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Hospital Administration as a Profession

Abstract: Many benefits accrue to an occupation that is described as a “profession,” including the ability to influence public debate, such as the current one over health policy in the United States. The label of profession frequently enhances the status, prestige, power, and legitimacy of an occupation, which usually translates into additional resources and power. This article examines the current status of the occupation—hospital administration—with respect to the literature pertaining to the concept of a profession. Hospital administration is assessed in terms of its relation to three common attributes associated with professions: collegial traits, knowledge base, and service orientation. The analysis indicates that there are important obstacles to be overcome before hospital administration can be considered a profession based on these three attributes.

Keywords: Profession, hospital administration, health care administration

Within the past decade, the health care landscape has seen a substantial amount of upheaval. The introduction of the Patient Protection and Affordable Care Act (PPACA) in the United States and its passage in 2010 triggered a series of changes in health care delivery across the country and has prompted the discussions of reform currently occurring. Within these legislative processes and policy debates, we see the influence and power of different health care stakeholders, including physicians, the insurance industry, and patient rights groups. However, the voices and positions of hospital administrators have not been clearly identifiable. Hospital administrators are at the forefront of the day-to-day decision-making and implementation of health care delivery policy and procedures. While individual organizations have issued statements supporting or speaking out against proposed policy changes, a consensus position from the field of hospital administrators has not been clear, in contrast to the positions of the medical profession or the nursing profession. This raises the question of what we perceive the role of hospital and health care administrators to be and how this role fits within the structure of our health care system.

As hospital consolidation becomes more frequent and as the separation of medical staff and administrative staff increases (Scott, 1982), the role of hospital administrators is likely to gain in autonomy and authority, prompting a new discussion of how that role is defined. It has been over 50 years since Wilensky (1962) examined the occupation of hospital administration with respect to the concept of professionalism. The current debate and public conversation about key elements of gaining insurance and accessing health care have prompted us to reconsider this idea of hospital administration as a profession. Wilensky (1962) identified several forces that were preventing the occupation from being designated as a “profession” at the time. However, he also discussed other forces, such as changing patient-physician relationships and increased community service focus, which may over

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time move hospital administrators closer to gaining professional status. The general tone of the article, which is consistent with others' work since, implied that hospital administration would need to continue to evolve before it would be considered a true profession. Obviously, many changes have occurred in the field of hospital administration since 1962. The subject has been written on by a few other researchers since (Scott, 1982; 2004), but we recognize this time of change and debate as an important moment to revisit the topic, particularly given the weight of influence often conferred on professionals and organizations that represent them. We ask, what is the role of a hospital administrator within the larger context of the medical field, and what does this say about the degree to which hospital administration is a profession?

Defining hospital administration

Within the United States, the occupation of hospital administrator is a relatively young one when compared to the traditional professions of physician or lawyer. As hospitals have emerged and evolved as institutions throughout the country's history, the nature of their management and administration has evolved as well. Early administrators of hospitals in the United States were known as superintendents, and these roles were often filled by clinical staff, such as physicians and nurses, though philanthropists or religious figures, such as Catholic sisters, also took on these responsibilities at times (Haddock, McLean, & Chapman, 2002). Even early on, there existed a conflict between superintendents and medical staff, with conflict arising regarding the power and legitimacy of each role (Rosenberg, 1987). Though hospitals within the U.S. began as charitable endeavours, as the twentieth century approached, they increasingly employed a market perspective in providing their services, with more patients paying for care and with the dominance of the medical profession becoming a stronger driving force within the organizations (Starr, 1982). As this trend continued, a demand arose for an educational curriculum for hospital administrators, one that would include accounting, management, policy, and public health, among other areas (Haddock et al., 2002). Administrators became more aware of the need for special training for the complex tasks they would face (Rosenberg, 1987). The first educational degree programs appeared in the 1920s and 1930s (Haddock et al., 2002; Neuhauser, 1983), and the establishment of the American College of Hospital Administrators (later to become the American College of Healthcare Executives) was established in 1933 (Stevens, 1999). These events indicate the establishment of the occupation. As reimbursement became more complex over the course of the 20th century, with the introduction of government payers and managed care, an increased focus on efficiency and strategic planning further grew the demand for career administrators with the appropriate managerial skills (Starr, 1982).

The increasing managerialization of health care has resulted in greater professionalization of the role of health care manager through the establishment of professional associations, with trappings such as journals and codes of conduct (Noordegraaf & Van der Meulen, 2008). Defining and standardizing the work done by health care managers and hospital administrators appears to strengthen occupational control (Noordegraaf & Van der Meulen, 2008). This paper explores whether that level of control, for hospital administrators, has solidified to the extent that the occupation can be considered a profession and can, therefore, have an influential and common voice in issues of health care policy and reform.

What constitutes a profession?

Researchers have had trouble isolating a specific definition for profession. Several factors account for this lack of definitional consensus, including different perspectives and methodologies, as well as the fact that it is a dynamic concept, with many occupations constantly trying to protect their professional “turf” in light of new meanings and implications for the term. In fact, Abbott (1991, p. 18) has suggested that “the term ‘profession’ is more an honorific than a technical one, and any apparently technical definition will be rejected by those who reject its implied judgments about their favourite professions or non-professions.” Friedson (1983, p. 22) indicates that the definitional problem results from attempts “to treat profession as if it were a generic concept rather than a changing historic concept, with particular roots in an industrial nation strongly influenced by Anglo-American institutions.” According to Friedson (1983, p. 32), “The future of profession lies in embracing the concept as an intrinsically ambiguous, multifaceted folk concept, of which no single definition and no attempt at isolating its essence will ever be generally persuasive.” Evetts (2013, p. 781) notes, “sociologists have been unsuccessful in clarifying the difference between professions and other occupations and identifying what makes professions distinctive.”

However difficult it may be to define, many benefits accrue to occupations that achieve such a designation. According to Guy (1985, p. 13), “It is fairly obvious why particular occupations want to be called professions: the name brings with it higher status and prestige, along with more autonomy, resulting in more control over members’ work-life.” Professional “legitimacy” means more power and influence for the occupation, which usually translates into additional resources (legal, political, financial, and otherwise). The ultimate reward of being designated a profession by society is occupational survival. In the current landscape, the understanding of hospital administration as a profession would potentially lend greater credence and influence to the opinions of those within it, perhaps permitting hospital administrators a more public voice in national debates over policy and oversight.

One approach researchers have taken to define the concept is the listing of traits or attributes that would characterize an occupation as a profession. Much of the classic early literature studying professions was based upon a trait model or approach (Carr-Saunders & Wilson, 1933; Cogan, 1953; Goode, 1969; Greenwood, 1957; Wilensky, 1964). While trait models have been criticized because the number and listing of traits seemed arbitrary or without theoretical rationale (Abbott, 1988; Johnson, 1972; Roth, 1974), the approach continues to exert a powerful influence over the study of professions. As stated by Leicht and Fennell (2001, p. 27), “In spite of criticisms of trait theories as explanations for and definitions of professions, they do provide us with a set of places to look for changes in professional life.”

Ritzer and Walczak (1986) acknowledge three basic approaches to the analysis of professions: process, focusing on the historical pathway of a profession; structural-functional, focusing on the distinctive characteristics; and power, focusing on the power needed to reach the designation and the power wielded afterward. They use all three to establish their definition of profession: “an occupation that has had the power to have undergone a developmental processes enabling it to acquire, or convince significant others that it has acquired a constellation of characteristics we have come to accept as denoting a profession” (Ritzer & Walczak, 1986, p. 62). Furthermore, they recognize that professionalization is a continuum, noting that some occupations meet some or even most of the criteria to be a profession but may be lacking in a key area.

In considering the field of hospital administration specifically, we must recognize that at the core of the hospital administration occupation is the representation of the organizations hospitals administrators work within. These hospitals and the field they exist within have changed drastically over time, which has set the stage for the evolution of the hospital administrator role. Starr, in his 1982 work, examines other

changing roles within health care, specifically that of physicians. Ritzer and Walczak (1986) acknowledge Starr's work and note that his analysis of the medical profession was influenced by all three approaches they discuss as central to defining a profession.

Starr (1982) has suggested that attributes found in definitions of the term "profession" fall under one of three categories: collegial, cognitive, and moral. Starr (1982, p. 15) describes collegial as the sense "that the knowledge and competence of the professional have been validated by a community of his or her peers." Cognitive is to mean "that this consensually validated knowledge and competence rest on rational, scientific grounds" (Starr, 1982, p. 15). Moral implies "that the professional's judgment and advice are oriented toward a set of substantive values, such as health" (Starr, 1982, p. 15). Starr (1982, p. 15) consolidates these three traits into the following definition of a profession: "An occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics."

For these reasons, Starr's approach will be at the core of our own analysis, which will also be informed by Ritzer and Walczak's concepts of process, structural-functional characteristics, and power. The inherent connection between the occupation and the industry make these factors relevant as we consider the current role of the hospital administrator in this time of a changing health care system. Our analysis is the result of reviewing relevant literature and conducting a targeted website search of governing and oversight organizations of the health administration occupations. These include the American College of Healthcare Executives (ACHE), the Association of University Programs in Health Administration (AUPHA), the Commission on Accreditation of Healthcare Management Education (CAHME), and the American Hospital Association (AHA).

Collegial traits of hospital administration

Many researchers (Goode, 1969; Friedson, 2001; Johnson, 1972; Wilensky, 1962) have emphasized collegial attributes when defining a profession. In fact, Friedson (2001, p. 32) maintains that when an occupation has a monopoly or complete control over its own work, it "is the essential characteristic of ideal-typical professionalism from which all else flows." Complete monopoly or control implies that one's behaviour is specified and judged by colleagues and peers (not outsiders). This professional autonomy includes control over educational and entry requirements for the occupation.

In terms of hospital administration, there is little evidence of such collegial control over educational and entry requirements. The main professional association for hospital administrators is the American College of Healthcare Executives (ACHE). Participation in the organization is voluntary, and the organization has minimal involvement in specifying educational requirements and content for aspiring hospital administrators, but it is the most prevalent resource for identifying professional standards for the field. While the expectation is for a hospital administrator to have graduate level training, ACHE does not specify whether an individual should pursue a Master of Health Administration degree, a Master of Business Administration degree, a Master of Public Administration or a Master of Public Health degree, or even a doctorate degree in one of these areas. A hospital administrator can enter the field through a variety of different educational routes and career paths, including either accredited or non-accredited programs, as well as traditional or online degree or certificate programs. At times, experience in another occupation may even be highly valued by a hiring committee.

Even within undergraduate and graduate programs specific to hospital or health care administration, there is a lack of programmatic consistency across universities;

however, there tends to be more regulation and oversight of health administration professionals practising in the industry. Although a corporate sponsor of the primary accreditation body for graduate programs in health services administration (Commission on Accreditation of Healthcare Management Education or CAHME), ACHE traditionally has not been a leader in defining curriculum content within the academic community. Rather, ACHE focuses most of its attention on individuals that are already employed in the field as hospital administrators. Once an individual enters the field of hospital administration, ACHE has more control over validating his/her knowledge and competence through their credentialing program. Although voluntary, board certification in health care management is well accepted throughout the field and is likely essential for an individual's career advancement and recognition. Individuals who become board certified are recognized as Fellows (FACHE) and display these credentials accordingly (ACHE, 2008). Though hospital administrators do not have controlled entry points, such as licensing processes that clinical providers often must complete, it is important to note that ACHE has established norms and standards that have done much to institutionalize the occupation.

These efforts of creating norms and standards are ongoing. ACHE increased their educational efforts recently through the 2014 creation of the Professional Development Task Force, comprised of 11 ACHE members of various professional backgrounds (ACHE, 2014). The goals of this Task Force were to determine educational gaps, align content with proper dissemination models, and identify leadership competencies in conjunction with the ever-changing health care industry.

ACHE also recently participated in the Healthcare Leadership Alliance, a consortium of six major professional membership associations designed to analyse and distinguish the major competency domains that are common to practising health care managers (Stefl, 2008). Five domains were identified, including communication and relationship management, professionalism, leadership, knowledge of the health care system, and business skills and knowledge (Stefl, 2008). From this experience and the development of the Healthcare Leadership Alliance Competency Model, ACHE produced a Healthcare Executive Competency Assessment Tool that is distributed and recommended to all of its members as a self-assessment and personal improvement instrument (Stefl, 2008). Again, however, the emphasis of all this is on practising managers and administrators. These efforts may create more standardized expectations for advancement in the field, but they do little to directly affect educational and entry requirements into the field.

Another organization worth considering in relation to the professionalization of hospital administrators is the American Hospital Association (AHA). Unlike ACHE, AHA has exerted its voice in the recent debate over health care reform, cautioning Congress and the Trump administration over potential consequences of proposed bills (AHA, 2017). This would be an instance of power, as described by Ritzer and Walczak (1986), which ACHE has not sought to replicate. However, whereas ACHE represents the administrators themselves as individuals in the occupation, AHA represents hospitals and health systems as organizations. This distinction weakens the argument for defining hospital administrator as a profession. ACHE could, in many ways, be considered inward-facing with its communications largely targeting its own members. AHA, on the other hand, interacts publicly with other stakeholders in the health care field, particularly in regards to issues such as health care policy. If the public face of hospital interests is representative of organizations rather than their leaders, the role of the leaders may be less defined and understood by the public, and therefore less likely to be viewed as a profession.

In sum, the autonomy of the occupation is not clear-cut. On the one hand, there is very little occupational control over educational and entry requirements for the field. There has been little change since Wilensky (1962, p. 21), when commenting about hospital administration, stated, "The professional association does not control entry and hence cannot fully impose its standards of training on all practitioners of the art." On the other hand, the professional association (ACHE) and its members do

have a fairly strong credentialing program that validates the knowledge and competence of individuals through a structured peer review (collegial) process. This is certainly a collegial attribute commonly associated with other professions, such as physicians and university professors. However, the professional organization lacks any indication of power, as discussed by Ritzer and Walczak (1986), with political and policy interests being conveyed at the organizational level through AHA, rather than the professional level, as is common with the American Medical Association or the American Bar Association.

The knowledge base of hospital administration

Professions are expected to have “a base in technical, specialized knowledge” (Starr, 1982, p. 15). According to Wilensky (1962, p. 9), “This competence is ‘technical’ because it comes from a systematic body of knowledge acquired only through long, prescribed training.” In fact, professions are typically viewed as “intellectual” occupations, based upon a lengthy process of formal assimilation of complex, theoretical knowledge that is a prerequisite for professional success. This cognitive attribute is generally found in most descriptions or definitions of a profession (Leicht & Fennel, 2008). Greenwood (1957) and Goode (1969) also emphasize that this assimilation process must go beyond just “book learning” and also incorporate applied or practical training experiences (internships, apprenticeships, etc.). More recently, the importance of knowledge within a profession has been emphasized by Siegrist (2002) and Friedson (2001). Brante (2011) goes a step further by discussing the specific nature of the knowledge needed to designate a profession.

Hospital administration would seem to fare poorly when comparing the occupation with this particular attribute of a profession. There is not a systematic body of knowledge that all potential hospital administrators must acquire before entering this occupation. As mentioned above, hospital administrators have different educational backgrounds and different career paths. Some administrators come from an entirely different professional path, such as physicians or nurses. In some cases, diverse backgrounds and experiences may be highly valued.

Thus, there is not a specific technical knowledge base that is common to or required of all hospital administrators. According to Begun and Kaissi (2004, p. 228), “Development as a profession, then, requires clear specification of a distinctive task domain, and development of educational requirements to earn the right to practice in that task domain.” Since many of the tasks (strategic planning, problem-solving, conflict management, negotiation, etc.) of the hospital administrator are common to other management positions and occupations, it is difficult to see how hospital administration (or health care management for that matter) can ever create its own specific knowledge base and distinctive task domain. Glouberman and Mintzberg (2001, p. 80) suggest “that the professional model—based on the standardization of skills and knowledge—hardly applies to management, where nothing can really be standardized and barely anything of significance has been codified with reliability.”

Nevertheless, the above statement stands in stark contrast with current initiatives being developed and implemented by ACHE and the National Center for Healthcare Leadership (NCHL). As discussed in the previous section, ACHE’s Professional Development Task Force has three main goals; the final goal is to identify leadership competencies in conjunction with the ever-changing health care industry. The leadership competencies developed include leadership, communication and relationships, professionalism, health care environment, and business (ACHE, 2014). The developmental purpose of these leadership competencies is to enhance a hospital administrator’s engagement in the process of talent management in order to gain a competitive advantage (ACHE, 2008), which could be key to organizational survival.

The other organization contributing to the educational knowledge base is the National Center for Healthcare Leadership (NCHL). This organization was founded in

2001 and is focused, among other things, on creating a competency model that can be applied to both the academic and practitioner communities (NCHL, 2003). NCHL addresses the growing demand for a leadership model specifically related to the health care industry. The additional competencies addressed in this model are tailor-made to address the intricacies and unique attributes associated with the ever-changing, heavily regulated health care industry. As a result, NCHL created the Health Leadership Competency Model, which developed initiatives for growth starting with graduate education (NCHL, 2006).

The growing demand for health administration competencies has driven the creation of competency initiatives aimed at improving higher education, particularly curricular content and educational reform process review. The competency-based educational focus includes:

A need for higher levels of mastery throughout the field, identification of the key knowledge, skills, and attributes that contribute to the success of health care organizations and managers, and measurement or assessment of learner mastery of these essential for career performance. (NCHL, 2006)

Competency-based education is gaining acceptance and has been identified for its potential to address the industry challenges, changing practice environment, educational accountability and accreditation development, and workforce development. Using a competency-based approach to curriculum development aids in the facilitation of inter-university communication, career development and growth, best practice standards, interactions among interdisciplinary professions, and creation of multi-setting professional development programs (NCHL, 2006). The Health Leadership Competency Model (HLCM) is currently being used and applied at several health care organizations and graduate programs in health care management (Calhoun et al., 2008). Though voluntary, this does indicate a further step toward the institutionalization of the occupation. In 2014, NCHL collaborated with AUPHA and CAHME to create the National Council on Administrative Fellows (NCAF) with the goal of exploring a more organized and collaborative approach to the health care management fellowship process (NCHL, 2016). These efforts resulted in the development of a “Code of Good Practice” that standardized the application and recruitment process and set the standards and oversight for fellowships (NCHL, 2016).

It remains to be seen how many programs will become involved with the NCHL Competency Model and/or will incorporate ACHE’s Professional Development competencies. Although they appear to face a challenging and daunting task, any success in their endeavours would appear to move hospital administration in particular, and health care management in general, closer to having its own distinctive knowledge base or task domain that is characteristic of the most well defined and developed professions. However, at this time, even with the shift toward and emphasis on various competency models and approaches in health care management, it is clear that no such distinctive knowledge base or task domain exists in the field of hospital administration.

In this sense, the process of professionalization of the hospital administrator is still ongoing. Although there is no one particular educational gateway or grasp of technical knowledge currently expected for all hospital administrators, there are institutionalized norms and expectations. The corporatization of hospitals over time has led to a greater emphasis on a blending of business and health care backgrounds within the top tiers of leadership. A key element of hospital leadership is the ability to manage other professionals. As hospitals and other health care organizations (such as physician offices) merge and form larger health systems, integrated health care organizations, and those that lead them administratively have greater control over what services to offer. This responsibility necessitates an understanding of the health care field that goes beyond standard managerial skills. As well, the ongoing evolu-

tion of payment and reimbursement structures, shifting from fee-for-service to capitated payments and negotiated contracts, requires increasing adeptness at navigating the financial demands of health care organizations (Shortell, Gillies, & Devers, 1995). Therefore, we can argue that the role requires specialized knowledge but not in a standardized manner.

Hospital administration's service ideal or orientation

Johnson (1972, p. 13), in a summary of literature pertaining to professions, indicates that many researchers have suggested "that professions are to be distinguished from other occupations by their *altruism* which is expressed in the 'service' orientation of professional men." This is the "moral" imperative referred to by Starr (1982). This particular trait or attribute is best described by Rueschemeyer (1964, p. 17) who claims, "that the professions are service- or community-oriented occupations applying a systematic body of knowledge to problems which are highly relevant to central values of the society." Individuals within the profession may not contribute to the service of their professions; not all lawyers do pro bono work, for example, and not all physicians volunteer time in free clinics. However, those elements of service are integral to what we understand those professions to be as a whole.

The idea of service orientation is sometimes considered to be a myth created by professionals to convey authority and autonomy because being seen as altruistic earns public trust (Ritzer & Walczak, 1986). In the context of hospitals, though, public trust is essential to organizational survival. Hospital administrators' primary interest is the good of the organization, and that means conveying a commitment to serving the community, both for the sake of public trust and (in the case of non-profit hospitals) to be eligible for tax-exempt status.

Indeed, a hospital administrator's primary role is to plan, coordinate, and deliver health care services to a defined community. A hospital administrator that does not define and address community needs and improve the health status of the surrounding region will not be successful. A service- or community-orientation is clearly an important priority for ACHE (ACHE, 2008). This is reflected by the following statement defining a health care executive's responsibility to his or her community:

But the health care executive's responsibility to the community does not end here—it encompasses commitment to improving community health status and addressing the societal issues that contribute to poor health as well as personally working for the betterment of the community-at-large. (ACHE, 2008, p. 86)

This service ideal is an important part of a hospital administrator's role, and it is reflected in a hospital's charity care for those unable to pay as well as other community outreach programs and initiatives. Wilensky (1962, p. 23) describes this responsibility as "administrative leadership" and contends that increasing focus in this area, as is happening in the current era of health care reform, will further facilitate the professionalization of the occupation. Weil (2001) commented on this service orientation within the field of hospital administration:

The movement toward community health is becoming a function of leading hospitals. In fact, to retain their non-profit tax-exempt status, hospitals are now required by the government to initiate community health efforts. Moreover, leading administrators are beginning to capture the hearts of their staffs, physicians, and trustees by embarking on community outreach services. (Weil, 2001, p. 88)

However, it should be noted that many non-profit hospitals are coming under increasing scrutiny regarding their provision of community benefits or services. In general, non-profit hospitals are exempt from federal, state, and local taxes as long

as they provide charity care or community benefit programs equal to the approximate size of their tax exemption. Over the past decade, greater standards of accountability have been implemented through revisions to the Internal Revenue Service reporting requirements and through community assessment provisions within the PPACA. This enhanced accountability would seem to further institutionalize or solidify the concept of a service ideal or orientation within the field. Though for-profit hospitals do not carry the same regulative expectations, ACHE's ethical code stipulates that all hospitals and hospital executives carry responsibilities to support health care access and meet community needs (ACHE, 2016).

Additionally, this orientation has appeared to become even further institutionalized through recent regulative and policy shifts. The Internal Revenue Service took a step toward increased accountability of community benefit participation through changes in reporting requirements in 2008. The 2010 PPACA included a stipulation that all tax-exempt hospitals must participate in community health needs assessments every three years (Young, Chou, Alexander, Lee, & Raver, 2013). Hospital administrators play key roles in the coordination and logistical implementation of such community-based efforts. The service obligations fall upon hospitals as organizations, rather than any particular individual within the organization. However, does the leadership of these efforts establish the hospital administrator occupation as being service-oriented? It is the hospital administrator's role, in conjunction with a board of directors and executive team, to set the strategic direction of the organization and meet the goals as outlined in the strategic plan. Therefore, efforts such as community needs assessments and other community engagement efforts would fall under the purview of the hospital administrator's responsibilities.

Before leaving this analysis of service orientation, it is important to discuss the concept of profit. Looking at the hospital administration occupation through Ritzer and Walczak's structural-functional lens allows us to identify stewardship of organizational resources as a key element of a hospital administrator's role. Both non-profit and for-profit hospitals require revenue in order to be successful in this highly competitive industry, and the administrator is ultimately the one responsible for financial outcomes. Does this preclude an occupation such as hospital administration from being termed a profession? Researchers appear to differ on this issue. The definition provided by Starr (1982, p. 15) at the beginning of this article suggests that a profession "has a service rather than profit orientation, enshrined in its code of ethics." Along these lines, Nosow and Form (1962, p. 199) maintain that conflict may emerge between service orientation and a market orientation: "one seeks to maximize service; the other seeks to maximize profit." On the other hand, Marshall (1962) believes that as long as the interests of the individual and service orientation are maintained, the essence of professionalism is preserved. Wilensky (1962, p. 10) supports this view by suggesting that "devotion to the client's interests more than personal or commercial profit should guide decisions when the two are in conflict." This appears to best describe the situation in terms of hospital administration. Hospitals, on a daily basis, provide care to individuals who are without financial means or health insurance. When the service and profit orientations collide, it does appear that the expectation is for the service ideal (sanctity of life) to prevail. Weil (2001, p. 89) reinforces this point by saying that "a code of ethics and professional policy statements underscore that decisions cannot be made solely based on economic criteria." As such, when balanced by a service orientation or ideal, it does not appear that the profit "factor" is a significant impediment in the way of hospital administration becoming a profession. Indeed, other classic professions (for example, the medical and legal professions) seem to engage in similar balancing acts.

Discussion

In a similar fashion to Wilensky (1962), the foregoing analysis does not provide adequate evidence that would allow one to place hospital administration alongside some of the more established or defined professions. The complexity of the health care field and organizations hospital administrators are tasked with operating, as well as the knowledge necessary to do so, would indicate that the occupation does belong somewhere on Ritzer and Walczak's (1986) continuum of professionalism. However, whether by design or not, there is little control over entry to the field of health care administration. Instead, the norm is to allow people to enter from a range of backgrounds, with more training and socialization into the occupation occurring through professional development and ongoing experience. This lack of gatekeeping weakens any argument for hospital administration as a profession. A substantial downside to this is the lesser voice hospital administrators, in comparison to physicians, nurses, or academics may have in regard to the ongoing debate in the field of health care. Without a defined identity as a profession, and therefore the ability to represent the occupation's interest in a cohesive and collective manner, administrators will have less influence in current and future discussions over policy and regulative changes.

Nevertheless, hospital administration remains a relatively young occupation, and it displays several traits or attributes that are frequently mentioned in the literature on professions. Perhaps, at this point in time, hospital administration is best labelled as a "semi-profession," which Etzioni (1969) describes as displaying some professional traits while also lacking other defining characteristics. Whether or not hospital administration will continue to move toward full designation as a profession or not depends greatly on the resolution of the following issues:

1. While ACHE exerts considerable control over validating the knowledge and competence of practising hospital administrators through its credentialing program, they exert minimal control over educational and entry requirements into the occupation. A well-developed profession will maintain collegial control over both sides of this coin, often in conjunction with appropriate authorities. It will be interesting to see if any inroads or advancements can be made in this area, particularly given the recent focus on the development of leadership competencies.
2. If the NCHL and other collective bodies make significant strides in the implementation of such competencies, hospital administration may move closer to creating its own specific knowledge base and distinctive task domain. On the other hand, a call (by Begun & Kaissi, 2004) to broaden the definition of health services administration to include other activities (such as health insurance, supply, and vendor organizations) beyond the administration of delivery organizations has been supported and embraced in the Final Report of the Blue Ribbon Task Force on Accreditation (Mick, 2004). Mick (2004) argues that the focus should remain narrow and specifically on the unique knowledge and training required to run health care delivery organizations. If the broader perspective prevails and becomes widely accepted throughout the industry, it is less likely that a specific task domain and unique knowledge base for health services administration in general, and hospital administration in particular, will ever be achieved.
3. A service ideal or orientation seems to be firmly entrenched in the field of hospital administration. Charity care and community initiatives abound in both the non-profit and for-profit hospital sectors, particularly in light of renewed emphasis on community-based efforts as a result of the PPACA. Ongoing public, regulatory, and political scrutiny should serve to further solidify and institutionalize this service ethic. Of course, future upheaval or transformation of the health care system as a result of

changing health care policies could alter the role or purpose of hospitals and hospital administrators alike. This could change the importance or relevance of this service orientation. Currently, the community service mission of hospitals and their need to balance a market (profit) orientation with a service orientation in order to achieve societal legitimization and support lend credence to the idea of hospital administrator as a profession.

One distinction worth noting is who is being represented by an individual's efforts. Physicians, teachers, nurses, and lawyers (all considered established professions) may work within organizations, but their functions are largely individualistic and pertain to the provision of specified services (Scott, 1982). Their professional identity and skillset extend beyond the organizational boundaries. Hospital administrators, however, work on behalf of an organization itself, which is indicative in the more public presence of AHA in comparison to ACHE. Administrators largely work to ensure that the organization that employs them is meeting its financial, social, and ethical obligations, rather than fulfilling a set of expectations at an individual level. This, perhaps, could be one difference between a profession and a professional: one is trained to serve a specialized role, and the other is trained to serve within a specialized environment. This contrast may be particularly pronounced when considering administrators who come from clinical backgrounds, who may very well retain their identity as a nurse or physician even when taking on the duties of an administrator.

At the same time, it is also important to note that the boundaries of defining a "profession" have become increasingly blurred in recent years. As many fields, including health care, have placed greater emphasis on interdisciplinary efforts, the more traditional structures of professions have faded somewhat (Fournier, 2000). Within hospitals, it is not uncommon for physicians or nurses to transition from clinical roles to managerial roles. In some ways, this harkens back to a long-standing struggle to define roles within hospitals, which have traditionally experienced a tug-of-war between physicians and managerial professionals over organizational control (Starr, 1982).

In sum, the hospital administration field continues to evolve and change. As health care laws have changed over the past decade, and as the debate about reform continues, depth of understanding of the health care field is becoming more and more valuable. Hospital administrators play an important role by accumulating this knowledge; however, the role lacks autonomy in that it represents the interests of the organization over the individual within it. This in itself is an institutionalized norm of the occupation, which is particularly evident in the political influence of AHA (which represents hospitals) and the lack of a public voice of ACHE (which represents the executives). Until hospital administrators are seen as authorities in their own right, the occupation is unlikely to be viewed as a profession.

It is also worth noting, however, that shifting political tides could actually contribute to de-professionalization of the occupation. As discussed above, the increasing complexity of the health care field and the necessity of building community relationships (the knowledge and service attributes, to refer back to Starr's terms) have perhaps moved hospital administration further along the continuum profession. If, over time, the United States chooses to implement a single-payer system, the nature of the administrative roles may change. A dominant governmental presence in the health care reimbursement system could negate the need for knowledge of concepts like managed care or community benefit requirements. Instead, hospitals may hire administrators with public affairs or governmental relations experience, redefining the occupation altogether and making many of the currently institutionalized norms irrelevant.

Regardless of the direction health policy moves in, it is important to periodically assess the occupation's standing in the light of key markers that tend to characterize

the most institutionalized professions in order to understand how it fits into this framework. Given the many benefits that accrue to occupations achieving societal designation as a profession, such an analysis is more than an academic exercise. Although the blurring of professional boundaries and roles makes defining a profession increasingly more challenging, critically considering the health administrator's role within the professional realm provides an opportunity to acknowledge professional priorities and identify the work and initiatives that remain to be done.

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