patient and professional to decide jointly on the applied treatment and care.

to be registered in the Dutch BIG-register³. The professional association—the Nederlandse Vereniging voor Psychiatrie [NVvP]—plays an influential role in development and policy in mental health care. It has its own disciplinary board and sets professional standards through a variety of activities assessing the quality of care, accreditation of professionals and postgraduate training.

Like psychiatrists, *psychologists* working in health care need to register in the BIG-register. Professional titles vary: general psychologist, psychotherapist, health care psychologist or clinical psychologist. There are several professional organizations for psychologists of which the Nederlands Instituut van Psychologen [NIP] is the most important. This organization represents all types of psychologists, not just the ones working in (mental) health care. In this study, we focus on health care psychologists and (more specialized) clinical psychologists, who received respectively two and six years of academic education and vocational training after finishing their master degree in psychology. These are the two most important professional groups of psychologists working in mental health care. Considering these characteristics the degree of professionalization of psychologists is quite high, albeit lower than that of psychiatrists.

The degree of professionalization of specialized *mental health nurses* is lower but still considerable—at least four years of training and education at bachelor level. Because nurses are qualified to perform medical procedures, they have to meet certain regulatory requirements and are also obliged to be BIG-registered. Nurses form a strongly organized but at the same time strongly differentiated profession. In the Netherlands, nursing studies range from a four-year program in secondary vocational education to master programs at universities of applied sciences. Professional titles, specializations, and qualifications vary similarly. Consequently, there are many different professional organizations each with their own specific professional profile and other professional frameworks. Recently steps have been made towards less fragmentation: A code of conduct for nurses, endorsed by all Dutch nursing associations, has been published in January 2015 (CGMV et al., 2015).

Finally, *social workers* in mental health care can be classified as having the lowest degree of professionalization. They are educated at universities of applied sciences in a four-year bachelor program. Specialization and further education is possible but not compulsory by following a master's in social work. Social workers are not BIG-registered. There used to be a professional organization for social workers in mental health care called Phorza founded in 2005 (Phorza, Beroepsvereniging voor sociaal-agogische professionals [Phorza], 2009). In 2011, due to insufficient members, it merged into the general professional association for social workers, the Nederlandse Vereniging voor Maatschappelijk Werk [NVMW]. The NVMW has a professional register and disciplinary system, a professional profile for social workers in general (Nederlandse Vereniging voor Maatschappelijk Werk [NVMW], 2011) and several professional codes tailored to specific types of social workers (e.g. working with youth or with mental health patients). The register and disciplinary code are, however, initiatives taken by the NVMW itself and not legally prescribed. In 2009 Phorza drew up a specific professional code for social workers in mental health care (Phorza, 2009) which was adopted by the NVMW and is still applicable.

³ Register Beroepen in de Gezondheidszorg: the BIG-register administers the registration of health care professionals in the Netherlands on behalf of the Ministry of Health, Welfare and Sport.

Methodology

As mentioned above, the objects of our study are professional frameworks for psychiatrists, psychologists, (mental health) nurses and social workers, in which guidelines on the patient-professional relationship are a central theme. The selected documents for our study are professional frameworks drafted and published by the various professional associations, which ensures their authenticity, credibility and representativeness (Scott, 1990; Platt, 1981a). For each profession, the most recent versions of two basic professional frameworks were selected: the professional profile and the code of conduct. This choice was made because these are generally the most determining and important documents used as a basis for professional practice, education and disciplinary procedures. According to Payne and Payne (2004) documents like these can be seen as concrete objects which indirectly mirror the social world of their composers. Therefore they can be considered an indirect but reliable display of applicable values and norms of each profession (although they do not mirror professional practices in their daily reality). From this perspective analyzing these documents can be seen as a valid method contributing to answering our research question. Some adjustments in our selection had to be made:

- There is no code of conduct specifically for health care psychologists; the code of conduct for psychologists, in general, is equally applicable to health care psychologists.
- A specific profile for health care psychologists was not found. Instead, we analyzed a document presenting required competencies for the profession.
- For nurses, we chose to focus on the frameworks developed by the Dutch nursing association that is most influential as to the contents of the profession, Verpleegkundigen en Verzorgenden Nederland [V&VN].
- Since there is no separate profile for social workers in mental health care, we used the general profile for social workers as drafted by the NVMW.
- The analyzed documents are presented in Table 1 as shown below.

Table 1
Selection of formal professional frameworks used in this study

Profession	Type of document
<i>Psychiatrists</i>	Professional profile for psychiatrists (Nederlandse Vereniging voor Psychiatrie [NVvP], 2005)
	Professional code of conduct for psychiatrists (NVvP, 2010)
<i>Psychologists</i>	Professional profile for clinical psychologists (Werkgroep Klinisch psycholoog/klinisch neuropsycholoog, 2013)
	Competence profile for health care psychologists (Werkgroep Modernisering opleiding GZ-psycholoog, 2012)
	Professional code of conduct for psychologists (Nederlands Instituut van Psychologen [NIP], 2015)
<i>Mental health nurses</i>	Professional profile for nurses (Verpleegkundigen & Verzorgenden Nederland [V&VN], 2012a)
	Professional profile for nurses specialized in mental health (V&VN, 2012b)
	New code of conduct for nurses and carers (CGMV et al., 2015)
<i>Social workers</i>	Professional profile for the overall professional group of social workers (NVMW, 2011)
	Professional code of conduct for social workers in mental health (Phorza, 2009)

We conducted a qualitative content analysis using a directed approach (Hsieh & Shannon, 2005). The documents were analyzed by extensively reading the full text, using selective coding based on our theoretical framework.

First, we searched for phrases explicitly referring to patient participation as a significant development in mental health care or to the changing attitude of patients (“the self-assertive patient”). As professional frameworks mainly focus on individual professional practice, most references relate to the micro level of patient participation, although we also searched for references to participation on meso and macro level.

Next, the frameworks were analyzed for their references to a set of sensitizing concepts linked to our hypothesis. During this process, an open eye was kept for emerging concepts that were not identified up front. The first concept was *patient autonomy*⁴, operationalized by searching in the documents for these exact words and terms and sentences related to this concept such as “self-determination,” “patient rights” or “(in)dependency of the patient.” Following that, references to *professional autonomy* were found by screening the documents for these words and terms and sentences related to professionalism, like “responsibility of the professional” or “professional attitude.” This way, we determined how professions envision possible tensions between patient participation/patient autonomy on the one hand and professional responsibility/professional autonomy on the other.

Finally, we focused on statements considering *patient influence on decisions* about treatment and care, as well as the balance between the application of professional guidelines and the input of patients. For example, “involving patient actively in the composing treatment plan” or “informing patients sufficiently to be able to give consent.” By doing this, we obtained a picture of the extent to which the frameworks stimulate or leave room for patient involvement. Delineations of the different aspects of the professional-patient relationship were also traced.

This approach ensured that possible tensions as described above were made visible. A disadvantage may be the researcher’s possible bias limiting reliability; it may be a matter of interpretation whether a certain word or phrase is indeed referring to the selected concepts. We strived to avoid this pitfall by adding citations to provide evidence for our findings (Platt, 1981b).

Results

In Table 2 we present an overview of our findings. Besides our initial concepts of *patient autonomy*, *professional autonomy* and *patient influence on decisions*, a set of other concepts is included. *Professional responsibility* turned out to be a key concept in all professional frameworks. All profiles describe and prescribe the *relationship* between patient and a professional and pay attention to the *power balance* and the patient’s dependent position. Despite these similarities the specific terms and sentences used in the frameworks to describe these issues show interesting differences.

⁴ In several documents, e.g. the frameworks of social workers, the usual term is “client” instead of “patient.” For reasons of consistency and readability, we here use “patient” as in the rest of the article, except in quotations.

Table 2
 Characteristics of four professions regarding the concepts of analysis

	References to patient participation as development in health care	Patient autonomy and self-determination	Professional autonomy	Professional responsibility	Patient-professional relationship	Patient influence on treatment decisions	Power balance in patient-professional
<i>Psychiatrists</i>	No	Patient autonomy is starting point. Several references. Can be limited due to patient's illness	Outweighs other (e.g. organizational) norms or demands, because of the primacy of the patient-professional relationship.	A highly important theme, considered of even higher importance if patient's illness limits his autonomy.	Central theme: described extensively and in detail. Explicitly connected with professional responsibility.	Informed consent regarding the decision on treatment. Limited patient influence on the content of treatment.	An explicit and repeated point of attention; professional should be aware of patient's dependent position.
<i>Psychologists</i>	No	One of the four basic principles in the code of conduct. Scarce references. Can be limited due to conflicting professional responsibilities or patient's illness.	Referred to as "characteristic for the profession."	Central theme: One of the four basic principles in the code of conduct and referred to as "the basic principle" for the profession. Frequent references in the text.	Explicit references frequent in the code of conduct ("professional relationship"), scarce or implicit in other documents.	Informed consent regarding start or termination of treatment. Limited patient influence on the content of treatment.	Patient's dependent position is mentioned as point of attention in preamble code of conduct.
<i>Mental health nurses</i>	Explicitly described in the professional profile. Positive and negative aspects are mentioned.	The important principle, to be enhanced by the professional "if possible." Several references. Can be restricted by patient's limited capacities, or other professional responsibilities.	Scarce references, "professional responsibility" is predominant as a concept.	Central theme: Described extensively and in detail. Explicitly connected with patient-professional partnership.	Professional works in partnership with the patient.	Patient involved in conducting plan, shared decision making if possible. Patient's perspective is important in decisions.	Several references to equivalence between patient and professional. Patient's dependent position is mentioned once.
<i>Mental health social workers</i>	Shortly described in professional profile. Negative consequences for "vulnerable" patients are mentioned.	Central theme: Starting point and goal of the profession is to enhance patient autonomy and self-determination.	Is referred to in negative sense: "Professional autonomy is not always fulfilled."	Scarce explicit references. Professional responsibility is regarding patient and society.	Cooperative and dialogic relationship between patient and professional is central.	Patient and professional have to agree on goals and content of relationship and treatment.	Equivalence between patient and professional is central. Professional dominance or paternalism is sometimes justified.

A first and marked difference comes forward regarding references to “the assertive patient” or the changing role of patients in (mental) health care. The professional frameworks of psychiatrists and psychologists do not refer to the increasing participation of patients in health care whereas the profiles for nurses and social workers do pay explicit attention to this development. This attention is focused on patient participation at the micro level, the relationship between individual patient and professional. Patient participation at meso or macro level is not discussed at all.

We describe our further findings per profession in order to give a clear picture of each professional group.

Psychiatrists

The professional profile for psychiatrists is elaborate on the patient-professional relationship. It discusses in detail the nature of this relationship, dissecting it in three layers: a contract (the patient as a customer), a counseling relationship (the patient as a client), and a relationship focused on the illness (where the word patient fits) (NVvP, 2005, pp. 12-13). It is concluded that the word patient is to be preferred, giving most weight to this aspect of the relationship: “the relationship between patient and psychiatrist is the starting point of the psychiatric treatment” (NVvP, 2010).

Considerable attention is paid to the dependency of the patient and the fact that patients can suffer reduced ability to make judgments:

Here it is relevant to state that illness in itself can limit the freedom of the patient in his relationship with the doctor.... This aspect puts extra pressure on the doctor’s responsibility. First, it implies that duties stemming from the treatment contract and the counseling relationship become even more pressing. Second, it can mean that the doctor sometimes has to act without the patient being able to explicitly voice his will. (NVvP, 2005, p. 13)

The code of conduct initially states that “respect for the autonomy of the patient” should be a guiding principle for psychiatrists. However, this is immediately followed by a comment pointing out that in many cases patients have limited autonomy due to their psychiatric condition. This tension is a recurring issue. It leads to dilemmas of conflicting duties: The psychiatrist should inform the patient about his condition and the proposed treatment, thereby paying attention to the patient’s autonomy. However, psychiatrists should also fulfill their duty to cure patients or reduce their suffering, and this might entail measures or activities which are undertaken without the patient’s consent. However, even in cases of limited patient autonomy, this should still be a guiding principle that psychiatrists should respect.

A power disbalance in the patient-professional relationship comes forward. In effect, it is the psychiatrist who assesses the degree of patient autonomy. The professional frameworks reflect on the complicated aspects of control and power brought into the relationship:

Because ... the patient’s own input can be diminished, simultaneously increasing the doctor’s power, the word “patient” is sometimes associated with this kind of power difference as an unwanted aspect of the doctor-patient relationship. However, it is often misunderstood that circumstances following from illness, even more, oblige the doctor to fulfill his duties. (NVvP, 2005, p. 13)

Here the power disbalance is connected directly with enlarged professional responsibility, a principle that is strongly emphasized in the frameworks, much more than professional autonomy. Both principles are connected by stating that the special responsibility of the psychiatrist for the patient should be secured in professional autonomy, which implies that “the physician lets his method of operation and its quality be determined by professional norms as applicable within his profession” (NVvP,

2005, p. 13).

Patient autonomy may be a guiding principle for psychiatrists, but this is not unequivocally translated into clear statements about involving the patient in decisions. Psychiatrists can only start the treatment if the patient, being informed sufficiently, has given consent, as regulated by law (NVvP, 2010, p. 7). However, the code of conduct and the profile do not prescribe to involve the patient actively in the process of drawing up a treatment plan. Overall the patient's role in decision-making is rather confined. The code states: "The psychiatrist informs the patient ... about the care that the psychiatrist proposes" (NVvP, 2010, p. 7).

This, in fact, shows the psychiatrists stronger influence in decision making: The professional drafts a plan and presents it to the patient, which leaves the patient a "following" position instead of a position of conducting the plan of care together. Involving the patient in the process of drawing up a treatment plan is mentioned only once in the profile when more treatment options are available the psychiatrist should not rely exclusively on professional expertise, but also on the patient's preferences (NVvP, 2005, p. 26). Strikingly, the profile recommends the involvement of the patient's family: "If possible, the patient's environment, with his consent, is involved in the process of drawing and executing the treatment plan" (NVvP, 2005, p. 18).

Psychologists

In the professional frameworks of psychologists, the emphasis is clearly on professional responsibility and professional autonomy. The foreword to the code of conduct states that 'the basic principle of responsibility is the general starting point' and that "professional autonomy and making independent decisions" are characteristic for the psychological profession. References to patient autonomy and self-determination are scarce and if they are made they are sometimes attenuated:

[Psychologists] respect and improve his (the client's) self-determination and autonomy, as far as this is compatible with other professional obligations of the psychologist and with the law. (NIP, 2015, p. 12)

The code of conduct shows one other reference to patient autonomy and one article that specifically prescribes to recognize "the patient's knowledge, insights, and experience."

References to professional responsibility, on the other hand, are abundant. There are many detailed descriptions of psychologists' responsibility regarding several elements of their work: informing the client, saving client records, cooperating with other professionals, and many more. Indeed, professional responsibility is the central theme for the profession of psychologists.

It should be noted that the code of conduct is drafted for psychologists in general and not specifically for psychologists in (mental) health care. However, looking at professional frameworks that are tailored to health care psychologists there is hardly more attention for patient autonomy. In the professional profile for clinical psychologists, this concept is not mentioned in any way. The formal text of the document is alternated with interviews with psychologists and only in a few sections some references to patient autonomy are found. The same goes for the competence profile for health care psychologists. The document focuses on the psychologist's tasks and responsibilities and the competencies and attitude required to accomplish them.

The psychologists' code of conduct includes several sections on informing and consulting the client, in particular with regard to entering or terminating the relationship. Seen from this perspective, the patient-professional relationship is an important theme. There is, however, no extensive description of the nature and aspects of this relationship, as in psychiatrists' frameworks.

Influence of patients is clear when it comes to entering or terminating the relationship: here the patient's consent is explicitly required. In addition, there is a clause on the informed consent of the patient concerning the psychologists' actions. Nevertheless, patient's influence on the precise content of treatments is limited:

The psychologist offers the opportunity to the client to discuss his wishes and opinions considering the content of the professional relationship unless this hinders a good progression of the professional relationship. (NIP, 2015, p. 18)

The profile for clinical psychologists contains two sentences referring to input from the client. The most far-reaching is: "[the psychologist] determines the plan of treatment in consultation with the patient" (Werkgroep Klinisch Psycholoog/klinisch neuropsycholoog, 2013, p. 18)

In the other reference, it is stated that the psychologist "evaluates the plan of treatment with the patient and adjusts it if necessary." Other references to patient influence are only found in the interviews that are included in the document. Just once the competence profile for health care psychologists mentions that the psychologist should ensure that there is shared decision making, but this is not elaborated or explicitly translated to competencies, or recurring in assessments.

The power disbalance between patient and professional is not a frequently mentioned issue. The code shows a separate article stating that patient self-determination can be limited because of (among other things) his mental condition. Moreover, in the preamble the patient's dependent position is mentioned: "In professional practice, many relationships are unequal by nature and therefore can easily lead to dependence of the persons involved" (NIP, 2015, p. 8).

Nurses

In the professional profiles for nurses (V&VN, 2012a; V&VN, 2012b) the patient's perspective and self-direction are presented as the guiding principles for nursing practice. However, patient self-direction is often attenuated by adding words like "if possible": "The nurse supports the patient in maintaining or regaining control over his own life, as far as possible" (V&VN, 2012a, p. 8).

The code of conduct for nurses (CGMV, 2015) shows the same attenuation: "This means I know ... the patient has the right not to contract the care relationship or to end it, and I respect that decision, as far as this is responsible" (CGMV, 2015, p. 9). Nuances like "as far as possible" imply ambiguity; patient autonomy is in fact placed *within* the professional norms and frameworks and thus subordinated to professional autonomy.

Furthermore, the attention for patient autonomy and self-determination is nearly always connected with the dominant issue of professional responsibility. Much more than patient autonomy, professional responsibility is the central theme in the professional frameworks for nurses. This resounds in several sections and phrases, for example:

The nurse has a professional responsibility in the execution of her profession...
Taking responsibility for nursing care means being open to the needs and experienced problems of the patient, and examine together what in his or her case is "good care." (V&VN, 2012a, p. 20)

In line with this, an expanded definition of "professional responsibility" is presented, consisting of three elements: functional (referring to the organizational role), professional (referring to the profession), and personal (referring to the individual) responsibility. Professional autonomy is scarcely mentioned and if so, it is in the context of nurses' position in health care organizations: "nurses have professional autonomy

and responsibility in connection with the organization” (V&VN, 2012a, p. 30).

Contrary to psychologists, nurses’ professional responsibility is linked explicitly to the nature of the patient-professional relationship. Nurses are supposed to function as partners of their patients; several sections of the profile describe how this relationship should take shape (V&VN, 2012a). Core element here is the nurse’s role to support the patient in (re)gaining autonomy and strengthening self-management.

The commitment to partnership and the principle to work “in partnership with patients and others” imply equality in the relationship with patients. A possible power disbalance is addressed only once, in the code of conduct: it is stated that respecting professional boundaries means that the nurse should not abuse the patient’s dependent position (CGMV et. al., 2015, p. 9).

As to active patient involvement in decisions on treatment, the code of conduct (CGMV et. al., 2015, p. 10) clearly states that the professional should co-operate with the patient, implying that the nurse conducts, executes and evaluates the nursing or care plan together with the patient. The nurse is obliged to give understandable information and to inform the patient about his or her rights. Comparable statements are found in the professional profiles. On the other hand, these principles about patient involvement again are weakened by regularly adding sentences like “if the patient is willing and able.”

Social workers

The professional profile of social workers emphasizes patient autonomy as central to the profession. Indeed the *goal* of the profession is “to stimulate participation, autonomy and the ability to manage oneself” (NVMW, 2011, p. 10). Patient autonomy is a main theme in the document, and the incorporation of this principle comes to the fore:

Autonomy is an important value in people’s lives, especially in health care, where people become dependent on professionals, due to problems in their ability to manage for themselves. The social worker will never let this dependency diminish the client’s own responsibility. (Phorza, 2009, p. 11)

It is considered an important responsibility for the practitioner to guard this value of patient autonomy since in care relationships there is an inherent dependency of the patient (Phorza, 2009, p. 11). Here professional responsibility and the issue of power disbalance come forth.

The frameworks show some ambiguity on the latter issue. On the one hand aversion of the professional to paternalism is seen as connected to the core value of patient autonomy (NVMW, 2011, p. 18). On the other hand, it is observed that “In recent years, there is a quest for ‘well-considered paternalism’ for people who have lost control over their life” (NVMW, 2011, p. 18).

However, the issue of power (dis)balance gets much less emphasis here than in the psychiatrists’ frameworks. Power and dependency are mentioned, but only briefly, and in terms of restriction of the professional, who should refrain from abuse of power towards the patient (Phorza, 2009, p. 12). References to this possible tension in executing the profession of the social worker are followed by statements that even in the case of limited patient autonomy the professional should keep striving to restore and enhance it.

Compared to the other professions, the frameworks of social workers put much less emphasis to professional autonomy and responsibility. References to both principles are scarce. Professional autonomy is noted to be “not always fulfilled” (NVMW, 2011, p. 28), but this remark is not further explained. Professional responsibility is mainly implicit and is not just related to the individual patient, but also to society as a whole. Improving patient autonomy can imply interventions directed at

the individual, but also directed at societal circumstances.

Overall there is a strong emphasis on cooperation, reciprocity, and equality in the patient-professional relationship. This comes forward in prescriptions about patient involvement. The professional code states that patients are supposed to consent to the plan for treatment or service (Phorza, 2009, p. 11). Patients have to be informed by the professional and can refuse the offered service. Additionally, patients are potentially given a contributive role in the drafting of the plan: “As a social worker I consult with my client when composing a treatment, service or activity plan, and ask for consent” (Phorza, 2009, p. 11).

To achieve this it is required that professional and patient agree about the definition of the patient’s problem(s) and the goals pursued (NVMW, 2011, pp. 13, 15, 18). The profile prescribes that social workers should use their knowledge, but also the experience, knowledge, and strengths of the patient. It even states: “In turn, the client is not just a ‘receiver’ of service but a co-producer” (NVMW, 2011, p. 29).

Discussion and conclusion

In Table 3, the essential guiding principles per profession are presented as we see them come forward from our analysis.

Table 3
Central starting point for professional practice

Profession	Central starting point
<i>Psychiatrists</i>	The relationship between patient and professional prevails over all other relationships
<i>Psychologists</i>	Professional responsibility is the basic principle for professional practice
<i>Mental health nurses</i>	Professional responsibility and partnership with the patient are central
<i>Mental health social workers</i>	Patient autonomy and equivalence between patient and professional are central

We expected highly professionalized mental health professions to leave less room for patient participation and to adhere more strongly to professional autonomy than less professionalized ones. This assumption turns out to be partly true. The studied professions indeed differ in the way their professional frameworks pay attention to this issue in the emphasis they put on professional autonomy or patient self-determination and in the degree they explicitly prescribe or promote active patient involvement, but this can only partly be linked to their degree of professionalization.

Social workers, being the least professionalized group, are clearly most far-reaching in allowing patient involvement in decisions about treatment and care. This supports our hypothesis.

Looking at nurses, being next in line regarding the degree of professionalization, our argument still holds. Being more professionalized than social workers, nurses give more weight to their professional responsibility and autonomy, but their openness to patient participation is still considerable, because of the character of the patient-professional relationship (“partners”) and because of the emphasis on patient influence in decision making.

The picture gets ambiguous when we turn to psychologists and psychiatrists. Both professions are highly professionalized, and psychiatrists the most so.

Nevertheless, psychologists put more emphasis on professional autonomy and responsibility than psychiatrists who take ample space to accommodate patient's preferences and autonomy. For psychologists, as for nurses, professional responsibility is the central theme in their professional frameworks, but they do not connect this extensively to the patient-professional relationship (as do nurses). Furthermore, substantial patient involvement in decision making is restricted in the frameworks of both psychologists and psychiatrists. In the latter, the patient-professional relationship trumps all other principles, thus putting more focus and giving more attention to the role and position of the patient than a psychologist.

Explanations for these differences between professions may be found in their different goals and orientations: Psychiatrists strive to cure their patients or lessen their suffering, psychologists are more broadly oriented and can also be assigned to diagnose, test or give advice. Nurses strive to support people in improving their health and prevent illness, while social workers strive to empower their patients.

The remarkable difference between psychologists and psychiatrists may also be related to a struggle over professional domains. Illustrative in this respect is a phrase in the competence profile for psychologists which explicitly refers to "the emancipation of the health care psychologist" (Werkgroep Modernisering GZ-psycholoog, 2012, p. 8).

Our study focuses on a Dutch context; this might limit the value of our findings for other more international contexts. However, since both changes in professionalism and patient participation are not specifically Dutch developments, as our theoretical frame points out, some insights offered here might also have some relevance for mental health care in other Western countries.

Finally, these conclusions about the different professions and their openness to patient participation are only based on document analysis. Professional frameworks, on the one hand, represent professional norms and orientations in a compact way, which makes studying them worthwhile. On the other hand, professional daily practice is not done "by the book." So empirical research is required to complete insights on responses of mental health care professionals to patient participation.

The fact remains that in mental health care practice all four professional groups can be involved with the same patients. This implies that people with mental health problems, receiving treatment and care, might be confronted with a variety of professionals that act from considerably different perspectives on patient autonomy and participation. Ignoring these differences may complicate or impede the further implementation and development of patient participation in mental health care.

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Barbara Fersch

Welfare Service Professionals, Migrants, and the Question of Trust. A Danish Case

Abstract: The aim of this article is to analyze migrants' interpretations of their encounters with welfare service professionals in Denmark, focusing on client trust and exploring its diversity across professions. It is based on qualitative interviews with migrants. Migrants as newcomers to the welfare state constitute an interesting case that might allow specific insights into how and in what ways trust and distrust emerge. Aspects such as procedural justice, professional morality, and personal feelings have emerged from the explorative analysis as important trust-generating features of encounters. Trust in the welfare state appears to be useful for "overriding" negative experiences with individual professionals and in other cases of distrust, and migration specific exit practices have been observed. Finally, some migrants do indeed seem to apply experiences of trust with welfare service professionals to the Danish state or even society, and thus the professionals involved can be called hidden "integrative" resources.

Keywords: Professional-citizen relationship, migrants, client trust, welfare state, qualitative

In various ways, welfare service professionals can be viewed as the connective tie between a welfare state and its citizens (e.g., Lipsky, 1971; Giddens, 1990). In his early contributions, Lipsky emphasized the importance of welfare state professionals (or, in his words "street-level bureaucrats") to the relationship between individual citizens and the state: "these 'street-level bureaucrats,' as I call them, represent American government to its citizens. They are the people citizens encounter when they seek help from or are controlled by, the American political system" (Lipsky, 1971, p. 392).

On a more abstract level, Giddens (1990) has termed welfare state professionals the "access points" to abstract systems. They are, according to Giddens, an important connection point between the system and the individual, and are crucial for the establishment of institutional trust in the system, in this case, the welfare state. In sociological theories of professions and professionalism trust is described as a characteristic of the professional—citizen relationship and is identified as an important precondition for the work of professionals in general (Di Luzio, 2006). Here, trust refers to the "risky investment" (Luhmann, 1979, p. 27) made by citizens when they engage in asymmetrical relationships with professionals. This so-called functionally specific trust (Endreß, 2012), also known as "client trust," bridges the gap between a citizen's need for help and incomplete knowledge on the one hand and the uncontrollable nature of professional work on the other. Without client trust, the (successful) work of service professionals would be almost impossible (Hirvonen, 2014; Di Luzio, 2006).

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Kumlin and Rothstein (2010) emphasize the role of welfare service professionals in the development of generalized social trust in Swedish society and argue that this is especially true of migrants who, as newcomers, might especially apply their experience with the face of the (welfare) state to society as a whole.

Migrants do indeed constitute a very interesting case when it comes to the question of client trust. As they arrive from another society and start living in the new country, they are, at least in a service-heavy welfare state such as Denmark, confronted with meetings with service professionals. In this article, I focus on an explorative analysis of the features of encounters with professionals as described and interpreted by interviewees in the context of trust and distrust, and explore the differences and similarities between the different professional fields and their roles in building trust.

The focus on migrants as newcomers to the welfare state enables us to study the individual interpretations of and the meanings extracted from these meetings in a distinct way, as it opens up for reflection that would otherwise be hindered by tacit knowledge (Legido-Quigley, McKee, & Green, 2014). It can be argued that this particular empirical case, that is, migrants in Denmark, is particularly likely to exhibit trust-building processes. Usually classified as belonging to the Scandinavian or Social-Democratic welfare state model, the Danish welfare state is characterized by high levels of social protection, universalism, and predominantly tax-financed welfare state arrangements (Esping-Andersen, 1990). Despite retrenchments and marketization in recent decades, a large part of the social services are still in the hands of the public sector. Usually, therefore, it is the “front-line” welfare professionals who “bring” these services to the citizens. Additionally, Denmark tends to score highly in quantitative measures for both generalized social trust and institutional trust (Larsen, 2013), also among migrants (Dinesen & Hooghe, 2010), and its welfare state institutions appear to be more trusted than those of other countries (Fersch, 2012). It could also be contended, however, that the opposite dynamic, that is, that experiences of exclusion due to immigration and integration policies, which potentially foster distrust rather than trust, could be expected in the case of migrants—especially in Denmark, due to its ever-stricter immigration policies (e.g., Mouritsen & Olsen, 2013) and duty-oriented integration policies (e.g., Breidahl, 2012). However, encounters of this kind did not play a role in the interview material. The empirical materials analyzed in this article are qualitative interviews with migrants in Denmark on their experiences, perceptions, and practices concerning the welfare state institutions in their host country.

First, I will introduce theoretical perspectives and empirical insights on the topic of client trust and the role of citizens’ encounters with welfare state professionals; second, I will present and discuss the methods used; and third, I will present and discuss the empirical material. Finally, conclusions and further perspectives will be presented.

Theoretical background and the state of research

In sociological theories of professions and professionalism, trust is described as an important ingredient of the professional—citizen relationship and has been identified as an important precondition for the work of professionals in general (Di Luzio, 2006). There is a broad consensus that this is a form of impersonal trust (although there may be borderline cases, such as that of a long-term general practitioner). Di Luzio states (2006, p. 554): “The object of trust is not the practitioner as such—it is rather institutions that provide the main basis and justification for client trust.”

Thus, in this tradition, trust between the client and the professional is seen as possible because it is embedded systemically, that is, the client can trust the professional because there is a reliance on a system of autonomous control. This system of

professional control ensures the professional's orientation towards public welfare (Parsons, 1939) and the validity of his expert knowledge (Giddens, 1990). In a classical profession, such as medicine, this is based on scientific knowledge, which is certified and regulated, mainly by the profession itself (using regulations that are ultimately embedded in state regulations). In the view of, among others, Abbot (1988), the classical professions are constituted of an entanglement of knowledge and power, and this entanglement grants a form of authority.

In his account on trust and medical professions, Grimen (2009) emphasizes the importance of the power aspect and its consequences for trust. The power asymmetry between the professional and the client is caused by the expert's knowledge, professional autonomy, and discretion. Welfare service professionals, including medical ones, often serve as gatekeepers to services, which gives them considerable power vis-à-vis the citizen. Thus, sometimes the exit options and the alternatives to trusting are very limited or very extreme (especially when it comes to the health sector). It can even be questioned whether, in these cases, we can speak of trust after all.

In their theoretical deliberations on trust, both Luhmann (1979) and Giddens (1990) mention the connection between client trust and institutional or system trust. Luhmann states that in trusting the professional one trusts something abstract in a generalized, yet diffuse way. This stems from a form of trust in a diffuse system, Luhmann argues, which basically relies on the inherent controls installed in the system. In the case of welfare service professionals, we can establish that the welfare state is in charge of some of these control mechanisms (Luhmann, 1979). Giddens (1990) particularly emphasizes the role of professionals as access points to the system. He argues that encounters with these "face workers" of the system are of crucial importance for trust: "They are places of vulnerability for abstract systems, but also junctions at which trust can be maintained or built up" (Giddens, 1990, p. 88).

Research in the field of the medical professions tends to back up this claim—in this strand of research the role of the professional in the meeting with the citizen is emphasized in terms of both client trust and the emergence of institutional or system trust in health care institutions in particular (Brown, 2009; Legido-Quigley et al., 2014).

Having provided a general introduction to client trust, I want to introduce the substantive features of this relationship in order to provide an adequate framework for the analysis. What characterizes trust-boosting encounters between professionals and citizens? Which micro-processes enable trust or lead to distrust? First I will present some specific aspects of functionally specific client trust in the public sector and in professionals, and then I will present some more general theories on the function of trust on the micro-level.

Several authors (e.g., Kumlin & Rothstein, 2005; Van Ryzin, 2011) have emphasized the role of procedural justice as a substantive feature of the working practice of welfare service professionals that contributes to being considered trustworthy. In the context of trust in civil servants, Van Ryzin lists the following characteristics of encounters between civil servants and citizens as playing a role in the perceived trustworthiness of the civil servant:

- fairness (including a lack of bias or favoritism);
 - equity (in the sense of distributing public benefits evenly or according to true needs);
 - respect (including courtesy and responsiveness to citizens);
 - honesty (in the sense of an open, truthful process and a lack of corruption).
- (Van Ryzin, 2011, p. 747)

In his study, Van Ryzin finds that these characteristics play a role in the trust placed by citizens in civil servants and the civil service in general (Van Ryzin, 2011).

Hardin (2002) presents another, related argument. He emphasizes the importance

of the concept of trustworthiness. Among other things, he identifies competence and the moral disposition of the trustee as possible causes of trustworthiness. This is very much in line with the ideas of the aforementioned sociological classics on the foundations of client trust, Parsons and Giddens. In the context of this paper, the interesting point is whether the professional in the encounter is viewed as being competent, as behaving morally, or both, and how this is interpreted by the interviewee. Taking the considerations about procedural justice into account, we can also discuss whether the trustworthiness of professionals is based on perceived moral behavior by the professionals in question or perceived procedural justice.

As mentioned above, the findings of studies in the field of medical sociology strongly emphasize the importance of encounters with medical professionals for the development of trust, both in professionals and in the health care system in general. Concerning the question of the specific aspects of these encounters, in their study on trust in the Spanish health care system by British pensioners living in Spain, Legido-Quigley et al. (2014, p. 1254-1255) write that trust is “fostered through interpersonal elements such as the communication of reciprocity, respect, and (often embodied) empathy.” More importantly, the authors add that it “has to be earned by clinicians, and earned primarily through the skilled performance of interrelational skills rather than clinical competence.”

This also seems to be confirmed by Brown’s findings among gynaecology patients in the UK, which he illustrates with the following example:

[O]ne consultant, who (as verified by the researcher) drew diagrams for patients purely because he preferred his own depictions to those available in published materials, was referred to by several patients as trustworthy due to the apparent care and effort he went to in these illustrations. (Brown, 2009, p. 403)

Concerning the nature of the encounters upon which the decision to trust or distrust a professional is made, Zinn’s (2008) thoughts on the intersections of trust, intuition and emotions appear relevant. The author emphasizes that trust is something that is built in between rationality and irrationality, and states: “[...] the key characteristic of trust is not its combination of rationality and belief but rather its use of pre-rational knowledge and intuition placing trust in between rationality and non-rationality, neither fully rational nor irrational” (Zinn, 2008, p. 446).

According to Zinn, this gives rather intangible characteristics, such as feelings and emotions, a role in the development of trust. He argues that

[T]rust, intuition, and heuristics are indeterminate judgments as they are embedded in specific social relations. They are influenced by thought and reflection, but also draw on feelings and personal preference or taste. The underpinning logic is not one of cause and effect but one of analogy, a situation or event is like a previously-experienced situation. (Zinn, 2008, p. 446)

To sum up, concerning the substantive aspects of encounters between professionals and citizens, several issues emerge in the literature. One emphasizes the elements of procedural justice that can be operationalized, for example, as in the list by Van Ryzin (2011) above, while others instead emphasize the perceived moral dispositions of the trustees as an important precondition for trust. Research in medical sociology points to the importance of interpersonal and communicative characteristics that show care. Last but not least, feelings are named as an important element. In the analysis, both general assumptions about client trust (as presented in the first part of this section) as well as assumptions about the substantive features of encounters (as presented in the second part of this section) are taken up and discussed. Thus, the following analysis aims to contribute to the exploration of client trust in the context of public welfare professionals.

Research design and methods

This article is based on the empirical material consisting of 14 guided interviews with migrants in Denmark. Qualitative methods are especially suitable for analyses of how people make sense of experiences because they allow for the differentiated and open inclusion of topics and individual background information in both data collection and analysis. Concerning the criteria for choosing interviewees, the logic of “maximizing differences” (Glaser & Strauss, 1999) was applied. Thus, migrants with quite different backgrounds (from Western and non-Western countries, with different educational backgrounds, male and female, refugees and expatriates, etc.) were interviewed. Following Glaser and Strauss’s concept, the idea was that if commonalities among very different migrants could be found, the differences in the background would strengthen the argumentation that these commonalities are connected to the setting and experiences in the host country. As the focus of the project was on experiences with social policy and the welfare state, one important criterion for choosing interviewees was that they had actually had enough time to have such experiences, as well as having access them (i.e. they needed to be entitled to social rights). Thus we chose relatively settled migrants, and all of them had been resident in Denmark for at least 4.5 years (see Table 1).

The interview guides were generally constructed as open and explorative—using open questions with the aim to create narratives on meanings, interpretations, and practices concerning the encounters with the welfare state and front-line professionals. The structure of the interview guides was designed to follow the experiences of the interviewees. After some general, open questions about their experiences with the Danish welfare state, the interviewees were asked which specific parts, institutions and professionals they had encountered. This was followed by open questions that aimed to stimulate a free narrative about their respective encounters and experiences. Direct questions about the research topics such as trust were only included at the very end of the interview. The aim was to generate empirical material suitable for qualitative analysis about the characteristics of encounters with the welfare state and its professionals. This meant that topics such trust were frequently brought up by the interviewees themselves. The downside, however, was that a wide range of interview material was created that included several parts of the welfare state, and thus encompassed professionals who differ profoundly in their roles (see Appendix 1 for a full interview guide).

Table 1 provides an overview of the interviewees and their socio-demographic characteristic

Table 1
Interviewees' sociodemographic characteristics

<i>Name</i>	<i>Country of origin</i>	<i>Age</i>	<i>Gender</i>	<i>Duration of residence in Denmark (years)</i>	<i>Children</i>	<i>Occupation, activity, source of income</i>
Yuki	Japan	41	F	13	1	Part-time job, supplementary unemployment benefit
Ajda	Iran (Kurd)	43	F	14	0	Student
Gulda	Iran (Kurd)	40	F	13	3	Social assistance
Stavros	Greece	36	M	4.5	0	Part-time job, supplementary unemployment benefit
Stefania	Italy	36	F	7	1 (+2)	Engineer, full-time employment
Marta	Brazil	39	F	6	1 (+2)	Student
Oksana	Ukraine	36	F	7	1	Ph.D. fellow, full-time employment
Dana	Former Yugoslav Republic of Macedonia	39	F	13.5	2	Associate professor, full-time employment
Sandor	Hungary	25	M	4.5	0	Unemployment benefit
Yin	China	42	F	14	1	Student
Laima	Lithuania	32	F	11	2	Student
Vanida	Thailand	30	F	5–6	1	Student
Antone	Italy	37	M	13	2	Engineer, full-time employment
Imre	Hungary	46	M	5	3	Social assistance

The interviews were coded thematically in Nvivo and the analysis was guided by a hermeneutical understanding (Gadamer, 1989) of each interview as a separate case. The coding process included both open, in-vivo codes, and codes that were generated beforehand by the research questions. The following Table 2 contains a list of codes.

Table 2
Coding List

<i>No.</i>	<i>Level 1</i>	<i>Level 2</i>
1	Assimilation process	
2	View of Danish welfare state - general	
3	Experiences	Experiences with welfare state (general) Experiences with welfare professionals
4	Family	Family and working life Family and elder care Norms Motherhood norms
5	Welfare state legitimacy	
6	Personal background	
7	Welfare state problems	
8	Comparison to home country	
9	Trust	Welfare state (general/system) Professionals: front-line staff

The following presentation of the analysis is thus guided by the topics that emerged during the analysis and appeared relevant to the topic of professional-citizen relationships from the perspective of trust. For instance, the issue of feelings and emotions emerged from the empirical analysis, while procedural justice was a topic that had already been identified as potentially relevant in the research literature. All of the topics could be identified in several interviews, although not every topic could be found in each of the narratives, and certain specific individual practices and interpretations were identified. These are contextualized in the specific individual narratives, as this was a crucial aspect of the analytical approach. As the research approach follows the logics of hermeneutics (Gadamer, 1989; Fersch, 2013), the findings and insights are not seen as established once and for all but are able to change in the light of new empirical knowledge or theoretical approaches. Considering the relatively limited number of interviews and the methodological perspective, the presented claims drawn from the empirical material are, of course, limited. The aim of this analysis is to reveal some (new) tendencies that can be investigated further in future research.

Analysis

The focus of this article is, as previously mentioned, the topic of client trust in the context of welfare service professionals. Due to the open structure of the interview guide, information and stories about encounters with professionals were only collected if the interviewees themselves considered them relevant, as the original research interest focused on institutional trust in general and not client trust in particular. However, the fact that many interviewees brought up encounters with professionals in this bottom-up way actually strengthens the assumption that welfare service professionals as the face of the welfare state play an important role not only concerning client trust but also concerning institutional or system trust as well (see above and Giddens, 1990).

In general, the interviewees tell rather positive stories about their encounters with

professionals, although some also report negative experiences. The focus of this section is to have a closer look at the meaning-making processes: how did the interviewees interpret their experiences and what does this mean for the development of client trust?

Procedural justice and Danish representatives

Stavros, a 36-year-old man originally from Greece, reports the most positive encounters; and, not surprisingly, he is also the one who appears to be most trusting of the Danish welfare state. Regarding his encounters with welfare professionals in the context of unemployment benefit (in Denmark, this includes encounters with both the unemployment fund and the municipal job center), he says:

All of them have been very friendly, really. They have been very gentle, and I think ... they had in their mind this stuff that they would need to be in a specific way, gentle as they were, so people do not feel uncomfortable that they would have to receive some money. I don't know; this made an impression on me.

Thus, what he describes here is very respectful treatment, which is one of the aspects of procedural fairness. He continues:

Interviewer: So would you, in general, say that people from the job center and also from the unemployment fund [A-kasse] have treated you...

Stavros: Very well, yeah in a very fair way. In a very civilized way, something more than fair.

Here it becomes even clearer that Stavros feels that procedural justice was very much in place in this encounter. His use of the word “civilized” as something more than fair appears to imply that he was not only treated fairly but also in a respectful and honest way. These are all aspects of procedural fairness that follow the operationalization of Van Ryzin. Stavros reports some similarly positive encounters with teachers from the language school, a service provided by the municipalities in Denmark:

Again, I would say the same professionalism as in the other subjects. I mean, in the sense of teachers, they are really very friendly, very nice. I mean, for example, you know what, if I would have to use someone to advertise Denmark ... that would be a teacher of mine, Jette. Really, very friendly with everyone. Jette is awesome.

In this quote, Stavros refers directly to his statements above about his encounters with the unemployment service. It is notable that he refers to this perceived behavior and fair treatment as professionalism. However, based on this quote and his narrative in general, we can also see that he views them as behaving morally. At this point, we can return to the discussion in the theory section about whether it is procedural fairness or the moral dispositions of professionals that boost trust. However, it does not appear to be possible to differentiate between them—rather it appears that fair treatment and the moral behavior of professionals go hand-in-hand. The two dynamics appear to reinforce each other.

Another interesting point is that the interviewee seems to see the welfare service professionals (in this case his teacher) as some kind of representatives of the Danish state or even Danish society. This is a point Kumlin and Rothstein (2005) make when referring to the importance of front-line welfare state professionals, who are often the first “natives” migrants interact with closely.

When asked about his experience with “face workers” in connection with his un-

employment, Sandor, a 25-year-old male originally from Hungary tells—unsolicited—a story of trust:

Well, I have a very positive experience about it. Well, it is a trust that I experience, a general trust towards people from the state. And even for a foreigner, I feel that they are positive and that they have trust in me, and that is just a great feeling, and I don't feel like a parasite. But they look at me in a way that they see a potential worker in me, so that is quite a good experience.

Again we can trace the notion, mentioned by Lipsky (1971) and Kumlin and Rothstein (2010), that welfare state professionals are representatives of the state. Here, again, it can be questioned whether we are confronted with morality or procedural justice as the basis for trustworthiness as in Stavros's example. Sandor's account of his encounter appears to describe very respectful behavior from the professionals, respect being one of Van Ryzin's criteria. However, we cannot deny that their behavior also appears to be morally right.

Switching professional fields in order to trace what procedural justice could mean in the medical sector, I now present the account of Stefania, a 36-year-old woman originally from Italy, about her experiences during her recent pregnancy:

All ... organizations during pregnancy and maternity leave ... it was also a very good experience, all the scannings. I had to do a few extra scannings at some point because the development was a bit off the normal range, and they were very supportive and explained what was happening. An extra scanning, if you think from an economical point of view, that means extra money and extra time, but the person was put in the center, the well-being, so that was again a positive experience.

It is notable here that in order to illustrate and give reasons for why she had had a good experience during pregnancy Stefania chose the experience of having extra checkups when her pregnancy did not follow the normal course. Taking into account the fact that the medical sector follows a different logic to granting services then, for instance, the unemployment benefit system, the above quote can be seen to describe an experience where procedural justice was applied within this field. In combination with some of the above-described mechanisms from the literature on medical professionals (note that the interviewee describes "them" as very supportive, possibly referring to the caring aspect of the medical profession), this might explain her very positive and trust-evoking experience.

The last account in this section again refers to the topic of professionals as representatives. Yin, a 42-year-old woman originally from China, describes how, to begin with, it was difficult for her to trust the childcare professionals who looked after her son:

But, how to say, my husband told me I should trust. Then I tried to learn to trust, which is hard for Chinese, to trust, because our country is quite bad in this part. The moral trust is really hard for us.

Here, beginning to trust the childcare professionals is described as a learning process. She brings in her Chinese background to explain why this is so hard for her:

"I need to push you, go out, I need to go first," so this kind of feeling made the people when I grew up. Often I trusted the people, but sometimes, people cheat on you, which is often right now in China. Therefore, you lose the trust feelings among the others. But in Denmark, I trust.

Thus, in an indirect way, she seems to make a link between generalized social trust and client trust in professionals—she has learned how to trust the childcare professionals, and hence she states later on, in a very general way, that in Denmark she is trusting. This is an interrelation that can be found in some of the other interviews too.

Intuitions, feelings, and a “chemical thing”

Yin also reports that she changed the childcare center her son attended after a few months, because of the childcare professionals:

He changed to a new kindergarten after seven months in the old one. Because of the ... I didn't like the old one. But this kindergarten ... I like it a lot, because of ... the staff, the harmony. I can easily feel because they have been working together for over 10 years, minimum 10 years, that they have already harmony, feelings among each other. Therefore, I could feel, the kid is very easy to go in with this harmony feelings compared with the new one. Where all the staff still requires a lot of communication, cooperation, therefore I get the ... it's not bad feelings; I was not that satisfied with that kindergarten.

Here, Yin explains how and why she took the decision based on her feelings and intuition. Some rather intangible feelings about how the professionals interacted with each other enabled her to trust one place more than the other. It should be mentioned here that these feelings are not the only basis of trust here, but appear to help her levels of trust considerably. This is also an aspect that Laima, a woman in her thirties and originally from Lithuania, emphasizes when talking about why she changed childcare places for her child:

Because sometimes it works like a chemical thing, you know, if you like a person or not.... That's why at this place there wasn't the right chemical thing.

At this point, Zinn's considerations on the role of feelings for trust are useful. It becomes quite clear in these two cases that client trust is also a phenomenon that sits between rationality and intuition, feelings and emotions. Ex-post reflections on rational explanations as to why an individual did not trust a certain professional but was inclined to trust others are not always possible, as Laima's case demonstrates, and sometimes trust appears to be very much helped by the emergence of feelings, as in the case of Yin. According to Zinn, this happens because the decision to trust sometimes strongly relies on intuition and feelings that do not follow the conventional rational logic of cause and effect.

It is not surprising that in both of the cases that relate to “chemical things” the professionals in question were working in childcare. The “right feelings” appear to play a stronger role in the caring professions than in the role of jobcentre advisers.

Bad experiences and transnational exit options

Concerning welfare state professionals, Dana, a 39-year-old woman originally from the Former Yugoslav Republic of Macedonia, recounted some bad experiences with the health sector and doctors. For example, her husband's health problems were not taken seriously by her family's general practitioner (GP) and thus went undiagnosed for a long time. It was only during a stay abroad in Spain that her husband was finally diagnosed. Disappointing experiences such as this led to the following family practice:

Most of the time our experience is that you do not get any detailed kind of examination [referring to their Danish GP], so actually we have created our own health care system: When we go home we do all the detailed checks that we want to do.

So, as she and her family do not trust their GP and thus the Danish health care system in general, they have found an alternative method to ensure that their health is checked in a way that they find adequate. Grimen (2009) has rightfully mentioned that exit options, especially concerning medical professionals, might not always be available. However, it appears that in this case being a migrant has provided Dana and her family with the chance to use certain transnational exit options. It is also clear that Dana and her family have actually researched alternative ways to get the level of assurance she needs.

As Möllering (2006) states about how trust and distrust function in general:

[T]rust is essentially not so much a choice between one course of action (trusting) and the other (distrusting), but between either accepting a given level of assurance or looking for further controls or safeguards. System trust (and also personal trust) fails or cannot even be said to exist when this state of suspending doubt is not reached. (Möllering, 2006, p. 72)

This definition can be applied to the risks and vulnerabilities handled by professionals and the welfare state. With this in mind, we can see in Dana's case a clear pattern of distrust towards the Danish health care sector, as she and her family have installed other safeguards concerning health risks. Here "distrusting" practices are in place.

The account of Oksana, a 36-year-old woman originally from Ukraine, demonstrates that "untrustworthy" encounters with professionals do not necessarily lead to the use of exit options and a general distrust of the medical sector. Oksana, like Dana, reports some bad experiences with the Danish health care sector. Like Dana's husband, it was not until she was ill and after many attempts that she was able to convince her GP to investigate a health problem she had. About medical doctors as a profession, she states:

Oksana: If the clan of doctors is given the opportunity to have an easy job, to not do anything and still have money, they would still do this. They don't have doctors in Denmark who have ... disciplinary responsibility. If they don't treat you good then a person writes a complaint and then the certain committee says "we express our critique" and that is it and nothing else.

Interviewer: So you would say that it is not functioning like it should?

Oksana: Yes.

Interviewer: Yes. So you do not trust the doctors anymore?

Oksana: No, no. I don't trust.

It is interesting to note that what she accuses the doctors of is basically immoral behavior. If according to Hardin, perceived moral behavior fosters trust, the opposite probably fosters distrust. Here, again, one finds support for Hardin's theory.

When asked if this has had an impact on her trust in the Danish welfare state—which appears to be quite high during the rest of the interview—Oksana states: "No, I see that the state is trying to solve the problem."

These different interpretations, which are at least partly based on comparable experiences, raise interesting questions about the role of client trust in professionals and its interrelations with forms of the system or institutional trust. Oksana, although apparently generalizing her experiences to cover all Danish doctors ("They don't have doctors in Denmark who have ... disciplinary responsibility") and criticizing the internal control mechanism of the profession (the appeals board), still appears to trust the other systemic control mechanisms found at higher levels, in this case at the

political level. Thus her trust in system controls appears to “override” her client distrust of a certain group of professionals, at least when it comes to the question of overall institutional trust. The case of Oksana appears to contradict other findings from the field of medical sociology. The findings of Brown (2009) and Legido-Quigley et al. (2014), for instance, strongly emphasize that personal experiences with medical professionals—almost exclusively—play a role in the emergence of institutional trust. It is possible, however, that this is due to the different perspective of their respective studies, which only looked at the intersection of client trust and trust in the health care system (and not any broader, overall system controls).

Concluding remarks

The analysis in this article was guided by the question of which substantive features in the encounter between the professional and the citizen established the professionals as trustworthy or otherwise with the interviewees. The analysis of the empirical material indicates that several aspects appear to play a role as sources of trustworthiness, namely procedural justice and the perceived morality of the professionals, with feelings acting as a possible enforcer. Further research into this subject and the relationship between the two possible sources of client trust would be fruitful. In all the interviews, accounts mentioning procedural fairness, morality, or both could be found regarding professionals related to services and the administration of social rights such as unemployment benefits or social assistance and, to a lesser extent and in a modified way, in the medical sector. Feelings as a promoter of trust, on the other hand, were mainly referred to in relation to childcare professionals. The material also brought up other insights into client trust, such as transnational exit practices in the case of distrust, and the “overriding” of client distrust by system trust.

The final aspect is a migration-specific one, namely the idea that welfare state professionals can be seen as “representatives” of the state and society of the host country, and that trustworthy experiences with front-line welfare service professionals could thus even enhance the development of generalized social trust (Kumlin & Rothstein, 2010). Indeed this was a dynamic that could be found across different professional groups. Thus enhancing client trust might even have a “hidden” integrative potential that could be relevant in the current climate.

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Appendix 1

Interview guide, English

Introductory and context questions		
	<i>Notes</i>	<i>Questions</i>
1		Can you briefly tell me something about yourself?
2		When and why did you come to Denmark (and not to another country)?
3		What is your educational background?
4		Are you married or cohabiting? With a Dane or a foreigner? What does your partner do?
TOPIC: General views on and meetings with the welfare state		
5	General views on the welfare state	What do you think of when you hear the term Danish welfare state? And what is your general view of it?
6	Here we may direct interviewee to relevant topic afterwards	What parts of the welfare state/public sector have you been in contact with since you came to Denmark?
7	Aspects of change	What picture of Danish society did you have before you moved to Denmark? (Especially of the state/welfare state/public sector.) Has this changed? How does it fit with your experiences in the country?
8	Aspects of experience	Can you tell me something about your experiences with the Danish welfare state/public sector?
9	Media discourse on welfare state (Possibly not as relevant to English language interviews)	What do you think about the presentation/discussion of the public sector/welfare state in the Danish media? How does it fit with your experiences?
TOPIC: Meetings with the unemployment system (unemployment fund/job centres)		
10	Experiences	Can you tell me something about your experiences with the Danish unemployment system?
11	Aspects of change	Do you have any experiences with the unemployment system in your country of origin? How is it different?
12	Meetings with front-line staff/professionals	What are your experiences of the staff/persons responsible at the jobcentre/unemployment fund? Could/Can you talk well with him/her? Did/Do you receive fair treatment?
13	Aspects of functionality	Did the development of contact with the unemployment system go well? Was the result satisfying? Did everything work as you think it should?
TOPIC: Language school and introduction programme		
14	Applicable if the interviewee attended language courses	What do you think about it? (Including teachers)
15	If the interviewee attended an introduction programme	Was there anything about women's role in

		Danish society in the introduction programme?
TOPIC: Work–life balance		
16	Children of pre-school age	What forms of childcare do you/do(es) your child(ren) make use of? (Or which ones did you used to use?) For how many hours per week?
17	If pre-school children or older ones have used services	What are/were your experiences of the childcare system?
18	Children of school age	Experiences with schools and school teachers, and so on
19		Do(es) your social network, acquaintances, friends, family etc. have opinions on how you make use of childcare? (Both in Denmark and in country of origin.)
20	Experiences from home country	Do you have experiences with the childcare system in your country of origin? Has your opinion of it changed since you came to Denmark?
21		Did Danish family policy (range of childcare options, parental leave, etc.) have an impact on your personal choices about family/family planning and work?
22	ALL	What would an ideal work–life balance look like for you?
23	ALL	When you were young, how did you imagine your family and work life would look? Did that change?
TOPIC: The meaning of work		
24		What does (your) work mean to you?
25		What are the characteristics of “good work”? Has your opinion changed since you came to Denmark?
TOPIC: Family norms		
26	Ideal upbringing of children	There are different opinions about what constitutes a good upbringing: Some people think that women with small children should stay at home, others think that childcare is beneficial for small children. What is your opinion on this issue?
27	Working	There are also different ideas about how satisfying it is to be a working mum. What do you think? What makes a good mother for you? Has your opinion changed?
28	Child and elder care	There are also different views on who should provide care for children and the elderly. Some think this should be a task for the family, others think this should be the responsibility of the public sector. What do you think?
29	Family policy	As you probably know, in Denmark there is a lot of public support that enables women with young children to work. What do you think about that? Has your opinion

		changed?
30		Do you feel that there are certain expectations (by others, society in general) regarding mothers and ideals about good motherhood?
TOPIC: Direct questions on trust		
31	The function of trust	Can you tell me a little bit about your future plans? For instance concerning work, career, family (planning), old age, etc.
32	Direct question	Earlier in the interview you talked about your experiences with XXX. On these grounds, would you say you trust the way the Danish public sector/welfare state works? (Or trust the welfare state in general)?
33	View on welfare state/legitimacy	What do you think about the fact that people in Denmark pay a lot of income tax? Do you think the welfare state uses this money in a fair/good way?

Lars Thorup Larsen

No Third Parties. The Medical Profession Reclaims Authority in Doctor-Patient Relationships

Abstract: A key aspect of the classic doctor-patient relationship is the idea that doctors exert a professional authority through medical expertise while also taking care of the patient. Some professional organizations have held that “no third parties” should come between doctor and patient, be it governments or corporations. The sanctity of medical authority has also met resistance, and doctors are often said to face more demanding patients today with their own information about diagnoses. This article concerns how the medical profession reacts faced with challenged authority. Do they seek to reestablish a classic authority position or develop an alternative relationship with citizens? The analysis compares approximately 1.000 editorials in American, British and Danish medical journals from 1950 to the present. The analysis shows that all medical professions see their authority challenged by third parties, but some react defensively while others try to rethink the authority relation between professionals and citizens.

Keywords: Authority, doctor-patient relationship, document analysis, health care system, critique of medicine, social authority, cultural authority, self-diagnosis

A common assumption in studies of cultural history holds that we live in a society where authorities have fallen off the pedestal (Jensen, 2006). Similar assumptions are also found in the sociological literature on reflexive modernization, for instance in Giddens’ claim that a “non-traditional culture dispenses with final authorities” (1994, p. 87). In understandings such as these, what undermines authority are not particular actors nor their overt resistance to power. The previous obedience to religion, science, political institutions and father figures simply erodes through modernization (Inglehart, 1997). Narratives of a broadside erosion of authority are problematic for a number of reasons. They may easily lead us to the mistaken assumption that authority was somehow uncontested before modernity, and they may also lead contemporary sociologists to treat the problem of authority as more or less overcome in the present (Furedi, 2013, p. 3). Both of these sets of assumptions are problematic. Even if some authorities do of course change, it is important to maintain the analytical starting point that authority relations were never uncontested nor are contestations in the present necessarily signs of a general loss of authority.

If we consider doctors’ professional authority towards patients specifically, there are also dominant narratives about why doctor authority is not what it used to be. One narrative typical claims that medical authority has been overrun from above so to speak, that is undermined by managerialism and political controls (Freidson,

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2001; Dent & Whitehead, 2002; Pedersen, 2011; Togeby, Andersen, Christiansen, Jørgensen, & Vallgård, 2003, p. 145). Another common story is that medical authority has been undercut by patients who google their own diagnoses or in other ways refuse to respect the doctor's superior medical expertise (Furedi, 2006; Hughes, McElnay, & Fleming, 2001; Scott, Deary, & Pelosi, 1995; Stevenson, Kerr, Murray, & Nazareth, 2007). All of these narratives may have some merit, but there may also be developments in another direction. For example, reflexive modernization can undermine our belief in authority, but at the same time increase the number and complexity of situations in which individuals need to depend upon specialized expertise (Beck, Giddens, & Lash, 1994). Further, by focusing on the decline of authority, one can easily naturalize the "before" as being a classic, uncontested relationship between doctor and patient.

Bearing these problems in mind, this article seeks to analyze how the medical professions in three different countries try to reclaim professional authority faced with various threats or challenges. Whether or not professional authority has indeed eroded, it is possible to compare how the profession perceives changes to doctor-patient relations and which solutions are proposed. The analysis here focuses specifically on how the medical profession characterizes the doctor-patient relationship and possible challenges to this relationship posed by external actors or by new developments in either science or society. The analysis also compares which courses of action the profession proposes as means to overcome the perceived challenges and reinstall authority. Who should do or understand what differently according to the profession? For example, does the challenge force the profession to act or should the problem be resolved by others? Or, as another alternative, does the profession present the case as if no changes are needed to restore authority?

Finally, it is important to underline the article's comparative ambition and explain the underlying case selection. Aside from comparison over time, the analysis also compares the medical profession in three countries, the United Kingdom, the United States and Denmark. These countries vary significantly with respect to the proximity of the medical profession to the state including variation in the health policy contexts in which doctor-patient relations are inscribed. The United States represents a market-based health care system with partial public funding (Medicare and Medicaid) and most doctors employed privately. The United Kingdom and Denmark both represent state-centered single-payer health care systems with a large proportion of doctors in public employment. In contrast to Denmark, however, the British medical profession has perhaps a stronger historical tradition of independence from the state, for instance through its autonomous scientific societies. These differences are not used for a parsimonious test of the general effect of health care systems on professional authority nor is the expectation that authority claims diverge completely between the cases. Nonetheless, the three different combinations of health care contexts and professions offer a variety of possible authority positions and threats from "third parties."

The article is structured into four parts. The first section develops a historical and theoretical background for the study of doctor-patient authority. This involves a clarification of the key concepts such as professional authority, but also a discussion about why the relationship between professionals and citizens, here patients, cannot be entirely separated from the policy context in which the professional work is embedded, here the organization of medicine and health care. The second section presents the empirical basis for the analysis and explains the essential methodological choices. Third is the analysis, which is structured by country, that is a country-by-country analysis of the dominant challenges to medical authority and the solutions or actions prescribed by the profession. Finally, the fourth section offers a comparative discussion about differences and similarities across the three countries. First, however, it is necessary to place the analysis within a broader theoretical literature on medical, and more generally, professional authority.

Scholarship on doctor-patient authority

The relationship between professionals and clients is not an entirely new field of study. In some situations, however, the connection to clients is mostly used to simply classify and separate professional knowledge from other types of abstract knowledge without discretionary or practical application (Brante, 2011; Freidson, 2001, p. 34), and thus not given detailed consideration in its own right. Other scholars explore the client relation more in detail, but typically limited to a single profession. One example here is Bourdieu's discussion of the ideal-typical relationship between lawyers and legal clients, although this is illustrated through a relational field perspective rather than a profession-centered perspective as such (Bourdieu, 1987). Besides classical works on the role of doctors and patients (Merton, 1957; Parsons, 1951), there is limited literature on the current status of doctor authority toward patients. One study investigates General Practitioners' perceptions of changing patient relations (Brown, Elston, & Gabe, 2015) while another study examines the reverse relationship, that is patients' ability to control doctors' orders (Menchik & Jin, 2013). Before analyzing whether the profession perceives its authority as being intact, it is useful to specify a yardstick of what medical authority could look like, even if it is merely the profession's wishful thinking.

The main title "no third parties" designates a key aspect of this yardstick, which is the idea of an unmediated relationship between doctor and patient. The expression itself comes from a famous declaration made by the American Medical Association in 1934. As the second out of ten "commandments" on health insurance, the declaration simply stated that "[n]o third parties must be permitted to come between the patient and his physician in any medical relation" (American Medical Association, 1934, p. 2200). The professional organization definitely had the federal government in mind when they drafted this New Deal era document, but it is important to remember that the medical profession also opposed the entry of corporations and private insurance companies into the organization of medicine during this period (Starr, 1982). The declaration also specifies that doctor-patient relations should be permanent and confidential, but although the patient should be free to choose his or her doctor, the relationship between doctor and patient is by no means equal in this understanding. This archetypical understanding of a "pure" doctor-patient relationship without the interference from third parties is still based on the doctor's superior authority position. No matter how benevolent a doctor is, the patient is subject to and dependent upon the doctor's superior medical competence, a significant dependence given the simultaneous exclusion of third parties.

The principle of no third parties is a good starting point for an ideal type of pure professional authority as seen from the point of view of the profession itself. It is, however, not an empirical characterization of how medical authority actually worked in the 1930s nor is it in any way a "natural" or normatively superior state of affairs. Most importantly, what presents itself as a doctor-patient relationship entirely free from political interference has immense implications for the organization and financing of health care. For instance, a later passage in the same document states that "[t]here should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession" (American Medical Association, 1934, p. 2201). The principle clearly limits the scope of health policy decision-making, which means that a ban on third parties between doctor and patient implies a sort of "shadow" political conflict about health economy and resources. Few scholars of professional studies would be surprised to find that professional organizations argue in their members' interests. Nevertheless, it is a healthy reminder that an uncontested authority position with no intervening third party is not the same as an interest-free or equal relationship. By excluding third parties, doctors also monopolize access to the patient with significant policy implications even when it is presented as being entirely apolitical.

If we turn to the generic theoretical notion of authority, it is built on a Weberian

tradition. Weber famously defined authority as “the probability that certain specific commands ... will be obeyed by a given group of persons” (1978, p. 212). By implication, professional authority is not intrinsic to a profession nor to its members and therefore cannot be studied solely through them. Ultimately, it is a question of whether or not professionals are able to command authority in the eyes of outsiders, here mainly patients, but also their command on having exclusive control with patient interaction. Weber’s focus on obeying commands and his three “pure types of authority” (1978, p. 215) do, however, seem too rigid to analyze what it means to accept a professional’s authority today. Instead, this article draws on Starr’s modernized Weberian definition of professional authority as a relation of “dependence on the professional’s superior competence” (1982, p. 15). Do citizens feel compelled to depend on the professional’s competence, and which factors explain their willingness to do so are thus the essential questions for a Weberian study of professional authority. As the methods section below clarifies, this article does not have any direct evidence of citizens’ acceptance of authority, since the data analyzed here only shows how the professional organization perceives and discusses possible threats and solutions to doctor-patient authority.

To adapt the general notion of authority more clearly to professions, the article uses Starr’s distinction between social and cultural authority as two conditions of a strong professional authority. Social authority concerns people’s willingness to follow the professional’s prescribed course of action. Cultural authority concerns whether people see the professional’s specialized knowledge as being necessary to interpret a given problem. In both cases, “people” should be understood simply as outsiders, which can include political authorities or, as here, individual citizens in their capacity as patients seeking medical advice. A profession’s lack of social authority would thus make citizens contest their recommended actions, and a lack of cultural authority would make them doubt the need for professional expertise. Previous studies have exemplified that while social and cultural authority can in some cases be separated historically because a profession may develop them in stages (Haber, 1991; Starr, 1982), the two categories are difficult to separate empirically in a present setting (Harrits & Larsen, 2016). It is rarely possible to code empirical sources as being solely about either social or cultural authority, but this is not necessary for the concepts to be analytically relevant.

It is a theoretical distinction between two necessary conditions for a strong professional authority. In empirical settings, however, a given profession at a given time and place may be more challenged on one of these dimensions, and therefore the professional organization’s authority claims will most likely reflect the status of their authority. In the case of a doctor-patient authority, some patients may accept or contest it out of habit, whereas others may do so because of how they understand the need for medical expertise. Similarly, the medical profession may see their authority as being challenged on some dimensions or in some types of situations interacting with the patient, or the profession may identify given social or political developments as the causes of the loss of authority. There are several conceivable outcomes of a broken or compromised authority relation, for instance, patients trying to control the outcome of professional decisions (Menchik & Jin, 2013).

Irrespective of what actually happens in doctor-patient encounters, this article focuses on the medical profession’s perception and the claims it puts forward to reestablished a compromised authority position. Does the professional organization go on the defensive and simply refuse to recognize third parties that pose a threat or challenge to their authority? Or do they choose to comply with the external demands, either willingly if the challenge is understood as being reasonable, or unwillingly if the challenge is somehow overwhelming or unavoidable? Key here is that there is a wide scope of possible strategies and responses, which calls for a qualitative exploration of the specific argumentation used by each professional organization.

Based on this overview of scholarship on professional authority, the following

three-legged research question can be formulated for this study: 1) What, if anything, does the medical profession (in Denmark, the United States, and the United Kingdom) identify as intervening “third parties” in their authority relation towards patients; 2) Which aspects of authority do they see as being contested, and 3) Which courses of action do they propose as solutions to reclaim authority?

Methods, data, and coding

The first methodological problem in the study of professional authority is to find credible sources to indicate whether or not—and perhaps also why—a profession commands authority over citizens in a given relation or capacity. The choice of research strategy easily becomes a dilemma between on the one hand a type of experimental setup designed to measure citizens’ willingness to comply with hypothetical authority “tests,” and on the other hand studies of real-life situations where the citizen’s compliance with authority is more difficult to measure and isolate. This study does not presume to be able to measure citizens’ willingness to comply with professional authority because there is no available empirical material from which to evaluate this willingness, and certainly not back in time. The material here can only show the professional organizations’ perception of professional authority, and it can only describe and explore these perceptions of authority, but not explain authority or its effect in practice.

The analysis uses editorials from professional journals as a proxy “voice” of the medical profession, although of course not all doctors are members of the underlying professional organizations. This material has the advantage of being published text, which can reasonably be said to represent the opinion of the professional organization. Even if editorials have different authors, they are subject to some sort of scrutiny by an editor appointed by the professional organization, and the texts can thus be said to speak for the profession. The journals selected for the analysis are the professional organization’s main general medical journal in each country, specifically the British Medical Journal (BMJ, 1840-present), the Journal of the American Medical Association (JAMA, 1883-present) and *Ugeskrift for Læger* (UfL, the Journal of the Danish Medical Association, 1839-present). Because these journals are aimed at a broader audience than just members of the profession, their editorials give a sort of window into how the profession portrays itself to the outer world. They are of course also aimed at doctors and can thus be read as instructions to doctors on how to act or react when faced with challenges from patients or from society. As mentioned before, the material is clearly limited in depth and does not claim to uncover an underlying “real” mechanism of authority. It is, however, quite well-suited to the specific task here, that is to describe how professions perceive threats to their authority and which authority claims and actions they prescribe as solutions.

The material further has the advantage that it facilitates comparison because editorials have similar length and scope across time and space. The data set here comprises a sample of 25 randomly selected editorials from every fifth volume since 1950 giving 13 volumes in each country and a total of 975 editorials. The analysis starts in 1950 because professional power and authority is often assumed to be at a high point during this period of professional “sovereignty” (Starr, 1982). There is, of course, a risk that the sampling will overlook relevant discussions in between the sampling points. If a perceived threat to professional authority carries great weight, it would most likely be discussed several times and thus still appear in the broad patterns of authority claims described here.

The data set allows for comparison across time and country, but the temporal dimension is mainly included to provide a variety of possible challenges to professional authority over the analyzed period. The following analysis is structured by countries because professional organizations, as well as the social organization of

professions typically, follow national boundaries. As mentioned before, the three countries represent three different medical professions in three different health policy contexts, since for example Danish doctors have probably never been able to keep third parties out of patient relations to the same extent as American doctors. The British medical profession has a longer history of independence (Saks, 2003, p. 37), but nevertheless, work within a health care system much like the Danish.

Finally, a few words on the coding and interpretation of the sources. It is unlikely that profession will explicitly label its authority claims as such because having or exerting authority sounds less legitimate than promoting health based on scientific knowledge. As a consequence, the analysis must be able to interpret how an editorial—besides perhaps conveying a more specific piece of news or opinion—also entails an authority claim about doctor-patient relations. Since the editorials typically focus on problem areas or challenges, the claims typically identify how someone—could be patients, the state or other social organizations—should act differently in order to respect medical expertise. As an initial coding, the sources were first separated depending on whether their embedded authority claims—provided there were any—could be said to involve the doctor-patient relationship, or whether they mainly concerned conflicts with the state or simply contained news about recent developments in medical research. Only editorials on or with implications for doctor-patient relations were included in the analysis. The remaining sources (216) were finally subjected to a second coding process in order to identify for each editorial 1) what constituted a challenge or threat to doctor-patient authority, for instance, a perceived third party, and 2) who should do what differently according to the editorial. Although the tables do not specify the underlying source text for each individual source, which would expand the text significantly, the analysis exemplifies the dominant themes with key examples¹.

Another issue in coding the material concerns the built-in ambivalences of medical discourse, which the analysis automatically inherits. For example, the editorials often refer to “doctors” without specifying whether the text mainly concerns general practitioners, specialists or rather the whole profession. Many sources appear to talk about issues in general practice, but the authority question is no less relevant for specialists or hospital doctors who more often interact with patients whom they do not know in advance. This is precisely why a generic understanding of doctor authority is relevant, even if it is imprecise, as it concerns the authority ascribed to a doctor simply because he or she belongs to the profession.

Danish doctors’ authority toward patients

The first thing to notice in the Danish case is what is not there, and what is, in fact, missing in all three countries. One topic that many would perhaps intuitively associate with the change in doctor-patient relations over time is the effect of individualization, for instance, if patients in large numbers begin to google their diagnoses or preferred treatments instead of relying on the doctor’s advice. Whether or not this phenomenon is real in practice, it does not register in the material analyzed here. The individualization of patients may be an undercurrent in some of the typical authority claims that do appear here, but it is always mediated through other perceived challenges to medical authority, for instance, the increase in media attention and legal regulation in the area of doctor-patient relations.

¹ To facilitate transparency, the coding list can be obtained by contacting the author. References to the sources are not entirely uniform, because the three journals subdivide volumes in different ways. The Danish references indicate issue number within one singular volume per year whereas the US and UK references tend to have more volumes per year, but with continuous pagination.

One theme that receives considerable attention already in the 1960s and onwards is the question of medical malpractice or side effects emerging from treatment prescribed by doctors. This challenges the cultural authority of medicine because it may hurt the belief in medicine as a necessary means to achieve health. The editorials do not explicitly reference the ongoing international debates about anti-medicine, such as Illich's "Medical Nemesis" (1975), but they appear to refer implicitly to these broader debates. For instance, a 1965 editorial discusses the issue of iatrogenetic effects, that is medical problems caused by treatment, rather than the underlying disease, while another discusses the issue of side effects in broad terms (UfL, 1965, 05). In both cases, the editorials ward off the critique by saying that members of the public tend to misunderstand these problems as doctors' mistakes, but that they are really just indications of how complex diseases are. In consequence, the editorials see no need for doctors to act differently to overcome this challenge to cultural authority, except perhaps try to educate the public on the complexity of medical situations. Later editorials under the same theme, for example, a 1990 editorial on whether doctors' mistakes are really mistakes, tend to focus less on denying the existence of medical malpractice as the earlier texts did. Instead, focus is on the formal system of medical supervision, which should be controlled by doctors and not the state (UfL, 1990, 33).

A large number of the authority claims are the profession's reactions to contemporary discussions and proposals that seek to formalize or otherwise advance patient rights. In these situations, the formalization of patient rights works as a third party that comes between doctor and patient and threatens the social authority of the former. The editorials clearly warn against this development. The standard response to these types of proposals—for instance proposals about a patient ombudsman (UfL, 1995, 13), formalized medical ethics, patient complaints system, etc.—is that the previous unmediated relationship between doctor and patient were preferable. Not just preferable for doctors, but rather that the immediate needs of the patients were better served without formal regulation entering the social authority relation. Some patient rights such as the "waiting time guarantee" (Larsen & Stone, 2015) are not actually designed to empower patients in relations with individual doctors, but toward the public health insurance and public hospitals. Again, the reaction of the medical profession is to defend the status quo, a less regulated social authority relation toward patients (UfL, 2000, 35; 2005, 25-31). The threatening third party in these discussions is a new policy proposal that formalizes doctor-patient relations, which the profession clearly warns against. The profession presents itself as a sort of guardian of the patient's interests, for example, in protecting patients against marketization in the health care sector (UfL, 1995, 51), employers seeking access to health information on individual patients (UfL, 1995, 15), or the state seeking a doctor's evaluation of individual patients' fitness to be a parent (UfL, 2010, 45).

The editorials are particularly defensive against new transparency policies. For example, regulations that give patients and the public access to transparent records are fiercely opposed, for instance, transparency regarding possible competing interests (e.g. pharmaceutical sponsorship of doctors or research) or regarding complaints records on individual doctors. Almost all of these transparency regulations are criticized as being an unnecessary "public pillory" (Danish: *gabestok*) for doctors (UfL, 2005, 23, 35). These later period editorials do not go as far as to deny the existence of malpractice, competing interests or other compromising actions performed by doctors. They characterize the allegations against doctors as being overblown, but mainly they systematically favor solutions that intervene as little as possible into medical practice, for instance promoting an "open culture" where mistakes can be admitted without the need for whistleblower protection systems and similar formalized legal arrangements (UfL 2000, 19). The best remedy to doctors being in the pocket of the pharmaceutical industry is allegedly to promote an ideal of "openness,"

which on one hand does recognize competing interests as an actual problem for doctors' authority, but nonetheless, opposes all intervening third parties into the relation.

Finally, another perceived threat to medical authority comes from the media whose attention to problems in doctor-patient relations is also presented in the editorials as an unnecessary third party. Similar to the reactions against politically induced transparency measures, the editorials here are equally furious against media "scares" and "witch hunts" against doctors and medicine. This discussion concerns cultural authority because the public reputation of medicine is on the line, but indirectly also social authority if patients act on information from the media rather than relying on the doctor's traditional knowledge monopoly.

Table 1 summarizes the dominant themes in the Danish editorials. At least three characteristics stand out. First, the Danish editorials do not present an explicit ideal of how doctor-patient should work, but indirectly they oppose all potential changes to the existing, unmediated authority relation. This fits with the thematic discussion of "no third parties" in the introduction, but only rarely do the discussions concern actual interactions with patients. The perceived threats to both cultural and social authority are not seen as coming from patients themselves, but from other intervening third parties who claim, wrongfully in the eyes of the medical profession, to take care of the patient. Second, the Danish editorials are not particularly clear on solutions, that is who should do what differently than now. A large number of editorials simply identify a problem without any clear indication of who should do what differently. Third and finally, when there are suggested courses of action, they usually defend the status quo. To the extent that a need for change is even recognized, the Danish editorials mostly suggest that outsiders should understand them better or that problems can be solved within the status quo. In other words, the Danish medical profession reclaims authority in a quite defensive manner and without any real attempts to find a new foundation for the profession's social or cultural authority.

Table 1

Danish doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Malpractice/side effects/iatrogenetic effects	Educate the public on complexity of medical situations
Regulation of medical ethics	Remain unregulated patient interaction
Patient rights (legal, ombudsman and choice)	Avoid regulation, but protect patients against marketization
Media scares	Resist witch hunts
Transparency policies (competing for interests/complaints)	Resist public "pillory"

American Doctors' Authority Toward Patients

The American editorials are surprisingly similar to the Danish in terms of their defensive tone and their clear preference for status quo solutions with as little formalization of doctor-patient relations as possible. The similarity is surprising, given how different political and social circumstances American doctors' work under compared to the Danish, although parts of the material reflect the diverging health care systems.

The first area where the US editorials resemble the Danish is in their reactions to

broader social critiques of medicine such as anti-medicine. These critiques are especially relevant for the profession's cultural authority because the public's willingness to accept professional decisions and various privileges may depend on whether or not they believe medicine to be a necessary means to achieve health. While the editorials do not say explicitly that patients increasingly challenge their authority, there is nevertheless a clear recognition in JAMA that the public image of doctors influences patient relations. One editorial from 1965 references the "Dr. Jekyll image" of doctors, but finds comfort in a report showing that doctors still rank highly on occupational prestige (JAMA, 1965, 194(11), p. 22). Similarly, other editorials address various media critiques or panics, typically by stating that the public should stop blaming doctors, but without any suggestions that either doctors or patients should act any differently than they did before. In other words, the editorials try to defend doctors' honor and demand respect from the public, but without any suggestions for actions to improve the cultural authority of doctors.

The American editorials also resemble the Danish when it comes to the later discussions about transparency policies, typically fueled by proposals about the disclosure of competing (financial) interests, industry funding and complaints records. The similarity is perhaps surprising, considering that a larger proportion of American doctors compared to Danish work in privately owned, profit-seeking or even outright capitalist organizations. The proposed alternatives offered in the US editorials are similarly devoid of real changes in authority relations, and they generally just propose that conflicts of interest should be addressed through informal appeals to 'balance and openness.

The social authority of American doctors is clearly more challenged by the introduction of "managed care," DRG systems and other economizing instruments in the health care sector. These developments are generally viewed as disruptive, because incentives work "differently" in medicine, as one editorial says (JAMA, 2005, 294(14), p. 1821). JAMA stays very close to the original no third party argument here, which is to oppose any development that interferes with an imagined, "pure" fee-for-service interaction with the patient. When I say imagined, it is not to suggest that there is no real threat to the social authority of doctors in policy tools like managed care and health economy. Imagined, however, is the absence of economic incentives in unregulated fee-for-service medicine, both in these editorials and in the original 1934 AMA declaration. The editorials do not say that authority is threatened, but instead, it is argued that patients' access to medical services will be limited by these policy reforms. Again, the profession's preferred solution is to maintain the status quo. Ironically, the JAMA editorials also criticize the opposite development, such as reforms seeking to expand access to health care, either through a new single-payer health care system (JAMA, 1975, 234(9), p. 25) or through expansions of Medicaid coverage for uninsured children (JAMA, 1995, 274(18), p. 33). The editorials clearly oppose such expansions of access to health care, for instance, arguing that any single-payer health care system would interfere as a third party between doctor and patient (JAMA, 1975, 234(9), p. 25).

End-of-life decisions constitute another threat to the unmediated social authority of doctors. From 1990 and onwards, there are several discussions about do-not-resuscitate-orders and other related proposals for formalization (JAMA, 1990, p. 264(10), p. 33). These are situations where the patient is—either temporarily or permanently—unable to consent to the doctor's proposed treatment. The profession again prefers the unregulated status quo where a doctor exerts social authority and decides on a case-by-case basis. This means opposition not only towards policies that would regulate end-of-life decisions, but also legal action or general juridical models that would also act as a sort of a third party between doctor and patient. The editorials do not really seem to consider that some of these court decisions or proposals may come from patients' wishes, or at least the profession prefers to remain

the sole interpreter of patients' wishes and thus to preserve an authority relation toward patients.

Unlike the Danish editorials, an increasing number of the American documents in the past few decades do actually point to doctors as the agents responsible for taking action in the given situation. For instance, there are discussions about how doctors should work to avoid social exclusion among the elderly (JAMA, 2010, 304(17), p. 1955), how they should handle informed consent in interactions with patients from multicultural backgrounds (JAMA, 1995, 274(10), p. 39), or doctors' role in the prevention of opium addiction (JAMA, 2010, 304(14), p. 1612). These editorials do not refer to a clear and identifiable challenge to professional authority, and no unifying third parties are involved. It is, however, an increase in the number of situations where JAMA calls on doctors to act instead of only pointing fingers at others, even if it is not a fundamental change from how they worked before. There are also a few editorials in the most recent volume that call on doctors to cooperate when faced with crisis over surgical mortality or questions about financial impartiality (JAMA, 2010, 304(15), p. 1721; 303(1), p. 75). These types of situations would previously have been brushed off as witch hunts against doctors. So, while the American medical profession's standard response to perceived challenges is to avoid general regulation models and maintain a largely unregulated social authority relation towards patients, there may be small steps towards cooperating with these systems that regulate the doctor's professional work.

Table 2

US doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Doctors' image as Dr. Jekyll, critique of medicalization	Demand respect for patient guardianship, defend honor in public
Transparency policies (competing for interests/industry funding/complaints)	Resist regulation, call for "balanced" policy or culture of openness
Managed care/health economy/incentives in doc-patient relations	Resist incentives and bureaucratic third parties, maintain fee-for-service remain.
Uninsured patients/children	Avoid Medicaid solution, avoid third parties
End-of-life decisions, "do not resuscitate"—orders, etc.	Avoid general or legally formalized model, preserve discretionary judgment

British Doctors' Authority Toward Patients

The British editorials reflect some of the same themes as in the US and Denmark, such as challenges to their work situation brought on by managerialism as a third party coming between doctor and patient. For example, there are complaints about "hamster health care" with doctors running like hamsters in a wheel while seeing patients less (BMJ, 2000, 321, pp. 1541-2). Another editorial criticizes the adoption of "personal medical systems" for each individual patient because the system is managerially and not professionally driven (BMJ, 2000, 321, p. 1359-60). We see other topics that could just as easily have been written in JAMA or UfL, for instance, about

the need for doctors to maintain the social authority position as gatekeeper to specialist referrals (BMJ, 1995, 311, p. 1447), or the public being “totally misguided” in its perception of facial transplants (BMJ, 2005, 331, p. 1349).

There are also situations, however, where the perceived challenges to medical authority prompt new types of responses and solutions compared with the other countries. One editorial, for example, reminds doctors that problems in the NHS are no excuse for “cavalier” treatment of patients and their relatives (BMJ, 1990, 301, p. 1407-8). This editorial exemplifies a common characteristic in many if not most British editorials, which also set them apart from the Danish and the American: The agents responsible for acting differently are doctors themselves, either with the aim to make the threatening third party go away or to reconstitute doctor-patient authority in light of the given challenge. The authority claims made by Danish and American doctors were almost exclusively met with calls for someone else—patients, the public, the state, the media, or other perceived third parties—to act differently. The British editorials are different here. The implications for action they derive from challenges to existing authority positions typically say what doctors can or should do differently. Also, while a few editorials in BMJ also ward off critique, they do not automatically defend the status quo as fiercely as the other journals do.

When the BMJ calls for doctors to act differently in light of a given situation or challenge, it does not mean that the profession does not assert its social or cultural authority toward third parties. It is perhaps more accurate to say that the authority relation towards patients is reconfigured according to the given challenge. A large proportion of the British editorials describes a specific type of delicate situation—supposedly one that many doctors face in encounters with patients—that requires the doctor to handle the interaction differently than hitherto and to do this with some professional diligence. For example, there are editorials about how doctors should handle patients seeing prostitutes (BMJ, 1960, 2, p. 1974), how to handle addicts who try to trick the GP for prescriptions (BMJ, 1975, p. 541), when to go against patients’ wishes with electroshock treatment (BMJ, 1980, 281, p. 1588), how doctors can be sensitive while still treating male rape victims (BMJ, 1990, 301, p. 1345), how to act on seizure patients’ access to driving again (BMJ, 2010, 341, p. 1260), or how to prevent heart disease with binge drinkers (BMJ, 2010, 341, p. 1146).

There are numerous situations like these in the material. What binds them together is that although some of them may be related to new diagnoses or treatments in medicine, the editorials’ key message is not about new scientific evidence. It is about how the doctor should take care for and handle a potentially difficult situation with a specific group of patients. In this sense, what challenges the normal doctor-patient relationship in these situations is usually not new medical knowledge, but rather the part of the doctor-patient relationship that is not simply an exchange of purely scientific expertise. It can be situations that may be potentially embarrassing for the patient, or where the doctor has regulatory functions, such as giving or taking away a driver’s license.

What makes this group of authority claims interesting here is on one hand that the British medical profession appears more willing to take responsibility for new developments in doctor-patient relations, and thereby to offer a more genuine form of patient guardianship. On the other hand, these types of authority claims are also particularly interesting because while doctors appear much more willing to change here, this is not an end to the authority between a doctor and a patient. The new type of doctor-patient relationship described in these editorials is still an authority relation. It is precisely the doctor’s responsibility—not the state’s nor the patient’s—to handle or take care of a potentially difficult situation for the patient, even when the delicate nature of the encounter is prompted by the patients’ actions, special problems or social circumstances. The social authority of the doctor is reconfigured as a type of guardianship here, which is not necessarily completely new because many doctor-patient encounters were of course also difficult before this period. Nevertheless, one

could potentially see this as a medical profession that has taken the critique of medicalization and medical domination seriously and pursued a reconfigured form of professionalism and authority. Conceptually, this change mainly refers to social authority because of its orientation towards action, but indirectly it may also seek to rehabilitate belief in the benefits of medicine more broadly, i.e. cultural authority.

Table 3

UK doctors' perceived threats to authority and proposed solutions

<i>Threat/challenge/third party</i>	<i>Who should do what differently?</i>
Complex medical/social situations with patients (mental health, prostitution, obesity, elderly, pregnancy, male rape)	Doctors should manage situation with care, take responsibility for handling patient relations diligently given difficult situation (topical or new knowledge)
NHS limitations hurt patients and doctors	Treat them well despite limitations
Patient demanding direct access to specialists	Maintain GP gatekeeper function (referrals)

Comparative Challenges to Medical Authority

If we look across the medical professions in the three countries, they often identify some of the same developments as possible third parties threatening their authority towards patients, such as managerialism, formalized patient rights or critical media attention. Nevertheless, there does not appear to be any direct relationship between what threatens professional authority and the responses it provokes. There seems to be a range of possible ways that doctors can react to having their authority—cultural as well as social—questioned in public. The profession may choose to push back hard as Danish, and American doctors do against all challenges and simply argue that the public scrutiny of medicine is unreasonable and that no formal, legal or policy changes are necessary. It can also be less defensive and come up with more constructive ways to rethink the authority of doctors in light of how external conditions change or given that the public's trust can no longer be taken for granted. The range of possible responses may reflect that we are talking about a profession with a well-established professional monopoly, a status quo to defend. In any case, it is remarkable that Danish and American doctors are more similar than their British counterparts in this analysis. This pattern suggests that authority relations between doctors and patients are not determined solely by the policy subsystem on a macro level, which means being in either a market- or state-centered health care system.

If we ask more generally what challenges professional authority, there is no real evidence in this material to support the initial idea that doctors see their authority as being undermined by individualization or the spread of medical information on the internet. The topic simply receives very little attention and more broadly one could argue that patients have relatively little impact on the content of these editorials. The exception here are the specific debates in the BMJ on how doctors should address a potentially difficult situation prompted by the patient's situation or by some other social development. Even in these cases, the argument rarely calls for doctors to enter into a dialogue with patients on equal footing. The doctor should, both as cultural and social authority, take responsibility as guardian for the patient in a given situation, but few situations call for doctors to involve the patients in medical decisions.

The limited attention devoted to patients indirectly says something about the state of medical authority. It appears that the medical profession in all three countries sees little need to legitimize their authority position towards patients, perhaps because they see this relationship as being primarily defined by the exclusion of third parties. They do see professional authority as being contested, however, but mainly from external third parties such as political institutions, managerialism, negative media attention or the opening up of medicine to systematic scrutiny, for instance on medical malpractice, competing interests or medical decision-making in broad terms. Here, we also see how both dimensions of doctors' professional authority—social and cultural—are in play at once. It is difficult to expose medical decision-making to public transparency without a perceived threat to the profession's general reputation, and the protection of doctors' reputation against skepticism in public is often presented as an argument against change. So, while all medical professions continually try to command authority, they may do so either through action and change or, on the contrary, through a defensive refusal to make any changes to the status quo.

As a final note, it is worth to underline how this article answers the research question as well as reflect upon the reliability of the answer. The article argues that the medical profession continuously identifies external parties as intervening third parties that disrupt the idealized, unmediated authority relation between doctor and patient. The third parties are not simply actors, however, but also developments such as increased media attention, patient rights or marketization. The analysis points to challenges against both the social and cultural authority of doctors, but the two have proven difficult to separate. This is no surprise given Starr's original use of the terms but nevertheless, points to a limitation in the analytical setup. It is also essential to consider the possibility that when the study finds no major erosion in doctor-patient relationships, it is simply because the selected material and selected type of material is unable to show such a development. This is possible, and as the methods section argues, the study only provides a broad overview of what the profession says about authority. It would require other sources and another depth of analysis to determine the status of authority in practice, and it would most definitely require a combination of different methods.

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