&PROFESSIONS
PROFESSIONALISM

Vol 8, No 2 (2018)

Table of Contents

Articles

&PROFESSIONS
PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), 2265 http://doi.org/10.7577/p2265

Margo Trappenburg and Mirko Noordegraaf

Fighting the Enemy Within? Challenging Minor Principles of Professionalism in Care and Welfare

Abstract: Wilensky's seminal article on professionals mentions three identifying characteristics besides the familiar specialized knowledge, autonomy and professional ideology. These are the referral principle, which states that professionals should refer clients to a colleague with a different specialty if necessary, the principle of sloughing off, which dictates that professionals allocate less rewarding parts of their job to lesser paid assistants, and the principle of impersonal service delivery, which admonishes professionals to treat clients equally. A changing clientele in health care and social care warrants a reappraisal of these three principles. Population ageing necessitates a reappraisal in health care. The deinstitutionalization of people with psychiatric or mental disabilities necessitates a reappraisal in social care. Referral, sloughing off and impersonal service delivery are professional characteristics that concur with managerial or political objectives. Managers and politicians are partly responsible for their widespread application. Hence, professionals need their help to fight this "enemy within professionalism."

Keywords: Professionalism, principles of professionalism, Wilensky, new public management, health care, social care

In 1964 Harold Wilensky wrote a famous article entitled "The Professionalization of Everyone?", in which he reflects on the way various occupational groups use their technical expertise and moral norms to acquire the status of the profession. Wilensky discusses different types of knowledge that may or may not further professionalization and looks at threats and barriers along the way. In this article, we will use Wilensky, but not to discuss the fate of occupational groups on their way to professional status. We found in Wilensky's article six implicit "principles of professionalism"—three major ones and three minor ones. These principles serve as hooks for our analysis in this article.

The three major principles, specialized knowledge, the service ideal and professional autonomy, are also identified in other classical studies in the sociology of professions (e.g. Freidson, 2001) and have inspired a large body of literature. Part of this literature investigates professionalism from a "rise and fall" perspective, discussing how one or more professions gained or lost professional status. Another part depicts professions from a "war and peace" perspective, analysing how marketization and managerialism threaten professional autonomy or the service ideal of one or another profession.

Margo Trappenburg,
Utrecht University,
Netherlands

Mirko Noordegraaf,
Utrecht University,
Netherlands

Contact:
Margo Trappenburg,
Utrecht University,
Netherlands
M.J.Trappenburg@uu.nl

Received:
15 Sept 2017

Accepted:
22 Jan 2017

The three minor principles are: the *referral* principle (“refer clients to more competent colleagues”), the *sloughing off* principle (“allocate less difficult parts of the job to other, lower-level personnel”), and the principle of *impersonal* service delivery (professionals should display “little personal and emotional involvement”). In contrast to the three major principles, these minor ones are not at odds with market principles, managerial ideals or political objectives. Both managerialism and marketization reinforce these implicit dimensions of professionalism. However, as the clientele in care and welfare changes, these three minor principles have adverse consequences that need to be addressed. Hence, we will advocate the weakening of referral, sloughing off and impersonal care. Care and welfare professionals, as well as managers and policymakers, should focus on these principles to rethink professional practice.

In this article, we first briefly discuss the three major principles and the “rise and fall” and “war and peace” traditions in scholarly thought. We then discuss Wilensky’s minor principles and show how they concur with managerial and political goals. After that, we outline the undesirable consequences of the three minor principles in present-day health care and social care. We also portray recent attempts to fight the deleterious consequences of referral, sloughing off and impersonal care. Finally, we will show why these attempts are fragile and difficult to sustain. We argue that the fight against the three minor principles should be a collective endeavour, to be undertaken by professionals, managers and policymakers, thus placing this article in the “peace” corner of the scholarly literature on professionals and managers.

Major principles of professionalism

The three defining major characteristics of professionalism in Wilensky (1964) are well-known to scholars of professionalism. Firstly, professionals have *specialized knowledge*. Secondly, professionals have a *service ideal*, an ethical code. Professionals do not seek to maximize profits; they use their knowledge to the benefit of their clients. Although critics have argued that the service ideal is a mere myth and that professionals are just as money-driven as everyone else (see, for example, Saks’, 2016 account of the critical theories of professions), Wilensky posits that professions discourage mercenary students when they first apply for a place in the profession. Their service ideal appears to be genuine.

Thirdly, if professions succeed in establishing a knowledge claim and a service ideal, they may accomplish a large degree of *professional autonomy.*[1] Because of their specialized knowledge doctors, lawyers, or accountants are presumably the only ones who can judge the competence of other doctors, lawyers, or accountants. And because of their service ideal, they can be trusted to do so with the benefit of their clients or patients in mind.

Rise and fall

A large number of studies since 1964 used the three defining characteristics to determine whether occupations had acquired the status of a profession. Medicine, law and accountancy are long acknowledged professions (see, for example, Abel, 2004; Bloomfield, 1988; Lee, 1995; Starr, 1982). Social work, nursing, and teaching never acquired as much status and privilege and are often characterized as semi-professions (Etzioni, 1969; Svensson & Åström, 2013; Toren, 1972; Weiss-Gal & Welbourne, 2008). Researchers also studied the professionalization of the military (Trim, 2003); nursing (Keogh, 1997); child and youth care (Clarijs, 2013; Lochhead, 2001) and the clergy (Schilderman, 2005).

---

[1] Wilensky refers to “professional control” or “jurisdiction” rather than autonomy.

Other studies analysed processes of de-professionalization (for example Brooks, 2011). Haug (1975) foresaw that patients would gather ever more medical knowledge and insight. Thus, they would no longer have to rely on their physician's judgement: they might diagnose their own medical needs. This development could make many professionals superfluous in the long run. Decades later, Harshman, Gilsinan, Fisher, and Yaeger (2005) studied the impact of the internet on professionalism. They argue that, on the one hand, the internet may empower clients by giving them access to specialized knowledge that used to be a professional monopoly; on the other hand, the internet offers imposters ways to pose as professionals, hollowing out the public's trust in professional expertise.

War and peace

Many studies in the "fall part" of the "rise and fall" literature simultaneously adopt a "war and peace" perspective. They identify a villain—usually the market, or new public management (NPM)—and subsequently describe the decline of professions, as a result of actions performed or developments caused by the villain at issue. Thus, Dwarswaard, Hilhorst, and Trappenburg (2011) argue that medical professional ethics (Wilensky's service ideal) has changed, because of market elements in the Dutch health care. Ackroyd (2013) studied the advent of NPM in the UK in health, housing, education and social work, hypothesizing that resistance would be greater in highly professionalized health care than in lowly professionalized housing. Rogowski (2010) and Ferguson (2008) witnessed a de-professionalization of social work in the UK with regard to professional autonomy and its service ideal, caused by the advent of neoliberalism. The emphasis on targets, organizational values and consumer input decreased social workers' autonomy and their commitment to their profession. Krizova (2008, p. 111) argues that a decline of professional autonomy due to marketization might cause "a decrease in altruistic or service-oriented attitudes toward patients." Diefenbach (2009, p. 897) claims that NPM causes greater cost-awareness among professionals, which leads to a "deletion of activities that are not profit-making." In a seminal book on professionalism, Freidson (2001) argues that the professional logic is inherently different from the logic of the market and the logic of the state (bureaucracy).

In this part of the "war and peace" literature, professionals are portrayed as "victims" of "evil forces." However, the war and peace literature has representatives of a different persuasion as well. These authors point out that the relationship between professionals and managers is not a battle between right and wrong. Rather, both parties are driven by large-scale societal developments, which they cannot ignore or resist. A few examples of societal developments allow us to get the drift of the peace part of the literature:

- People have become highly educated and individualized. They do not accept professional authority as they did in the past.
- Computer technology changes lay people's access to information and thereby their contacts with professionals.
- Women's participation in the labour market is growing; hence professional work needs to become less demanding, as it has to be combined with family obligations.

According to peace authors, professionals have to adapt to large-scale developments, and this requires managerial capacities (Brandsen & Honingh, 2013; Evetts, 2009; 2011; Noordegraaf, 2007; 2013). Moreover, according to these "shades of grey" authors, professionalism has never been perfect in the first place; hence, a certain amount of de-professionalization might prove beneficial.

Whereas the first group of the war and peace authors usually urge politicians and managers to retrace their steps and make room for professional autonomy, the second group tends to advocate a truce. Professionals should give in and cooperate with managers, so as to adapt to societal developments. Professional services, in the words of Noordegraaf (2013), should be "reconfigured, restratified, relocated, reorganized." Professionals, in the words of Evetts, must develop from "occupational professionals" to "organizational professionals" (Evetts, 2009; 2011). Professionals, in the words of Brandsen and Honingh (2013), need to organize in networks and develop networking skills. Professionals, in the words of Olakivi and Niska (2017), must draw from "a multiplicity of professional and managerial discourses."

These developments—the demise or reconfiguration of professionalism in relation to its major characteristics—have been discussed elsewhere (e.g., Carvalho, 2014; Duyvendak, Knijn, & Kremer, 2006; Noordegraaf & Steijn, 2013; Olakivi & Niska, 2017). In the next sections, we will look at Wilensky's minor principles and outline how they are affected by large-scale developments.

Minor principles of professionalism

The three minor characteristics are mentioned in passing, each in a different section of the 1964 article. The *referral principle*. Wilensky (1964, p. 141) is phrased as a command for professionals, essential for the maintenance of technical competence: "Be aware of the limited competence of your own specialty within the profession, honour the claims of other specialties, and be ready to refer clients to a more competent colleague."

The *sloughing off principle* (Wilensky, 1964) is described as a process that takes place while the profession seeks to define its core tasks:

> [a] pecking order of delegation occurs. The doctor allocates much of his job to less-trained nurses and laboratory and X-ray technicians; the nurses … allocate much of their less attractive work to practical nurses, aides, and nurse assistants; and these, in turn, allocate some of their chores to ward helpers. A similar tendency exists among all professional groups: dentists, teachers, engineers, scientists, and social workers, all of whom are … sloughing off their dirty work, that is, their less-technical or less-rewarding tasks. (Wilensky, 1964, p. 144)

Lastly, the principle of *impersonal service delivery* is described as a norm related to the service ideal:

> Supporting the service norm are several additional ideas which influence relations with clients and colleagues but which distinguish professional occupations in only minor degree. For instance, norms covering client relations dictate that the professional be impersonal and objective (limit the relationship to the technical task at hand, avoid emotional involvement) and impartial (not discriminate, give equal service regardless of personal sentiment). (Wilensky, 1964, p. 140)

Relevance and restrictions of minor principles

Neither of the three minor principles seems problematic for clients or citizens. If something is bothering you, you want to be helped by the right professional. If you happen to first meet someone whose field of expertise does not cover your illness, you will be glad that they will *refer* you to a professional with more expertise in the field. As for the *sloughing off* principle: although it might be attractive to be helped by just one professional, you understand that time is costly and that it is cost-effective to delegate easier tasks to the assistants of your professional. Regarding the norm of *impersonal and objective service delivery*: it seems reassuring that your professional will not refuse treatment because of your gender, your skin colour, or your personal morality. He does not care that you committed adultery, or behaved ill-mannered toward fellow drivers in rush hour traffic. Nor is the professional allowed to harbour feelings for you, be they disgust or sexual attraction. A proper professional simply considers the case at hand: your chance of winning your lawsuit, the evidence against you, your illness or your needs.

Thus, the minor professional characteristics concur with our preferences as clients and citizens. Below we will elaborate on how they relate to management objectives and political goals.

***Referral and the search for excellence**.* There is some tension between the referral principle and marketization. In the market, service providers defer from referring potential clients to the competition, even if competitors provide better services than they do ("you should try the grocery over there; they have much better vegetables"). However, real marketization seldom occurs in the public sector, despite all rhetoric admonishing politicians to run the government as a business (e.g., Beckett, 2000). The referral principle ties in with the quest for *quality* or *excellence* that steered the NPM movement alongside the search for efficiency (e.g., Clarke & Newman, 1997; Diefenbach, 2009).

The developments in the Dutch health care provide a telling example. In 2006, a new system was introduced. Citizens buy health insurance from private insurers. Private insurers negotiate with doctors and hospitals about the price and quality of healthcare provisions. Hence, doctors and hospitals compete for both patients' and insurers' attention. This might make them into competing "groceries," oblivious of the referral principle. However, the NPM approach in Dutch health care simultaneously emphasized transparency and high quality—or *excellent*—care: hospitals have to provide excellent brain surgery, excellent heart transplants, et cetera. This can only be accomplished if there are sufficient patients for doctors to keep their skills up-to-date and hospital facilities to accommodate this. Thus, care providers are encouraged to concentrate care in specialized hospitals, for heart surgery, paediatric oncology, neurological procedures, and so on. Patients are referred to specialized hospitals where they can get treatment from the best medical specialists.

Sloughing off and the search for efficiency. The sloughing off principle exists outside the world of professions as well. Political economist Braverman (1998[1974]) describes it in a treatise on labour and management. He calls it the Babbage principle (after Charles Babbage, inventor of the calculator). Companies wanting to make a profit, should divide their work in packages and leave easy tasks to lowly paid employees. Only complicated parts of the job should be entrusted to highly paid workers. According to Braverman (1998[1974]), the Babbage principle is also one of the building blocks of Taylor's scientific management. Taylor started his career as a factory worker and then was promoted to supervisor. He knew from experience that his former fellow workers could deliver more than they did, so he set out to maximize production. However, his workers fought him every step of the way. Taylor concluded that a manager should disempower his workers by cutting up their work in numerous tiny pieces, so it could be done by lowly paid workers from outside the factory (Braverman, 1998[1974]).

Gruening (2001) studied the origins of NPM. He thinks the NPM ideology consists of many building blocks including "the separation of provision and production" and "the separation between politics and administration." These building blocks are subsequently traced back to classical public administration in the Weberian style.

Sloughing off is not just a professional prerogative. It has economic foundations and a family resemblance to classical bureaucracies. Hence, it will not often be fought by managers and politicians.

Impersonal service and the search for objectivity. As for the last minor characteristic, objective, impersonal service delivery is a professional characteristic that seems to have been actively supported from the outside, for example, by strongly encouraging professional groups to draw up guidelines and protocols, ensuring uniformity, and objectivity. Impersonal service delivery ties in with higher values like transparency, neutrality and equality before the law.

The minor characteristics of professionalism do not seem to have enemies, neither within nor outside the professions. However, as will be shown in the next two sections, a changing population in care and welfare warrants a reappraisal of the minor principles in these two sectors. For each sector, we start with an anecdotal impression to get a feel for the changes that are taking place. These anecdotal impressions are inspired by sociological research, which will be discussed subsequently.

The minor principles in healthcare

In this section on health care, we describe the deleterious effects of the minor principles on an ageing population by drawing up two scenarios, backed by studies into changing populations, demographics and client needs (e.g., Bury & Taylor, 2008; Oliver, 2012; Plochg, Klazinga, & Starfield, 2009; Shipway et al., 2015). We used these studies to generate ideal-typical scenarios that show what goes on in client populations and how this affects care processes. The patient in the two scenarios has the same medical condition but belongs to a different age group. This changes the impact of referral, sloughing off and impersonal care. Subsequently, we provide background information on the effects of ageing in health care and give an impression of attempts to fight the minor principles.

Scenario 1: Age 40. Suppose you are in your early forties. You have an interesting job, a loving spouse and two children, 14 and 9 years old. Then, out of the blue, fate strikes a blow. You have colorectal cancer. Curing you will be difficult, says your doctor. First, you will need radiation to shrink a tumour. After that, a surgeon will remove the tumour, and you need chemotherapy to destroy any remaining cancer cells. The best hospital for colorectal cancer is a two-hour drive from your home, and you will be getting treatment for a whole year. At age forty, you go along with the treatment, because you want to be there when your children grow up. Your spouse needs you. You feel needed at work. Hence, you will fight. You are glad that your doctor referred you to his more competent colleagues in another part of the country. His adherence to the referral principle maximizes your chance of survival.

Once your treatment starts, you meet an impressive number of health professionals. You must go to the radiology unit five days per week for three weeks in a row, and you meet with—rough estimate—twelve different nurses. There are two appointments with a radiologist. After that, you are scheduled for a meeting at the anaesthesiology department where a junior doctor determines whether your body is fit for surgery. The surgeon in charge of your operation explains the procedure. Many people are involved in the actual surgery. There is a whole bunch of faces gazing down at you as you count back from twenty to glide into unconsciousness at 13. Afterwards, the surgeon takes an occasional look at you. Nurses come in to check on you. The next phase is chemotherapy. Again, different doctors, different nurses.

You probably meet one hundred different professionals during treatment. Some are warm and caring and inquire after your children. Sometimes you appreciate this approach. At other times, you prefer the business-like attitude of the less caring professionals, because you do not want to be emotional all the time. But none of all that is terribly important. What matters is that you get well in the end.

In your early forties, you appreciate the referral principle, you do not care about the sloughing off principle, and you do not mind or appreciate the principle of impersonal service delivery.

Scenario 2: Age 83. Suppose you are in your early eighties. You are retired. Your wife is recovering from a stroke. You help her talk again by practising words. She still feels insecure and is glad to lean on your arm when walking the dog. Your son lives nearby and visits you often. Your daughter and her family live on the other side of the country. Then after your wife's stroke—fate strikes another blow. You have colorectal cancer. Curing you will be difficult, says your doctor. You need radiation to shrink the tumour. After that, a surgeon will remove the tumour and then you need chemotherapy to get rid of any remaining cancer cells. The best hospital for your type of cancer is a two-hour drive from your home, and you will be getting treatment for a whole year.

At eighty-three, this prospect sounds totally different. A two-hour drive is a logistical nightmare. Can you leave your wife alone for that long over such a long period? Seeing one hundred different physicians, nurses and nursing assistants in the course of a year will not be easy either at eighty-three. One whole year of medical treatment no longer sounds like a dreadful episode from which you will eventually recover. At eighty-three, your medical history will become—as surgeon Atul Gawande (2014) vividly writes—one damn thing after another. In the future, there may be arthritis, diabetes, sight problems, another stroke, or Alzheimer's disease for yourself, your spouse or both of you. From a medical perspective, it may seem wise to consult the best hospital for colorectal cancer, but from a more mundane perspective, the referral principle does not look sensible at all. You prefer to be treated in an average nearby clinic. You might die of colorectal cancer, but at eighty-three dying is no longer a tragedy (Callahan, 1987). You have had a good life. Your children have lives of their own. Your working days are over. You know the pleasure of becoming a grandparent. Surviving colorectal cancer is no longer overwhelmingly important. Being referred to the best medical specialist for your wife's stroke, the best hospital for your colorectal cancer, or any other condition, no longer seems the best way forward. You are better off with a doctor who knows your medical history, who can see how treatment would impact your life. You do not want a referral and sloughing off. Nor do you want impersonal service delivery. At eighty-three, you want a professional who sees the bigger picture and takes your personal situation into consideration.

Prevalence of scenarios. In the near future, the second scenario will be increasingly common. Marengoni et al. (2011) carried out a meta-review on the prevalence of multi-morbidity (the presence of two or more chronic medical conditions in an individual). Among older persons (differently defined) they found percentages varying from 55 to 98 percent. Several studies observe that clinical practice guidelines are usually geared at patients suffering from one medical condition. They do not take into account that treatments for one condition may conflict with medications prescribed for another ailment (e.g., Boyd et al., 2005; Campbell-Scherer, 2010; Hughes, McMurdo, & Guthrie, 2013; Lugtenberg, Burgers, Clancy, Westert, & Schneider, 2011; Mutasingwa, Hong, & Upshur, 2011).

Fried, Tinetti, and Iannone (2011) did a focus group study among primary care clinicians and found that clinicians worry about the detrimental effects of guidelines on patients with multi-morbidity. They conclude that doctors must pay more attention to their patients' priorities and find ways to reconcile these with the clinical guidelines. Likewise, Boyd et al. (2005) suggest that doctors should try to incorporate patients' short and long-term goals in their treatment plans. The Dutch association for medical specialists (Dutch Association for Medical Specialists, 2015) published a mission statement advocating integrated care rather than ongoing specialization, arguing that, "sensible care for a 50-year old is not always the same as sensible care for an 80-year old." Similar pleas for integrated care are discussed by Plochg, Klazinga, and Starfield (2009), Oliver (2012) and Nolte and McKee (2008). These attempts to accomplish integrated care may be seen as attempts to diminish the relevance of Wilensky's minor principles in health care.

The minor principles in social care

In this section on social care we describe the deleterious effects of the minor principles on the changing population in social care by drawing up two scenarios, again backed by studies on changing client needs (e.g., Millett et al., 2016; Mowbray et al., 2005, Parish & Lutwick, 2005; Robinson, Dauenhauer, Bishop, & Baxter, 2012; Spratt, 2011; Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016). The first portrays a patient with a mental disability in the nineteen fifties. The second describes the life of people with a mental disability in the 21st century. Obviously, between the 1950s and 2017, the second scenario has become increasingly common, as we will show in the background section after the scenarios. After that, we will give a brief impression of the attempts to fight the minor principles in social care.

Scenario 1: 1950s. In 1950 Pearl Buck (1992[1950]), a Nobel prize-winning American novelist, published a moving book about her mentally retarded daughter Carol. After struggling with the grief that her daughter would never grow up, she embarked on a quest to find her daughter a place to live. In the end, she found a high-quality institute and left her nine-year-old daughter in the care of professionals, who taught her what little she could grasp, and made her life as safe and comfortable as possible. Carol would never marry or have children. Her life was perhaps agreeable, but very limited.

Scenario 2: 2010s. Jim is mentally retarded. At age 18, he meets 22-year-old Sharon. They fall in love and move in together. They have an apartment in an ordinary neighbourhood. Sharon gets pregnant very fast. She has mental retardation too; it is difficult for her and Jim to take care of their child. Fortunately, there is a lady from social services who drops by once a week, to see how the toddler is doing. Unfortunately, Sharon is now expecting their second child, which will make matters even more complicated. Jim used to have a (subsidized) job at the supermarket but was fired a year ago. Once a month Jim has to report to the welfare agency, where a social worker helps him—in vain so far—find a new job. Jim uses marihuana on a daily basis. The social worker at the welfare agency has referred him to a special clinic for substance abuse. Jim is supposed to go there twice a week, but regularly misses appointments.

Jim and Sharon also have financial problems. The social worker at the welfare agency has given Jim a card with a phone number. Apparently, there is an agency in town where specialized social workers know all about debts and the legal difficulties they entail. Jim should pick up the phone and make an appointment. Jim has dialled the number once, but then they put him on hold, and he ended the conversation. As the children of Jim and Sharon grow older, many more professionals will enter their lives. The chances are that the problems will prove hereditary and that the children need therapy for behavioural disorders or extra tuition because of learning disabilities.

Prevalence of scenarios. In the 1950s, many people with mental retardation or a severe chronic psychiatric condition spent their lives in large-scale institutions. Social workers who were employed outside those institutions catered for easier clients: many were poor, some had marital difficulties, others struggled with their religious beliefs, yet others were coping with substance abuse. Often some of these problems went together, but the Jim and Sharon scenario was rare.

From the nineteen-eighties onward, social work underwent a process of specialization. Social workers either specialized in specific clients (women, people with an immigrant background, youngsters), or in specific problems (relationships, debts, substance abuse) (Blom, 2004). This—in terms of Wilensky's minor characteristics—ample use of the referral principle was intensified by NPM inspired government policies that aimed at specialized agencies, producing tangible results (Ferguson, 2008; Rogowski, 2010).

Simultaneously, people with mental retardations and people with a chronic psychiatric condition were deinstitutionalized. Large institutions were discredited for making people overly dependent and seriously curtailing their chance to lead a full life. Hence, all over the globe deinstitutionalization was the way forward (Becker & Kilian, 2006; Fakhoury & Priebe, 2007; Novella, 2010) Although this process was usually acclaimed by patients, policymakers and professional carers, it raised new problems as well. People with mental retardations and people with a chronic psychiatric condition need help in many areas of life. Some struggle with health problems or substance abuse, because they do not take proper care of themselves (Salokangas, 2007; Slayter, 2010; Schmetzer, 2007). Many feel isolated and lonely (Amado, Stancliffe, McCarron, & McCallion, 2013; Asselt-Goverts, van Embregts, Hendriks, Wegman, & Teunisse, 2015; Forrester-Jones et al., 2006; Hall & Hewson, 2006). A relatively large number are sentenced to prison (Gostin, 2008; Wallace, Mullen, & Burgess, 2004).

Thus, social work has to cater for a changing clientele consisting of multi-problem individuals and multi-problem families. This changing clientele does not benefit from the referral principle since that would entail the help of numerous different professionals, each with an adjacent, yet slightly different specialty. It creates havoc for these clients if professionals slough off the less interesting bits of their job to lesser trained and lesser paid aides. Vulnerable people like Jim and Sharon would probably be better off with one all-round social worker, who could take charge of all of their problems simultaneously.

The same goes for the principle of impersonal service delivery. People like Jim and Sharon do not need to be treated like any other citizen who applies for an unemployment allowance, help with substance abuse or remedial teaching for her child. They need professionals who look at the bigger picture, taking into account the mental retardation, the debts, the addiction and the well-being of the children, whether or not this is stated in guidelines or protocols.

Like health care professionals, social workers and the policymakers who enable their work, attempt to fight Wilensky's minor characteristics. In Sweden, Norway, and the Netherlands, specialized social workers have been partially replaced by neighbourhood teams that embody a "one-stop shop" approach (Arum & Schoorl 2015; Blom, 2004; Kok & Briels 2014; Røysum, 2013). These neighbourhood teams are supposed to deal with the many problems that plague their clients in coherence.

Minor principles in the context

The minor characteristics of professionalism have negative consequences in health care and in social work. It is important to keep in mind that their impact is reinforced by managerial and organizational policies. Accountability and registration systems often foster performance and efficiency over integrated care. Hence, the initiatives to roll back the minor characteristics are fragile. Professionals, managers, policymakers and politicians need to realize this. In this last section, we will discuss four reasons why it will be difficult to sustain the attempts to reduce the effects of referral, sloughing off and objective, impersonal care.

A "fight" against a worthy enemy is an uphill battle. If we look at the initiatives to fight the minor principles from the rise and fall perspective, described in Section

2, they may be interpreted as a form of de-professionalization. Professionals derive their status from specialized knowledge. Heart transplants, chemotherapies and radiation undoubtedly qualify as such. Integrated care for elderly patients suffering from multi-morbidity, often consists of talking to the patient, after which patient and doctor together decide to opt for a policy of "medical abstinence." This seems much more like common sense than surgery or radiation. General practitioners used to be "talkers" in the fifties and sixties, but it made them feel inferior to their specialist hospital-based colleagues; they wanted to be "proper doctors" (Dwarswaard, 2011). Thus, they embraced guidelines and protocols and committed themselves to evidence-based medicine. This development concurred with NPM principles, since NPM emphasizes measurable results, and evidence-based medicine delivers just that. A development in the opposite direction, away from evidence-based guidelines and protocols; back to talking and individualized care, might happen at the expense of professional status but is also at odds with policymakers' belief in NPM principles.

A similar dilemma can be detected in social care. Social workers used to be talkers and doers in the fifties and sixties; they lacked evidence-based methods and shied away from doing research. This lack of scientific rigour was heavily criticized in the nineteen seventies both from within and from outside the profession. Thus, social workers tried to develop science-based methods, preferably systematically tested and evidence-based (Otto, Polutta, & Ziegler, 2009). The move toward evidence-based practice in social work was strongly encouraged by NPM ideas. Hence, criticizing and fighting the minor characteristics of professionalism is difficult, because it defers from the earlier chosen route toward professionalism, strongly backed up by politicians and policymakers.

A "fight" that saves money might lose professional support. There is a second reason why the fight against the minor characteristics is vulnerable. It does not deliver impressive results. Ailing octogenarians will remain fragile and die. Families like Jim and Sharon and their children will hardly ever become financially independent. The chances are that they can never do without help (with or without a referral, sloughing off and impersonal care). Thus, politicians and policymakers might be inclined to emphasize other effects of the fight against referral and sloughing off, notably a reduction of costs. Although the fight against the minor characteristics might indeed save money, touting this too much might give citizens the impression that "we no longer spend money on hopeless cases as they are hopeless anyway." This might make professionals abandon the project altogether and fall back on their usual routines.

Losing a battle means losing the war. The third reason why the development is vulnerable is that some things are bound to go wrong. The generalist medical doctor catering for elderly patients might misdiagnose one of them and opt for watchful waiting when a timely intervention in a specialized hospital might have led to a number of extra years in good health. The one social worker who oversees the Jim and Sharon household might miss something crucial (indications of child abuse, lingering depression, criminal activities). The professional at issue might feel guilty and might fall back on the referral principle: "I should have referred to my colleague who knows about this particular problem." This effect might be even stronger if politicians, as they are tempted to do, give in to a phenomenon known as the "risk regulation reflex", in other words, the tendency to take measures and change policies after an incident has happened (Trappenburg & Schiffelers, 2012).

The "fight" may be perceived as ageist and stigmatizing. The last reason why the fight against Wilensky's minor principles is vulnerable is that this is a move that should only be applied to parts of the population, especially clients whose situations are too varied to approach them with generic (technical) programs. It is important to acknowledge that integrated care is not optimal-service-delivery-plus-personal-attention. Non-specialized care is suboptimal care for many people in many cases. The forty-something colorectal patient described in Section 4 needs referral and objective, impersonal service delivery. Parents who merely need help because their child has a learning disability may seek a remedial teacher who specializes in dyslexia. It is just the fragile elderly and the multi-problem Jim-and-Sharons for whom the normal logic of professionalism no longer applies. This may be perceived as stigmatizing by outsiders but also by family members or representatives of fragile elderly and people with disabilities.

Conclusion

Diminishing the impact of referral, sloughing off and objective, impersonal care is necessary to address the medical needs of an elderly population and the needs of vulnerable people living in a difficult modern world. Professionals can take the lead in this project, as they can see the adverse consequences of the minor principles for large parts of their clientele. However, they cannot do this alone. This is an endeavour that requires careful steering and help from managers and policymakers. Future research might help in showing ways forward and identifying pitfalls and dilemmas. A concerted effort by all might help us criticize and fight the enemy inside professionalism.

References

Abel, R. L. (2004). *English lawyers between market and state: The politics of professionalism.* Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198260349.001.0001

Ackroyd, S. (2013). Professions, professionals and the "new" government policies: A reflection on the last 30 years. In Noordegraaf, M. & B. Steijn (Eds.), *Professionals under pressure: The reconfiguration of professional work in changing public services* (pp. 21–39). Amsterdam: Amsterdam University Press.

Amado, A. N., Stancliffe R. J., McCarron, M., & McCallion, P. (2013). Social inclusion and community participation of individuals with intellectual/developmental disabilities. *Intellectual and developmental disabilities, 51*(5), 360–375. https://doi.org/10.1352/1934-9556-51.5.360

Arum, S., & Schoorl, R. (2015). *Sociale (wijk)teams in beeld—Stand van zaken na de decentralisaties* [A view on the social district teams—the state of affairs after the decentralisations]. Utrecht: Movisie.

Asselt-Goverts, A. E., van Embregts, P. J. C. M., Hendriks, A. H. C., Wegman, K., & Teunisse, J. P. W. M. (2015). Do social networks differ? Comparison of the social networks of people with intellectual disabilities, people with autism spectrum disorders and other people living in the community. *Journal of Autism and Developmental Disorders, 45*(5), 1191–1203. https://doi.org/10.1007/s10803-014-2279-3

Becker, T., & Kilian, R. (2006). Psychiatric services for people with severe mental illness across western Europe: What can be generalized from current knowledge about differences in provision, costs and outcomes of mental health care? *Acta Psychiatrica Scandinavica, 113*(429), 9–16. https://doi.org/10.1111/j.1600-0447.2005.00711.x

Beckett, J. (2000). The “government should run like a business” mantra. *The American Review of Public Administration, 30*(2), 185–204. https://doi.org/10.1177/02750740022064623

Blom, B. (2004). Specialization in social work practice—Effects on interventions in the personal social services. *Journal of Social Work, 4*(1), 25–46. https://doi.org/10.1177/1468017304042419

Bloomfield, M. H. (1988). Law: The development of a profession. In N. O. Hatch (Ed.), *The professions in American history* (pp. 33–50). Notre Dame: Notre Dame University Press.

Boyd, C. M., Darer, J., Boult, C., Fried, L. P., Boult, L., & Wu, A.W. (2005). Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases—Implications for pay for performance. *Journal of the American Medical Association, 294*(6), 716–724. https://doi.org/10.1001/jama.294.6.716

Brandsen, T., & Honingh, M. (2013). Professionals and shifts in governance. *International Journal of Public Administration, 36*(12), 876–883. https://doi.org/10.1080/01900692.2013.798809

Braverman, H. (1998[1974]). *Labor and monopoly capital.* Canada: Monthly Review.

Brooks, R. (2011). *Cheaper by the hour—Temporary lawyers and the de-professionalization of the law*. Philadelphia: Temple University Press.

Buck, P. S. (1992[1950]). *The child who never grew*. Bethesda: Woodbine House.

Bury, M., & Taylor D. (2008). Towards a theory of care transition: from medical dominance to managed consumerism, *Social Theory & Health, 6*(3), 201–219. http://dx.doi.org/10.1057/sth.2008.9

Callahan, D. (1987). *Setting limits—Medical goals in an aging society.* New York: Simon and Schuster.

Campbell-Scherer, D. (2010). Multimorbidity: A challenge for evidence-based medicine. *Evidence-Based Medicine, 15*(6), 165–166. https://doi.org/10.1136/ebm1154

Carvalho, T. (2014). Changing connections between professionalism and managerialism: A case study of nursing in Portugal. *Journal of Professions and Organizations, 1*(2), 176–190. https://doi.org/10.1093/jpo/jou004

Clarijs, R. (2013). *Tirannie in de jeugdzorg—Een onderzoek naar de mogelijkheden van beleidsveranderingen* [Tiranny in child care services—A study into the possibilities of policy changes]. Amsterdam: SWP.

Clarke, J., & Newman, J. (1997). *The managerial state. Power, politics and ideology in the remaking of social welfare*. London: Sage Publications.

Diefenbach, T. (2009). New public management in public sector organizations—The dark sides of managerialistic “enlightenment”. *Public Administration, 87*(4), 892–909. https://doi.org/10.1111/j.1467-9299.2009.01766.x

Dutch Association for Medical Specialists. (2015). *Visiedocument—De medisch specialist 2015* [Position paper—The medical specialist 2015]. Retrieved from http://www.demedischspecialist.nl/sites/default/files/Visiedocument-De-Medisch-Specialist0-2015.pdf

Duyvendak J. W., Knijn, T., & Kremer, M. (Eds.) (2006). *Policy, people, and the new professional: De-professionalization and re-professionalization in care and welfare.* Amsterdam: Amsterdam University Press. https://doi.org/10.5117/9789053568859

Dwarswaard, J., Hilhorst, M., & Trappenburg, M. J. (2011). The doctor and the market: About the influence of market reforms on the medical professional ethics of surgeons and general practitioners in the Netherlands. *Health Care Analysis, 19*(4), 388–402. https://doi.org/10.1007/s10728-011-0166-z

Dwarswaard, J. (2011). *De dokter en de tijdgeest—Een halve eeuw van veranderingen in de beroepsethiek van huisartsen en chirurgen* [Doctors in changing times—Half a century of change in the professional ethics of surgeons and general practitioners]. Den Haag: Boom/Lemma.

Etzioni, A. (Ed.). (1969). *The semi professions and their organizations*. New York: Free Press.

Evetts, J. (2009). New professionalism and New Public Management: changes, continuities and consequences. *Comparative Sociology, 8*(2), 247–266. https://doi.org/10.1163/156913309X421655

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406–422. https://doi.org/10.1177/0011392111402585

Fakhoury, W., & Priebe, S. (2007). Deinstitutionalisation and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry, 6*(8), 313–316. https://doi.org/10.1016/j.mppsy.2007.05.008

Ferguson, I. (2008). *Reclaiming social work: Challenging neo-liberalism and promoting social justice.* London: Sage Publications.

Forrester-Jones, R., Carpenter, J., Coolen-Schrijner, P., Cambridge, P., Tate, A., Hallam, A., … Wooff, D. (2006). Good friends are hard to find? The social networks of people with intellectual disability living in the community 12 years after resettlement from long-stay hospitals. *Journal of Applied Research in Intellectual Disabilities, 19*(4), 285–295. https://doi.org/10.1111/j.1468-3148.2006.00263.x

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

Fried, T. R., Tinetti, M. E., & Iannone, L. (2011). Primary care clinicians' experiences with treatment decision making for older persons with multiple conditions. *Archives of Internal Medicine, 171*(1), 75–80. https://doi.org/10.1001/archinternmed.2010.318

Gawande, A. (2014). *Being mortal: Medicine and what matters in the end.* New York: Metropolitan Books.

Gostin, L. O. (2008). "Old" and "new" institutions for persons with mental illness: treatment, punishment or preventive confinement? *Public Health, 122*(9), 906–913. https://doi.org/10.1016/j.puhe.2007.11.003

Gruening, G. (2001). Origin and theoretical basis of New Public Management. *International Public Management Journal, 4*(1), 1–25. https://doi.org/10.1016/S1096-7494(01)00041-1

Hall, L., & Hewson, S. (2006). The community links of a sample of people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 19*(2), 204–207. https://doi.org/10.1111/j.1468-3148.2005.00249.x

Harshman, E. M., Gilsinan, J. F., Fisher, J. E., & Yaeger, F C. (2005). Professional ethics in a virtual world: The impact of the internet on traditional notions of professionalism. *Journal of Business Ethics, 58*(1–3), 227–236. https://doi.org/10.1007/s10551-005-1417-4

Haug, M. (1975). The deprofessionalization of everyone. *Sociological Focus, 8*(3), 197–213. https://doi.org/10.1080/00380237.1975.10570899

Hughes, L. D., McMurdo, M. E., & Guthrie, B. (2013). Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity. *Age and Ageing, 42*(1), 62–69. https://doi.org/10.1093/ageing/afs100

Keogh, J. (1997). Professionalization of nursing: Development, difficulties and solutions. *Journal of Advanced Nursing, 25*(2), 302–308. https://doi.org/10.1046/j.1365-2648.1997.1997025302.x

Kok, E., & Briels, B. (2014). *Evaluaties van sociale wijkteams—Inventarisatie van afgesloten onderzoeken van sociale wijkteams* [Evaluations of social district teams—An inventory of completed studies of social district teams]. Utrecht: Movisie.

Krizova, E. (2008). Marketization of health care and changes in the professional status of the medical profession. In N. E. H. M. Zeegers & H. E. Bröring (Eds.), *Professions under pressure: Lawyers and doctors between profit and public interest* (pp. 99–111). Den Haag: Boom Juridische Uitgevers.

Lee, T. (1995). The professionalization of accountancy. *Accounting, Auditing & Accountability Journal, 8*(4), 48–69. https://doi.org/10.1108/09513579510100725

Lochhead, A. (2001). Reflecting on professionalization in child and youth care. *Child and Youth Care Forum, 30*(2), 73–82. https://doi.org/10.1023/A:1011677117810

Lugtenberg, M., Burgers, J. S., Clancy, C., Westert, G. P., & Schneider, E. C. (2011). Current guidelines have limited applicability to patients with comorbid conditions: A systematic analysis of evidence-based guidelines. *PLoS One, 6*(10), e25987. https://doi.org/10.1371/journal.pone.0025987

Marengoni, A., Angleman, S., Melis, R., Mangialasche, F., Karp, A., Garmen, A., … Fratiglioni, L. (2011). Aging with multimorbidity: A systematic review of the literature. *Ageing Research Reviews, 10*(4), 430–439. https://doi.org/10.1016/j.arr.2011.03.003

Millett, L. S., Ben-David, V., Jonson-Reid, M., Echele, G., Moussette, P., & Atkins, V. (2016). Understanding change among multi-problem families: learning from a formative program assessment. *Evaluation and Program Planning, 58*, 176–183. https://doi.org/10.1016/j.evalprogplan.2016.06.010

Mowbray, C. T., Collins, M. E., Bellamy, C. D., MeGivern, D. A., Bybee, D., & Szilvagyi, S. (2005). Supported education for adults with psychiatric disabilities: an innovation for social work and psychosocial rehabilitation practice. *Social Work, 50*(1), 7–20. https://doi.org/10.1093/sw/50.1.7

Mutasingwa, D. R., Hong, G., & Upshur, R. E. G. (2011). How applicable are clinical practice guidelines to elderly patients with comorbidities? *Canadian Family Physician, 57*, 253–62

Nolte, E., & McKee, C. M. (2008). Integration and chronic care: A review. In E. Nolte & C. M. McKee (Eds.), *Caring for people with chronic conditions: A health system perspective* (pp. 64–91). London: European Observatory on Health Systems and Policies Series.

Noordegraaf, N. (2007). From “pure” to “hybrid” professionalism: Present-day professionalism in ambiguous public domains. *Administration & Society, 39*(6), 761–785. https://doi.org/10.1177/0095399707304434

Noordegraaf, N. (2013). Reconfiguring professional work: Changing forms of professionalism in public services. *Administration & Society, 20*(5), 1–28.

Noordegraaf, N., & Steijn, B (Eds.). (2013). *Professionals under pressure. The reconfiguration of professional work in changing public services.* Amsterdam: Amsterdam University Press.

Novella, E. J. (2010). Mental health care in the aftermath of deinstitutionalisation: a retrospective and prospective view. *Health Care Analysis, 18*(3), 222–238. https://doi.org/10.1007/s10728-009-0138-8

Olakivi, A., & Niska, M. (2017). Rethinking managerialism in professional work: from competing logics to overlapping discourses. *Journal of Professions and Organization, 4,* 20–35.

Oliver, D. (2012). Transforming care for older people in hospital: Physicians must embrace the challenge. *Clinical Medicine, 12*(3), 230–234. https://doi.org/10.7861/clinmedicine.12-3-230

Otto, H., Polutta, A., & Ziegler, H. (Eds.). (2009). *Evidence-based practice-Modernizing the knowledge base of social work?* Farmington Hills, MI: Barbara Budrich.

Parish, S. L., & Lutwick, Z. E. (2005). A critical analysis of the emerging crisis in long-term care for people with developmental disabilities. *Social Work, 50*(4), 345–354. https://doi.org/10.1093/sw/50.4.345

Plochg, T., Klazinga, N. S., & Starfield, B. (2009). Transforming medical professionalism to fit changing health needs. *BMC Medicine, 7*(64), 1–7. https://doi.org/10.1186/1741-7015-7-64

Robinson, L. M., Dauenhauer, J., Bishop, K. M., & Baxter. J. (2012). Growing health disparities for persons who are aging with intellectual and developmental disabilities: the social work linchpin. *Journal of Gerontological Social Work, 55*(2), 175–190. https://doi.org/10.1080/01634372.2011.644030

Rogowski, S. (2010). *Social work: The rise and fall of a profession.* Bristol: Policy Press.

Røysum, A. (2013). The reform of the welfare services in Norway: One office—one way of thinking? *European Jnl of Social Work, 16*(5), 708–725. http://dx.doi.org/10.1080/13691457.2012.722982

Saks, M. (2016). A review of theories of professions, organizations and society: the case for neo-Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organizations, 3*, 170–187. https://doi.org/10.1093/jpo/jow005

Salokangas, R. K. R. (2007). Medical problems in schizophrenia patients living in the community (alternative facilities). *Current opinions in psychiatry, 20*(4), 402–405. https://doi.org/10.1097/YCO.0b013e328122d99b

Schilderman, H. (2005). *Religion as a profession.* Leiden: Brill.

Schmetzer, A. D. (2007). Deinstitutionalisation and dual diagnosis. *Journal of Dual Diagnosis, 3*(2), 95–102. https://doi.org/10.1300/J374v03n02_11

Shipway, D. J. H., Partridge, J. S. L., Foxton, C. R., Modarai, B., Gossage, J. A., Challacombe, B. J. … Dhesi, J. K. (2015). Do surgical trainees believe they are adequately trained to manage the ageing population? A UK survey of knowledge and beliefs in surgical trainees. *Journal of Surgical Education, 72*(4), 641–647. https://doi.org/10.1016/j.jsurg.2015.01.019

Slayter, E. M. (2010). Disparities in access to substance abuse treatment among people with intellectual disabilities and serious mental illness. *Health & Social Work, 35*(1), 48–60. https://doi.org/10.1016/j.ridd.2012.02.009

Spratt, T. (2011). Families with multiple problems: Some challenges in identifying and providing services to those experiencing adversities across the life course. *Journal of Social Work, 11*(4), 343–357. https://doi.org/10.1177/1468017310379256

Starr, P. (1982). *The social transformation of American medicine.* New York: Basic Books.

Svensson, K., & Åström, K. (2013). The field of social regulation: How the state creates a profession. *Professions & Professionalism, 3*(2). https://doi.org/10.7577/pp.557

Toren, N. (1972). *Social work: The case of a semi-profession.* Beverly Hills/London: Sage Publication.

Tausendfreund, T., Knot-Dickscheit, J, Schulze, G. C., Knorth, E. J., &. Grietens, H. (2016). Families in multi-problem situations: Backgrounds, characteristics and care services. *Child & Youth Services, 37*(1), 4–22. https://doi.org/10.1080/0145935X.2015.1052133

Trappenburg, M. J., & Schiffelers, M. J. (2012). How to escape the vicious circle: the challenges of the risk regulation reflex. *European Journal of Risk Regulation, 3*(3), 283–291. https://doi.org/10.1017/S1867299X00002191

Trim, D. J. B. (Ed.) (2003). *The chivalric ethos and the development of military professionalism.* Leiden: Brill.

Wallace, C., Mullen, P. E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. *American Journal of Psychiatry, 161*(4), 716–722. https://doi.org/10.1176/appi.ajp.161.4.716

Weiss-Gal, I., & Welbourne, P. (2008). The professionalization of social work: A cross-national exploration. *International Journal of Social Welfare, 17*(4), 281–290. https://doi.org/10.1111/j.1468-2397.2008.00574.x

Wilensky, H. L. (1964). The professionalization of everyone. *American Journal of Sociology, 70*(2), 137–158. https://doi.org/10.1086/223790

& PROFESSIONS PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), e2381 http://doi.org/10.7577/p 2381

Nanna Mik-Meyer

Organizational Professionalism: Social Workers Negotiating Tools of NPM

Abstract: This article examines how social workers and managers perceive meaningful work and expertise in six care and treatment facilities in Denmark. Based on 29 interviews with social workers (n=22) and managers (n=7), the article shows how New Public Management-inspired tools such as scoring schemas align with social work values such as "client-centeredness" and working with the individual welfare recipient face-to-face. The article finds that fitting social work into organizational schemas changes the work practices of social workers and also the way members of this profession define meaningful work and expertise. In addition, the article also finds that scoring schemas cause conflicts among social workers regarding the character of expertise when values of social work (to meet a welfare recipient's need) must be aligned with NPM-inspired values of organizations (to meet managers' demand for documentation).

Keywords: Expertise, NPM, organizational professionalism, organizational scoring schemas, professions, social work

Since the late 1980s, European welfare states have undergone substantial changes concerning their objectives, areas of intervention and instruments of use (Bonoli & Natalie, 2012; Clarke, 2004). Public organizations are no longer primarily characterised by the classic traits of bureaucracy, for instance, routine-based office work and standardised administrative procedures (Sturdy, Wright, & Wylie, 2016). Public organizations have incorporated new systems of management, such as performance management, manual-based practices, New Public Management (NPM), scoring schemas, and other tools. These tools aim to provide high quality and effective work. A so-called managerial discourse has entered social work organizations (Banks, 2013; Clarke, 1996; Farrell & Morris, 2003; McDonald, Postle, & Dawson, 2008; Rogowski, 2010; Roysum, 2013; Shanks, Lundström, & Wiklund, 2015) as well as nursing practices (Carvalho, 2014; Debesay, Harsløf, Rechel, & Vike, 2014; Newman & Lawler, 2009) and doctors' work (Benish, 2014). Within the field of social work, research shows how a managerial discourse has suppressed classic social work values such as placing the welfare recipient at the centre of the work (Clarke, 1996; Ferguson, 2009) as well as focusing on the needs of the client (Rogowski, 2010).

The current study adds to this strand of research by investigating how social workers in their everyday work life manage organizational scoring schemas in care and treatment facilities housing vulnerable clients. The research question of the article is following: how do social workers perceive meaningful work and expertise in care and treatment facilities and how does this assessment relate to the increased

Nanna Mik-Meyer,
Copenhagen
Business School,
Denmark

Contact:
Nanna Mik-Meyer,
Copenhagen
Business School,
Denmark
nmm.ioa@cbs.dk

Received:
10 Nov 2017

Accepted:
17 April 2018

influence of organizational scoring schemas and tables?

Negotiating meaningful work and expertise in social work organizations

Some scholars argue that modern organizations are "Kafkaesque" because they operate on a logic that integrates very different rationales (Hodson, Martin, Lopez, & Roscigno, 2012). This unusual description pinpoints the fact that professionals are simultaneously held accountable according to values stemming from both their disciplinary background and according to bureaucratic and NPM-tools such as scoring schemas. According to Hodson and colleagues (2012), the co-existence of these different values may result in "chaos" in modern organizations (see also Mik-Meyer, 2017). For instance, is social workers' expertise to be measured against their ability to meet the demands for documentation set by their managers or should their expertise be measured against their ability to actually help to solve welfare recipients troubles (Rogowski, 2011)?

Whether current organizations are Kafkaesque and chaotic or not, they provide a paradoxical reality for the professionals working in them (Clarke, Newman, Smith, Vidler, & Westmarland, 2007; Evetts, 2009b; Ferguson, 2009; Mik-Meyer, 2017). Thus, vulnerable clients complex troubles fit badly with the current scoring schemas and guidelines of social work organizations (Gubrium & Holstein, 2001; Gubrium & Järvinen, 2014; Loseke, 2001; Mik-Meyer & Villadsen, 2014).The apparent context-independence of these new tools challenge the professional values of what it takes to conduct meaningful work and what it means to be professional (Kallinikos, 2004). Even though scoring schemas, guidelines and other organizational tools "*appear* to hold out the promise of greater reliability by establishing systematic, objective and uniform practices," these tools also suppress the "real need of users" and the importance of working individually with each welfare recipient and his or her troubles (Rogowski, 2010, p. 159, my emphasis).

When social workers translate their work into scoring schemas, they meet documentation demands of managers, and when they engage in pedagogical relations with welfare recipients, they accommodate classic values of social work. The tension of these dual goals result in new forms of expertise and—consequently—the social work professions' perception of what it takes to conduct meaningful work. Eyal's (2013, p. 864) definition of expertise as "networks that link objects, actors, techniques, devices, and institutional and spatial arrangements," locates the arrangements that are in place for staff to complete an assignment as well as the effects that the particular techniques and tools have on the work. Following this definition, expertise is the things organizational staff "do" and is not (only) related to the particular profession's disciplinary background (who they "are") (Carr, 2010).

Sometimes organizational tools hinder professions in conducting what they consider to be meaningful work. This dilemma is one of the reasons why scholars today engage in lengthy debates about what expertise looks like in modern organizations (Aldridge & Evetts, 2003; Baines, Charlesworth, Cunningham, & Dassinger, 2012; Broadbent, Dietrich, & Roberts, 1997; Evetts, 2009a; Freidson, 2004, 2014; Liljegren, 2012; Noordegraaf, 2007; Saks, 2012). This current scholarly discussion of expertise emphasises that professions do not occur in a pure form in any organizational context, which is defined in the notions of *organizational professionalism* (Evetts, 2009a), *pragmatic professionalism* (Liljegren, 2012), and *NPM-professionalism* (Evetts, 2009a). These concepts show that professionals in their daily work combine the managerial tools of the organization they work in with the disciplinary knowledge of their profession (Noordegraaf, 2015).

Evetts (2006, 2009a, 2009b, 2011) suggests the concept of organizational professionalism to pinpoint the important role of organizational factors—broadly speaking— in work, whereas *occupational professionalism* is a concept that directs attention to how professional values control the work. However, as Evetts explicitly states, both types of professionalism are ideal types. Everyday organizational work thus involves pragmatic professionalism (Liljegren, 2012, p. 309) in which staff combine the values and tools of their work organization with those of their occupational backgrounds.

Finally, the concept of NPM-professionalism (Evetts, 2009a) suggests that a managerial discourse has a strong effect on work conducted by professionals in modern organizations today and that the definition of expertise is therefore closely related to the values of NPM. The scholars that make this argument state that NPM values such as scoring schemas, performance measures, standardisation tools and so forth are very dominant in today's welfare organizations (Clarke, 2004, 2005; Clarke et al., 2007; Denhardt & Denhardt, 2000, 2003; Ferguson, 2009; Fountain, 2001; Jos & Tompkins, 2009; Kuhlmann, Allsop, & Saks, 2009; McCafferty, 2010; Rogowski, 2010). This branch of research also claims that NPM values create many dilemmas for professionals. For instance, social workers who give aid to homeless persons often work with highly ambiguous goals (Smith-Carrier & Lawlor, 2017; Stonehouse, Threlkeld, & Farmer, 2015) as they must sort out the complex troubles of the homeless individuals' situation as well as negotiate with them what a better life entails for them (Dwyer, Bowpitt, Sundin, & Weinstein, 2015). This relational work must hereafter be translated and documented into scoring schemas (Farrell & Morris, 2003; McDonald et al., 2008; Shanks et al., 2015). Hence, social workers cannot rely (only) on their professional skills deriving from their discipline when dealing with the imprecise nature of homeless persons' troubles; they are also dependent on organizational scoring schemas and guidelines as well as observations that can be "quantified" (McDonald et al., 2008, pp. 1382–1383). It is this tension in the work of the social work profession that is in focus in the upcoming analysis.

The study

This article's analysis is part of a larger project that examines vulnerable welfare recipients' situation in different welfare organizations in Denmark (Mik-Meyer, 2018). The larger project concerned how welfare recipients perceived their situation and how a broad range of professions and their managers described and tried to resolve welfare recipients' troubles in different organizational environments. In order to examine welfare recipient and staff perceptions of social troubles, I conducted interviews with 58 staff members, 21 welfare recipients, and eight managers. Most of the participants worked (staff) or were aided (welfare recipients) at care and treatment facilities such as homeless shelters, substance abuse clinics and social psychiatric clinics. The interviewed persons at these facilities included 22 social workers, eight nurses, six social and health assistants, seven managers who were mostly trained in the academia, and four doctors and police officers. After my research assistants had coded these 47 interviews, I discovered an issue that has been given little attention in empirical studies, namely, how the social worker profession and their managers working with vulnerable welfare recipients negotiate expertise and how their assessments relate to organizational tools such as scoring schemas and guidelines.

Data, procedure, and analysis

The current article's analysis is based on 29 interviews with social workers and managers working at six Danish care and treatment facilities. To engage participants in the study, I approached the managers who then provided contact with the social workers. All participants took part anonymously, which means that interviewees' names are fictional. The interviews were steered by an interview guide that included wide-ranging open-ended questions, and the focus of the interview was on how the interviewees perceived the scoring schemas and documentation work of the organization. For instance, among my questions were themes such as the organization of the work (e.g., How are the tasks organized?); documentation practices (e.g., How do you fit your observations in to the scoring schemas of the organization?), perception of professionalism (How are your disciplinary training and/or organizational factors affecting your work?), norms and ethics in the job (What norms and ethics do you consider important for your profession, the organization and/or the manager?), and the needs of the clients (What do you prioritise in your relation to welfare recipients?)

After all interviews had been transcribed verbatim, I re-read each interview in its full length to obtain an in-depth understanding of the material at large, for instance, the retold story about what to report in the organizational scoring schemas and which observations were considered "trivial." Hereafter all interviews were coded using the NVIVO software programme. The initial coding process included a broad range of issues, which were followed by a focused coding process (Charmaz, 2006) that resulted in categories such as "documentation practices," "computer work," "social workers' opinions of meaningful work/expertise" and similar. These categories included interviewees' stories about how they managed their reporting, their opinions about their assignments, and their own and their colleagues' expertise. I then compiled a list of the main topics in each category, for instance, the choice of using third person abbreviation of "signed" (detachment) in the individual reports. These topics were then highlighted in the text, and this highlighting was the direct point of departure for the detailed—often verbatim—analysis of the specific interview sequence (which always included the interviewer's questions and responses).

In disseminating my analysis, I have included a table with "proof quotes" (Pratt, 2008), that is, the many short, single quotes that are the analysis's outset and justify it. The proof quotes make it clear that the analysis is not only based on the opinions of a few social workers (see Table 1). However, the analysis presented in the paper is predominantly based on "power quotes" (Pratt, 2008), that is, longer quotes and dialogue sequences that illustrate the point of the analysis in a striking way.

The structure of the analysis is threefold. First, I present a brief introductory analysis of how the interviewees explain what they consider to be the core aspects of social work when conducted with welfare recipients with complex troubles. Second, I conduct a more detailed analysis of how social workers from two participating homeless shelters work with the scoring schemas and guidelines of their organizations. Third, I look at seven reports on the attitudes and behaviour of homeless persons living at a shelter (each report is written by 5−10 staff members) to show in detail the challenges social workers face when they must document the troubles and situations of homeless people in accordance with organizational scoring schemas.

Relational work and scoring schemas

Using scoring schemas and other NPM-inspired organizational tools in public organizations is spreading and has steadily won recognition in social work that is directed towards vulnerable groups (e.g., Ferguson, 2009; Rogowski, 2010). Written reports of staff have long been the norm for the clinical treatment of welfare recipients who abuse drugs and in psychiatric diagnostic work. However, it is a newer phenomenon for social workers to use scoring schemas and other organizational guidelines in their work with this group of troubled persons. According to two managers at a homeless shelter, their shelters' scoring schemas result from an increased requirement for evidence-based practice in social work—including work in homeless shelters. This belief is supported by multiple resources that are used to develop and test these tools (and their content). For instance, the participating social workers working at the organizations for homeless, drug addicts or persons with mental health troubles explain that their main job is to engage in pedagogical rewarding relationships with vulnerable clients/patients in order to help this group of individuals solve quite complex troubles. However, they also explain that they spend a significant part of their jobs recording observations in the scoring schemas of their organizations. Even according to a middle manager, the amount of reports at her organization has "grown too much" and is "useless."

> The idea that "if it's not written, then it did not happen" [as our manager declared] is very problematic. This solution generates too many entries where staff try to prove what they do at work. In addition, we cannot use these reports at all. … We do not need documentation of "Oh great, you played a board game and had a cosy evening."

In this version, descriptions of games and cosiness should not be in the client reports of the organization. Her opinion identifies a core tension for the participating social workers—they work within a managerial discourse that requires documentation ("If it's not written, then it did not happen"), but are at the same time expected to engage in a pedagogical relationship with the welfare recipients which may involve playing board games, and so forth. However, the scoring schemas of the organizations leave no room to record observations that originate from their "relational work" with welfare recipients, as social workers termed this pedagogical work. As Table 1 shows, relational work is a central characteristic of social work in the care and treatment facilities.

Relational work occurs in the daily morning gatherings of the organizations in which the social workers advise the welfare recipients to behave; in ball games and during other physical activities; and is the take-off point for computer activities where social workers collaborate with the welfare recipient on how to check e-mails, find letters from the municipality, and so on. "It is alpha and omega" as a social worker at a clinic for substance abusers explains. To him "relational work is the foundation for helping welfare recipients to develop." Relational work is also central to social worker Susan, who explains that she uses herself "a lot in order to become part of these peoples' lives." However, the breadth of the relational work also makes many social workers conclude that their work is diffuse, time-consuming and difficult to document. It is not always "that easy," as Alma says, it can be "a big task" and an "uphill" battle, as her social worker colleagues Sally and Laura explain. Staff's problem arises where not all welfare recipients are ready to enter this kind of pedagogical and psychological relation to the staff. However, the problems mentioned by staff also concern the fact that this kind of work is difficult to document in the scoring schemas of the organizations in which they work.

Table 1
Social workers reflections on documenting their work in scoring schemas

Social worker /name/age	**Goal of work**	**Practical experiences with scoring schemas**	**General opinion of scoring schemas**
Laura 30s	"The most amazing thing about being here is the relationship you get with the residents."	"It is hard to adequately write about all of them."	"I think documentation is good … because you know what has been talked about earlier."
Alma 40s	"All that pain and mischief, they arrive with, has happened in a relationship, and this is why I think they can only be cured by working on the relation."	"I have been struggling a lot with the reports because it is very important to have eye contact with the resident."	"I think documentation is important." "If no one reads it, then there is no continuity."

Caitlin 40s	"The most important thing is to establish a relationship based on trust."	"Documentation can be annoying … if you are in the middle of something with a resident."	"You cannot remember everything, so it gives you the opportunity to go in and read."
Sally 30s	"You can never have enough of it [relational work.]"	"Sometimes I think it is hard to find time for writing reports."	"It gives a picture of what has happened [with the resident]."
Pam 40s	"It is good to be engaged in an activity with other people about something social."	"No [documentation has not caused any problems]." "I rate on their stability, how often do they show up, how well do they perform, and such things."	"If someone is feeling bad, it is important to give the person a high rating, because then you can pull it out and get an overall picture of the person. So it makes good sense."
Peter 20s	"By establishing a good relationship, it gets easier to work towards a range of ends."	"You miss the time on the floor to do relational work because you have to document everything."	"It is an exceptionally good work instrument. And a very good way to get an insight of what you are really dealing with. … But I think that health professionals are more used to use it from their training."
Tony 50s	"To gather around some kind of activity and have a relation. That is the core task [of social work] in my opinion."	"It is hard to decide what is nice-to-know and what is need-to-know [in the documenting the work]."	"In my opinion, there are way too many possible ways to report and too little consensus on what we should measure, why, and when."
Alice 40s	"My goal is to facilitate a good development [of the resident]."	"You have to find time for scoring in the schemas outside [normal working hours]. Sometimes I have to start earlier to find time for it."	
Ben 40s	"Focusing on the relationship and why it went wrong."	"The more we write, the further away we get from the person."	"I think it is a big dilemma." "I think it is useful in order to pass information on to my colleagues. … But in the everyday work, I would like it to be an easier system."
Susan 40s	"To help them become part of society again. That it is okay to be a little different. That there is also room for [them]."	"We use a lot of time on documentation. Sometimes more time than on contact with the person. It is not always connected."	"It is okay. It is fine."
Margaret 40s	"Overall it is to connect these people to a range of public agencies that can help them out of the social status they are in."	"A dilemma arose because I did not want to document the details of the episode … because [the administration] sees it through a completely different lens. I do not want it to hurt [the person]. That is the kind of dilemmas documentation brings."	"I cannot see how it promotes cooperation. I cannot see how you can read a journal. Because every time you write something in a journal, it is subjective."
Alex 20s	"It is about being supportive in order to achieve the change that the person wants. … To motivate to change or stability."	"Basically I do not believe that these people can fit into these boxes. … I think it is hard to do it properly if I have to do it according to the guidelines."	"It is far from everything I find important. It is far from every instance of contact with the resident I find important. It is only if it is bigger things it makes sense."
Paul 30s	"The overall [purpose] is to make these persons as independent as possible in order to [enable them] to live by themselves."	"[Documentation] is what takes most of my time. It is funny I have not mentioned it, maybe it is because it is what I find the least exciting."	"It is good with documentation. It functions as a memory that you can look back at and see where we go and if you have any commitments to the person you are asked to help."
Theresa 40s	"To focus on the resident and to promote development."	"It takes a lot of time. It certainly does."	"It is good and bad." "It enables you to get a view over the development since the last meeting. It is more concrete, whereas earlier it was broader."
Robert 40s	"Our most precious task is to meet them where they are. … It is the relation that is the most important. The presence is crucial in order to establish cooperation."	-	-
Pauline 50s	"I would like to be there with hope and trust." "I am not afraid of demanding more of the residents compared to what I did earlier."	"I think it is problematic, now I am speaking about the resources [used for documentation]."	"Yes, sometimes I do [feel like it is pointless]. Our way of registering is just like click, click, click, click."
Paul 30s	"We seek to help them by establishing a good relationship with them."	-	-

Samantha 50s	"To me, it is really, really important that there is trust. That they feel safe around me; and to have time together. To have the time if someone comes up and needs to talk."	"2–3 months ago 80 % of my work was administrative." "But it has changed, and I would say some of [the documentation], I have asked myself, 'What use is this for?'"	"I would rather have conversations with residents. But it is not a big problem for me to sit behind a computer."
Vicky 20s	"We look at abuse, health … and finances. Sometimes it is about maintenance of basic skills, other times of course about personal development."	"Yes, it is. I think documentation is difficult. I think the hardest part is to do it collectively as an organization, and use it in the same way. That is the hardest."	"I think the idea about it is really, really good because you can extract ratings on something very specific. For example, abuse or contact."
Luke 30s	"To support the most basic everyday needs. Definitely food and medicine."	"I am in my 30s; I am basically born with a computer, so I do not see any problems with it. It seems logical to me."	"[It provides] control and structure of what is going in every individual's life."
Vanessa 50s	"We want to give our residents a sense of life quality and to a better life on their premises. What is good for them is probably not good for me, but when they are satisfied, we have to accept it."	"Every time we are told to spend more time on documentation, it is taken from time with the resident whom we still do not treat properly. It is so frustrating."	"It is important to journalize, and it is important to produce statistics, but let me 'have' fewer residents in my pool if I have to do both instead of making me run around beheaded."
Janice 40s	"Housing first and recovery. And also I think it is important to keep up their hope and faith that it can be better, that we can help them."	-	-

Documentation practices in two homeless shelters

At two of the participating shelters, staff report observations of welfare recipients in both text and numbers. Staff "rate" the welfare recipients' need for support in different situations from 0 to 4. This numerical assessment can be printed as graphs that show progress according to several pre-defined parameters, such as "empowering activities" and "mental well-being" as it says in the guideline. Most staff find writing reports a time-consuming task. In the following sequence, social worker Samantha elaborates about the issue of time:

> Every time you jot down an observation, you rate it. In addition, then you can get such fine graphs, so you can determine if the progress [of the welfare recipient's situation] goes back or forth. … Therefore, I can see the intention in it, but Jesus Christ! [Both laughing]. Well, it takes much time and requires many resources too. We have been understaffed for a long period. People are tearing their hair out and having breakdowns due to stress.

Although Samantha provides a graphic account of the flipside of documenting their work, social workers' criticisms are generally also accompanied by positive assessments of writing reports as found in other research (e.g., Banks, 2013; Farrell & Morris, 2003). The participating social workers emphasise that the scoring schemas create continuity and coherence in their daily work. Many argue that reporting supports a consciousness of their methods, "you can extract ratings on something very specific" and clarify where to "put some effort," as Vicky, a social worker, explains. A colleague agrees and states that reporting "focuses" the work by giving staff "goals and a way to structure their work." However, the question is how the demand for increased reporting by the social work profession align with this profession's focus on relational work with the welfare recipient. The following dialogue provides an elaborate and illustrative description of how a social worker (Peter) perceives ratings and the use of this instrument (no words have been left out in the dialogue).

> *Interviewer*: Do you think that ratings are useful in the work, from your perspective as a social worker?
> *Peter*: Yes, very much I think.
> *Interviewer*: Yes. Ratings agree with your discipline?

> *Peter*: Yes eh or [pause]. I'm having a hard time answering that question because I think maybe it… Therefore, I can easily see that ratings are very, very useful. Therefore, it's an extraordinarily good work tool. In addition, a very good way to get an insight of what you are really dealing with. Do you have to address someone who is well functioning? Where are the needs of support? In that way, it's a very, very useful tool. However, I think that nurses are more used to using it from their training. I mean, they address facts, and this is what you are aiming at. Where… In comparison, you are much more… I think in the study programme of social workers there is not really any… There is not really… Well, of course, there is some theory and some knowledge and… However, it is very much like, if you are good at arguing, then whatever you are saying is almost as true as what I am saying. Sometimes it is like, to put it in a very radical way… then I think that sometimes… then I sort of think that the study programme of social workers is not so fact-oriented. I mean not like that of nurses. Therefore, I believe in that sense that it is a good instrument for us social workers… That something more… Somehow something more… Of course, you can structure your work and set some goals for what you want to achieve. However, the very concreteness of scoring schemas allows you to say, "Well, that is the way it is, because that is what you can see." You cannot say, "Well, maybe because…" or "That is because…" Therefore, in that sense, it's a very, very good tool. In addition, it's much more constructive to do it that way.

Rating and scoring in schemas provide something you can "see," as Peter emphasises, and this clarity is "really, really good." His long monologue shows that he is very appreciative of the organizational demand of documenting the work because scoring your work in schemas means that his profession's conclusions also will hold weight in the organization.

However, his hesitant and constant self-interruption leads to another parallel analysis that points to another aspect of social workers' documentation. It may be the subjectivity of his professions' "argumentation" that makes it difficult for this profession to fill out the scoring schemas. While he is not proud of the fact that there is no universal way of deciding what is correct and false in social work, it is at the same time this exact focus on relational work and the context dependency of social work that defines meaningful work and expertise among social workers (see Table 1). It requires hesitation, pauses, and several attempts to draw a conclusion that his discipline is not "fact-oriented" ("then I think…," "then I sort of think…," "that something…," "somehow something…").

Health professions, on the other hand, report their observations in short and precise language, as he explains. Their expertise is in controlling medicine and measuring symptoms in pulse and blood pressure, and so forth. In comparison, the expertise of social workers involves reflections on how individuals behave in situations, for example, when playing a board game. Social workers' jobs include collaborating with the welfare recipient to push for changes in his or her life. Peter's social worker colleague Tony calls these things "to feel and sense." Unlike Peter, Tony is not enthusiastic about the numeric rating and organizational scoring schemas in his work. He rolls his eyes when the interviewer talks about the categories that are the basis for their "rating."

> *Interviewer*: What about these categories? You rate from 0-4, right? Now you're rolling your eyes, why is that?
> *Tony*: It's hard to do and then why do we do it? Rating has to do with evaluating welfare recipients' behaviour against different criteria. Then you can do a graph that displays, for example, an increase in alcohol consumption followed by escalating levels of problems with social contact. You can register correspondence between the one curve that goes upwards and another curve that goes upwards. Then you can look at them. However, in my opinion, there are way

> too many possible ways to report and too little consensus on what we should measure, why and when.
> *Interviewer*: So, you can actually measure everything?
> *Tony*: Yes.

Tony's body and spoken language show doubt in how rating can contribute to clarifying the social problems of the homeless individuals at his shelter. He explains in addition that ratings contribute to extensive paperwork and reports. He problematizes the absence of a consensus of what, why, and when to measure and thereby identifies social workers' chief problem—in principle, all welfare recipients' behaviour can be reported in the schemas of the shelter he works in. Thus, his frustration concerns the complexity and ambiguity of social problems that poorly align with the organizational scoring schemas. Whether positive (Peter) or negative (Tony), when evaluating the effect of scoring schemas in social work in homeless shelters, the interviews with all participating social workers show that most often the individual interview person is *both* positive and negative, when reflecting on NPM-inspired work tools such as scoring schemas and other documentary practices. This ambivalence of what to think about these newer tools shows that expertise is no longer only—or first and foremost—evaluated according to values embedded in the disciplines of professions. Expertise and perceptions of meaningful work are also evaluated according to values embedded in the managerial discourse present at their work organizations. Thus, current NPM-tools changes the work and result in new perceptions of what social work entails and how to define expertise among this group of professionals. This is an example of what Evetts (2009a) call organizational professionalism or NPM-professionalism.

Writing reports in a homeless shelter

Social workers' measure the need for aid on topics that are hard to define such as "empowering activities," "employment activities," "mental well-being," and so forth, whereas nurses assess easy-to-define topics such as "medicine intake."

For instance, a social worker notes about a welfare recipient, "Michael has asked for help to make sense of letters from the homeless unit" and rates her assistance to "3" under the topic "skills of perception," because there was a "significant need for social assistance." In other words, the expertise here has to do with measuring a quite complex area (e.g., skills of perception) in a relatively trivial way. Another distinct aspect of reports from social workers is the key role that he/she plays in the reports and its relation to social workers desired a focus on relational work with the welfare recipients. A third characteristic of the reports is social workers use of third person abbreviation of "signed" ("SN") in the report to hide the subjectivity of the many reported observations. Thus, social workers reports are stories of relationships that include both staff and welfare recipients as the main characters even though the staff's identity is often hidden under SN. The following extract of a report from a social worker (SN), illustrates this.

> Ibrahim looks SN up in the kitchen and is obviously sad. Ibrahim says he needs to talk. SN agrees with Ibrahim to meet in the rainbow office. Shortly thereafter, Ibrahim arrives at the office, telling SN that in addition to mental health problems, he is also physically ill.… Ibrahim says he hates himself because he was once a nice guy with work, and so on. SN tells Ibrahim that even though he has mental challenges, he should not hate himself. SN comforts and tells Ibrahim that there is no reason to hate himself because he is still a nice guy. SN tells Ibrahim that he must keep fighting to get better and even though SN has a job now, then SN can also suddenly get sick and get sad, but that one must not give up.… Be-

> cause Ibrahim has not eaten for several days, SN explains the importance of correct diet for well-being.

This sequence from a report highlights how relational work looks like in practice. Note that this report includes descriptions of how the social worker thinks Ibrahim's situation can develop, and the social workers own role in this identity work. This is a story of Ibrahim as well as a story of the social worker's role in helping Ibrahim get better. When the social worker describes himself in the third person (SN) as a substitute for using the first person ("I" and "me"), he makes a strong case for detachment. It is not him as a named person who interprets Ibrahim's situation; it is any person ("SN"). The report of this client is accompanied by the score "2" in the category "psychological well-being" and is in harmony with this scoring schema's demands for numbers. By attributing the text to the score "2" an alternative way of interpreting the report is made. The added number shifts the focus away from the nuances and ambiguities of Ibrahim's situation (and social work) and underscores the detachment of the social worker's observations. His repeated use of "SN" is characteristic in the reports of the social workers and shows the basic dilemma of documenting relational work. Thus, the social worker's role is pivotal on the record—as social work requires—but as a person whose identity is hidden. When reviewing all of the reports of the 58 participating staff members, the profession of social workers uses SN much more frequently in their reports compared to other staff members with different training. This indicates that social workers attempt to conform to the neutrality of organizational guidelines. However, it is doubtful if the social worker's use of SN instead of "I" or "me" solves this basic problem of the lack of "fact orientation" in social work, as Peter was stating earlier. By using SN no less than nine times in the short (condensed) report, the reader is left with a very strong impression that the reported observation is a report in which both parties played an essential role.

The social workers who explained in interviews that they wished for a stronger fact-orientation may thereby demonstrate that they do not personally identify with the key characteristic of their profession (to work upon relationships). However, this might not be the only interpretation—or the most likely. Their wish for more facts may also indicate that the lack of factual orientations in social work causes the social work profession to be ranked lowest in the hierarchy of professions. Because staff's documentation of welfare recipients' situations is conducted by tools that favour objectivity and detachment from the writer, social workers' expertise may be threatened more than their colleagues with other training such as, for instance, nurses. This finding suggests that scoring schemas and other NPM-inspired tools have effects on the way that expertise is defined in this type of organization. The current strong culture of documenting the work in scoring schemas as demonstrated in the two participating shelters may, therefore, cause new battles of professions (Abbott, 1988) around whether and how professions are successful in integrating NPM-inspired tools in what they consider to be their core competencies.

Concluding discussion

This present study has shown how social workers negotiate what counts as expertise in care and treatment facilities today. The analysis here shows that the expertise of social workers concerns their success in jotting down their assessments of clients in organizational scoring schemas. Thus, expertise has to do with integrating and quantifying social workers' relational work with welfare recipients in schemas and reports. In line with McDonald and colleagues (2008), this study also found that expertise concerns a numerical assessment of client behaviour. Hence, assignments that social workers cannot "quantify" are automatically defined as less important and depict a low level of expertise.

The article's analysis also reveals how work in care and treatment facilities contains two opposing ideals. On the one hand, perceptions of social workers' expertise have to do with their success in building a personal relation with welfare recipients (relational work) such as playing board games, soccer, and so forth. On the other hand, however, another important ideal for the social work profession is present. Social workers have to meet the targets of their organizations and managers that stem from NPM and other management's tools focus on documentation of work in scoring schemas. These two ideals create tension for the social work profession, as discussed in the article, because they conflict. It is difficult for social workers to fit assessments of their relational work with welfare recipients into the scoring schemas of organizations.

The organizational scoring schemas present social workers with other problems as well. For instance, when they are successful in recording the complexity of the welfare recipients' situation in the schemas, then the subjectivity of their assessments become less clear because scoring schemas hide or blur that social work by nature is subjective and based upon a personal relationship between a social worker and a welfare recipient. The apparent neutrality of the schemas and reports (Rogowski, 2010) hide and even downgrade this central characteristic of social work mentioned by all participating social workers. This apparent neutrality of scoring schemas may also challenge the power of welfare recipients and their ability to make their potential disagreement with the assessments of them applicable (because the subjectivity of social work is now hidden).

In addition, the categories of the scoring schemas influence what staff can jot down, and thus which activities are meaningful for social workers to suggest to welfare recipients. Hence, the chosen activities of social workers may not reflect their assessment of clients' needs but instead, reflect which activities can be fitted into the categories of the scoring schemas provided by the institutions. In sum, social workers critique of the scoring schemas often had to do with what social workers (still) think is their core competency, namely to build a good relation to welfare recipients. For instance, in their view, nurses can easily translate their professionalism into the sections of an organizational scoring schema, while social workers' professionalism (relational work) is difficult to fit into the small sections of the schemas. Thus, the analysis suggests that that the current focus on NPM-inspired tools in social work may even affect the internal hierarchy of professionals.

Nevertheless, the analysis also revealed that social workers welcomed the organizational scoring schemas. These positive stories show that many social workers thought that the lack of factual knowledge in social work made it difficult to have a distinct voice in their organizations. Documenting the work made social workers' job visible for managers (who may not work side-by-side with the staff) and colleagues from other professions when discussing work and reports in the regular staff meetings.

To conclude, this article shows how current welfare organizations balance different rationales and dilemmas leading to new perceptions of meaningful work and expertise (Mik-Meyer, 2017). Social workers disciplinary training stresses relational work with welfare recipients, but at the same time, they are held "accountable" according to organizational systems of documentation (Ferguson, 2009; Hupe & Hill, 2007). The notions of organizational professionalism (Evetts, 2009a), pragmatic professionalism (Liljegren, 2012), and NPM-professionalism (Evetts, 2009a) all emphasise that professionalism and expertise today is indeed an organizational phenomenon. The current increased use of scoring schemas in care and treatment facilities strongly influence the way social workers in a more general sense organize their work. NPM-inspired tools thus seem to have a profound influence on how expertise looks like today. Ironically, the expertise of social workers may perhaps primarily be about being successful in translating their relational work with the welfare recipient into organizational scoring schemas and only secondarily about meeting welfare recipients' needs.

Acknowledgements

The author would like to thank the A.P. Møller Foundation for providing financial support for this research project. I also sincerely thank my colleagues at the Department of Organization (CBS), student assistant, Simon Haugegaard, the three anonymous reviewers, and the editor of *Professions and Professionalism* for their valuable input.

Funding

This article was supported by the A.P. Møller Foundation.

References

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

Aldridge, M., & Evetts, J. (2003). Rethinking the concept of professionalism: The case of journalism. *British Journal of Sociology, 54*(4), 547–564. https://doi.org/10.1080/0007131032000143582

Baines, D., Charlesworth, S., Cunningham, I., & Dassinger, J. (2012). Self-monitoring, self-blaming, self-sacrificing workers: Gendered managerialism in the non-profit sector. *Women's Studies International Forum, 35*(5), 362–371. https://doi.org/10.1016/j.wsif.2012.07.002

Banks, S. (2013). Negotiating personal engagement and professional accountability: Professional wisdom and ethics work. *European Journal of Social Work, 16*(5), 587–604. https://doi.org/10.1080/13691457.2012.732931

Benish, A. (2014). Outsourcing, discretion, and administrative justice: Exploring the acceptability of privatized decision making. *Law and Policy, 36*(2), 113–133. https://doi.org/10.1111/lapo.12019

Bonoli, G., & Natalie, D. (2012). *The politics of the new welfare state*. Oxford: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199645244.001.0001

Broadbent, J., Dietrich, M., & Roberts, J. (1997). The end of the professions? In J. Broadbent, M. Dietrich & J. Roberts (Eds.), *The end of the professions? The restructuring of professional work* (pp. 1–13). London: Routledge.

Carr, E. S. (2010). Enactments of expertise. *Annual Review of Anthropology, 39*(1), 17–32. https://doi.org/10.1146/annurev.anthro.012809.104948

Carvalho, T. (2014). Changing connections between professionalism and managerialism: A case study of nursing in Portugal. *Journal of Professions and Organization, 1*(2), 176–190. https://doi.org/10.1093/jpo/jou004

Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis.* London: Sage.

Clarke, J. (1996). After social work. In N. Parton (Ed.), *Social theory, social change and social work*. London: Sage.

Clarke, J. (2004). *Changing welfare, changing states: New directions in social policy*. London: Sage.

Clarke, J. (2005). New Labour’s citizens: Activated, empowered, responsibilized, abandoned? *Critical Social Policy, 25*(4), 447–463. https://doi.org/10.1177/0261018305057024

Clarke, J., Newman, J., Smith, N., Vidler, E., & Westmarland, L. (2007). *Creating citizen-consumers: changing publics and changing public services.* London: Sage.

Debesay, J., Harsløf, I., Rechel, B., & Vike, H. (2014). Dispensing emotions: Norwegian community nurses’ handling of diversity in a changing organizational context. *Social Science and Medicine, 119*, 74–80. https://doi.org/10.1016/j.socscimed.2014.08.025

Denhardt, R. B., & Denhardt, J. V. (2000). The new public service: Serving rather than steering. *Public Administration Review, 60*(6), 549–559. https://doi.org/10.1111/0033-3352.00117

Denhardt, R. B., & Denhardt, J. V. (2003). The new public service: An approach to reform. *International Review of Public, 8*(1), 3–10. https://doi.org/10.1080/12294659.2003.10805013

Dwyer, P., Bowpitt, G., Sundin, E., & Weinstein, M. (2015). Rights, responsibilities and refusals: Homelessness policy and the exclusion of single homeless people with complex needs. *Critical Social Policy, 35*(1), 3–23. https://doi.org/10.1177/0261018314546311

Evetts, J. (2006). Short note: The sociology of professional groups: New directions. *Current Sociology, 54*(1), 133–143. https://doi.org/10.1177/0011392106057161

Evetts, J. (2009a). New professionalism and New Public Management: Changes, continuities and consequences. *Comparative Sociology, 8*(2), 247–266. https://doi.org/10.1163/156913309X421655

Evetts, J. (2009b). The management of professionalism: A contemporary paradox. In S. Gewirtz, P. Mahony, I. Hextall & A. Cribb (Eds.), *Changing teacher professionalism: International trends, challenges and ways forward* (pp. 19–30). Abingdon: Routledge.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology, 59*(4), 406–422. https://doi.org/10.1177/0011392111402585

Eyal, G. (2013). For a sociology of expertise: The social origins of the autism epidemic. *American Journal of Sociology, 118*(4), 863–907. https://doi.org/10.1086/668448

Farrell, C., & Morris, J. (2003). The ’neo-bureaucratic state: Professionals, managers and professional managers in schools, general practices and social work. *Organization, 10*(1), 129–156. https://doi.org/10.1177/1350508403010001380

Ferguson, I. (2009). *Reclaiming social work: Challenging neo-liberalism and promoting social justice*. London: Sage.

Fountain, J. E. (2001). Paradoxes of public sector customer service. *Governance: An International Journal of Policy and Administration, 14*(1), 55–73. https://doi.org/10.1111/0952-1895.00151

Freidson, E. (2004). *Professionalism: The third logic.* Cambridge: Polity Press.

Freidson, E. (2014). The theory of professions: State of the art. In R. Dingwall & P. Lewis (Eds.), *The sociology of the professions: Lawyers, doctors and others* (pp. 13–28). New Orleans, Louisiana: Quid Pro Books.

Gubrium, J. F., & Holstein, J. A. (Eds.). (2001). *Institutional selves: Troubled identities in a postmodern world.* New York: Oxford University Press.

Gubrium, J. F., & Järvinen, M. (2014). Troubles, problems, and clientization. In J. F. Gubrium & M. Järvinen (Eds.), *Turning troubles into problems: Clientization in human services* (pp. 1–13). London: Routledge.

Hodson, R., Martin, A. W., Lopez, S. H., & Roscigno, V. J. (2012). Rules don't apply: Kafka's insights on bureaucracy. *Organization, 2*(20), 256–278.

Hupe, P., & Hill, M. (2007). Street-level bureaucracy and public accountability. *Public Administration, 85*(2), 279–299. https://doi.org/10.1111/j.1467-9299.2007.00650.x

Jos, P. H., & Tompkins, M. E. (2009). Keeping it public: Defending public service values in a customer service age. *Public Administration Review, 69*(6), 1077–1086. https://doi.org/10.1111/j.1540-6210.2009.02065.x

Kallinikos, J. (2004). The social foundations of the bureaucratic order. *Organization, 11*(1), 13–36. https://doi.org/10.1177/1350508404039657

Kuhlmann, E., Allsop, J., & Saks, M. (2009). Professional governance and public control: A comparison of healthcare in the United Kingdom and Germany. *Current Sociology, 57*(4), 511–528. https://doi.org/10.1177/0011392109104352

Liljegren, A. (2012). Pragmatic professionalism: Micro-level discourse in social work. *European Journal of Social Work, 15*(3), 295–312. https://doi.org/10.1080/13691457.2010.543888

Loseke, D. R. (2001). Lived realities and formula stories of "battered women." In J. F. Gubrium & J. A. Holstein (Eds.), *Institutional selves: Troubled identities in a postmodern world* (pp. 107–126). New York: Oxford University Press.

McCafferty, P. (2010). Forging a "neoliberal pedagogy": The "enterprising education" agenda in schools. *Critical Social Policy, 30*(4), 541–563. https://doi.org/10.1177/0261018310376802

McDonald, A., Postle, K., & Dawson, C. (2008). Barriers to retaining and using professional knowledge in local authority social work practice with adults in the UK. *British Journal of Social Work, 38*(7), 1370–1387. https://doi.org/10.1093/bjsw/bcm042

Mik-Meyer, N. (2017). *The power of citizens and professionals in welfare encounters: The influence of bureaucracy, market and psychology.* Manchester: Manchester University Press.

Mik-Meyer, N. (2018). *Fagprofessionelles møde med udsatte klienter: Dilemmaer i den organisatoriske kontekst* [Semi-profession's encounter with vulnerable clients: Organizational dilemmas]. Copgenhagen: Hans Reitzels Publishers.

Mik-Meyer, N., & Villadsen, K. (2014). *Power and welfare: Understanding citizens' encounters with state welfare.* New York: Routledge.

Newman, S., & Lawler, J. (2009). Managing health care under New Public Management: A Sisyphean challenge for nursing. *Journal of Sociology, 45*(4), 419–432. https://doi.org/10.1177/1440783309346477

Noordegraaf, M. (2007). From "pure" to "hybrid" professionalism: Present-day professionalism in ambiguous public domains. *Administration & Society, 39*(6), 761–785. https://doi.org/10.1177/0095399707304434

Noordegraaf, M. (2015). Hybrid professionalism and beyond: (New) Forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization, 2*(2), 187–206. https://doi.org/10.1093/jpo/jov002

Pratt, M. G. (2008). Fitting oval pegs into round holes: Tensions in evaluating qualitative research in top-tier North American journal. *Organizational Research Methods, 11*(3), 481–509. https://doi.org/10.1177/1094428107303349

Rogowski, S. (2010). *Social work: The rise and fall of a profession?* Bristol, UK: Policy Press.

Rogowski, S. (2011). Managers, managerialism and social work with children and families: The deformation of a profession? *Practice, 23*(3), 157–167. https://doi.org/10.1080/09503153.2011.569970

Roysum, A. (2013). The reform of the welfare services in Norway: One office—one way of thinking? *European Journal of Social Work, 16*(5), 708–723. https://doi.org/10.1080/13691457.2012.722982

Saks, M. (2012). Defining a profession: The role of knowledge and expertise. *Professions & Professionalism, 2*(1), 1–10. https://doi.org/10.7577/pp.v2i1.151

Shanks, E., Lundström, T., & Wiklund, S. (2015). Middle managers in social work: Professional identity and management in a marketised welfare state. *British Journal of Social Work, 45*(6), 1871–1887. https://doi.org/10.1093/bjsw/bcu061

Smith-Carrier, T., & Lawlor, A. (2017). Realising our (neoliberal) potential? A critical discourse analysis of the poverty reduction strategy in Ontario, Canada. *Critical Social Policy, 37*(1), 105–127. https://doi.org/10.1177/0261018316666251

Stonehouse, D., Threlkeld, G., & Farmer, J. (2015). "Housing risk" and the neoliberal discourse of responsibilisation in Victoria. *Critical Social Policy, 35*(3), 393–413. https://doi.org/10.1177/0261018315588232

Sturdy, A., Wright, C., & Wylie, N. (2016). Managers as consultants: The hybridity and tensions of neo-bureaucratic management. *Organization, 23*(2), 1–22.

&PROFESSIONS
PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), e2112 http://doi.org/10.7577/pp.2112

Cory E. Cronin, Kristin A. Schuller and Doulas S. Bolon

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

Cory E. Cronin,
Ohio University,
USA

Kristin A. Schuller,
Ohio University,
USA

Doulas S. Bolon,
Ohio University,
USA

Contact:
Cory E. Cronin,
Ohio University,
USA
croninc@ohio.edu

Received:
01 May 2017

Accepted:
21 Jan 2018

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 evolution 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 nonprofit 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 is 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 hearkens 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.

References

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

Abbott, A. D. (1991). The future of professions: Occupation and expertise in the age of organization. *Research in the Sociology of Organizations, 8*, 17–42.

American College of Healthcare Executives (ACHE). (2008). *2008 Annual Report and reference guide*. Chicago, IL: ACHE.

American College of Healthcare Executives (ACHE). (2014). *Education: Professional development task force*. Retrieved from https://ache.org/ProfessionalDevelopmentTaskForce/index.cfm

American College of Healthcare Executives (ACHE). (2016). *ACHE Code of Ethics*. Retrieved from https://www.ache.org/abt_ache/code.cfm

American Hospital Association (AHA). (2017). Press Release. Retrieved from: https://www.aha.org/press-release/2017-06-22-statement-better-care-reconciliation-act-2017

Begun, J. W., & Kaissi, A. (2004). Definition and scope of health services administration. *Journal of Health Administration Education, 21*(2), 227–239.

Brante, T. (2011). Professions as science-based occupations. *Professions and Professionalism, 1*(1). https://doi.org/10.7577/pp.v1i1.147

Calhoun, J. G., Dollett, L., Sinioris, M. E., Wainio, J. A., Butler, P. W., Griffeth, J. R., & Warden, G. L. (2008). Development of an interprofessional competency model for health care leadership. *Journal of Healthcare Management, 53*(6), 375–391. https://doi.org/10.1097/00115514-200811000-00006

Carr-Saunders, A. M., & Wilson, P. A. (1933). *The professions*. Oxford: Clarendon Press.

Cogan, M. L. (1953). Toward a definition of profession. *Harvard Educational Review, 23*(Winter), 33–50.

Etzioni, A. (1969). *The semi-professions and their organization.* New York: The Free Press.

Evetts, J. (2013). Professionalism: Value and ideology. *Current Sociology Review 61*(506), 778–796. https://doi.org/10.1177/0011392113479316

Fournier, V. (2000). Boundary work and the (un)making of a profession. In N. Malin (Ed.), *Professionalism, boundaries and the workplace* (pp. 67–86). London, England: Routledge.

Friedson, E. (1983). The theory of the professions: The state of the art. In R. Dingwalland & P. Lewis (Eds.), *The sociology of the professions* (pp. 19–37). London, England: The Macmillan Press.

Friedson, E. (2001). *Professionalism: The third logic*. Chicago, IL: The University of Chicago Press.

Glouberman, S., & Mintzberg, H. (2001). Managing the care of health and the cure of disease—Part II: Integration. *Healthcare Management Review, 26*(1), 70–83. https://doi.org/10.1097/00004010-200101000-00007

Goode, W. J. (1969). The theoretical limits of professionalization. In A. Etzioni (Ed.), *The semi-professions and their organization* (pp. 266–313). New York, NY: The Free Press.

Greenwood, E. (1957). Attributes of a profession. *Social Work, 2*(July), 44–55.

Guy, M. E. (1985). *Professionals in organizations: Debunking a myth*. New York, NY: Praeger Publishers.

Haddock, C. C., McLean, R. A., & Chapman, R. C. (2002). *Careers in health care management: How to find your path and follow it.* Chicago: Health Administration Press.

Johnson, T. J. (1972). *Professions and power*. London, England: The Macmillan Press.

Leicht, K. T., & Fennell, M. L. (2001). *Professional work: A sociological approach*. Malden, MA: Blackwell Publishers. https://doi.org/10.4135/9781849200387.n18

Leicht, K. T., & Fennell, M. L. (2008). Institutionalism and the professions. In R. Greenwood, C. Oliver, K. Sahlin & R. Suddaby (Eds.), *The Sage handbook of organizational institutionalism* (pp. 431–448). Thousand Oaks, CA: Sage.

Marshall, T. H. (1962). Professionalism and social policy. In S. Nosow & W.H. Form (Eds.), *Man, work, and society* (pp. 219–235). New York, NY: Basic Books, Inc.

Mick, S. S. (2004). Must we broaden the definition of health services administration? A response to the final report of the blue ribbon task force. *Journal of Health Administration Education, 21*(2), 173–177.

National Center for Healthcare Leadership (NCHL). (2003). *2003 Annual report.* Chicago, IL: NCHL.

National Center for Healthcare Leadership (NCHL). (2006). *The NCHL leadership competency model*. Chicago, IL: NCHL. Retrieved from http://www.nchl.org/Documents/NavLink/NCHL_Competency_Model-full_uid892012226572.pdf

National Center for Healthcare Leadership (NCHL). (2016). *National council on administrative fellowships*. Chicago, IL: NCHL. Retrieved from http://nchl.org/static.asp?path=2851,6549

Neuhauser, D. (1983). *Coming of age: A 50-year history of the Americanc of hospital administrators and the profession it serves, 1933–1983*. Chicago: Pluribus Press Inc.

Noordegraaf, M., & Van der Meulen, M. (2008). Professional power play: Organizing management in health care. *Public Administration, 86*(4), 1055–1069. https://doi.org/10.1111/j.1467-9299.2008.00746.x

Nosow, S., & Form, W.H. (1962). *Man, work, and society*. New York, NY: Basic Books, Inc.

Ritzer, G., &Walczak, D. (1986). The changing nature of American medicine. *The Journal of American Culture, 9*(4), 43–51. https://doi.org/10.1111/j.1542-734X.1986.0904_43.x

Rosenberg, C. E. (1987). *The care of strangers: the rise of America's hospital system.* Baltimore, MD: Johns Hopkins University Press.

Roth, J. (1974). Care of the sick: Professionalism vs. love. *Scientific Medical Management, 1*(2), 173–180.

Rueschemeyer, D. (1964). Doctors and lawyers: A comment on the theory of professions. *Canadian Journal of Sociology and Anthropology, 1*(February), 17–30. https://doi.org/10.1111/j.1755-618X.1964.tb01197.x

Scott, W. R. (1982). Managing professional work: Three models of control for health organizations. *Health Services Research, 17*(3), 213–240.

Scott, W. R. (2004). Competing logics in health care: Professional state, and managerial. In F. Dobbin (Ed.), *The sociology of the economy* (pp. 295–315). New York, NY: Russell Sage Foundation.

Shortell, S. M., Gillies, R. R., & Devers, K. J. (1995). Reinventing the American hospital. *The Milbank Quarterly, 73*(2), 131–160. https://doi.org/10.2307/3350254

Siegrist, H. (2002). Professionalization/professions in history.In *International encyclopedia of the social and behavioral sciences* (pp. 12154–12160). Oxford, England: Elsevier Science Ltd.

Starr, P. (1982). *The social transformation of American medicine.* New York, NY: Basic Books, Inc.

Stefl, M. E. (2008). Common competencies for all health care managers: The healthcare leadership alliance model. *Journal of Healthcare Management, 53*(6), 360–374. https://doi.org/10.1097/00115514-200811000-00004

Stevens, R. (1999). *In sickness and in wealth: American hospitals in the twentieth century*. Baltimore: The Johns Hopkins University Press.

Weil, P. A. (2001). Commentary on managing the care of health and the cure of disease (Parts I and II). *Health Care Management Review, 26*(1), 87–89. https://doi.org/10.1097/00004010-200101000-00009

Wilensky, H. L. (1962). The dynamics of professionalism: The case of hospital administration. *Hospital Administration, 7*(Spring), 6–24.

Wilensky, H. L. (1964). The professionalization of everyone? *American Journal of Sociology, 70*(2), 137–158. https://doi.org/10.1086/223790

Young, G. J., Chou, C. H., Alexander, J., Lee, S. Y. D., & Raver, E. (2013). Provision of community benefits by tax-exempt US hospitals. *New England Journal of Medicine, 368*(16), 1519–1527. https://doi.org/10.1056/NEJMsa1210239

& PROFESSIONS
PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), e1973 http://doi.org/10.7577/pp.1973

Tomi J. Kallio, Terhi Tevameri, and Mervi Vähätalo

Nurses' organizational roles—Stakeholders' expectations

Abstract: In this study, we analysed stakeholders' organizational role expectations for nurses. We defined organizational role expectations as a set of informal expectations in behavioural patterns and formal expectations in work tasks related to a certain position in the organization. A qualitative study was conducted, and content analysis was applied to 150 articles published in a Finnish nursing trade journal. We identified five general organizational role expectations of patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators in our analysis: "the alongside stroller," "the patients' advocate," "the reliable colleague and team member," "the expert and skills developer," and "the organizational underdog." This study explores these nursing roles and links stakeholder perspective to the organizational role expectations in professional services.

Keywords: Organizational role, role expectations, profession, nurse, healthcare, stakeholders

Tomi J. Kallio,
Linnaeus University,
Sweden;
University of Turku,
Finland

Terhi Tevameri,
University of Turku,
Finland

Mervi Vähätalo,
University of Turku,
Finland

Contact:
Tomi J. Kallio,
Linnaeus University,
Sweden
tomi.kallio@lnu.se

While perhaps not nearly as much as the physician profession, the nursing profession has received considerable attention in the extant research literature. To a large extent, the extant research deals with the nursing profession's content and changes (see Mason, 2011). In addition, some more specified research themes have gained considerable interest, including ethical perspectives, professional positioning, nurse education, the shortage of nurses, and nurses' intentions to leave the profession (see Flinkman, 2014; DeNisco & Barker, 2013; Kankaanranta & Rissanen, 2008; Tadd, 2003).

Traditional sociological research on professions has been related to professional power, autonomy, and self-regulation (Freidson, 1970). Abbott (1988) further suggested that professions are constantly changing systems rather than stable entities. In line with this, more recently, Muzio, Brock, and Suddaby (2013) encouraged scholars to study professions from the process perspective and thereby aim to understand the mechanisms that create, maintain, and change them. In this study, we perceive stakeholders' expectations as a mechanism that affects the nursing profession. Based on Muzio and associates' (2013) process perspective, we argue that stakeholders' expectations influence the nursing profession, nurses' professional identities, and the roles that nurses play in healthcare organizations.

Received:
13 March 2017

Accepted:
27 April 2018

In this study, organizational role expectations are defined as a set of informal expectations in behavioural patterns and formal expectations in work tasks related to a certain position in an organization.[1] In this sense, the work tasks originating, for instance, from legislation, as well as the associated rules, procedures, and job descriptions, constitute formal behavioural expectations (see Mintzberg, 1979). At the same time, many stakeholders of healthcare organizations, such as professional associations, patients, colleagues, and members of other professions, set somewhat more informal, yet similarly important, behavioural expectations (Robbins & Judge, 2010).

Besides the actual organizational roles, it is essential to recognize the stakeholders that set expectations. Although a lot of literature deals with stakeholders and their identification in healthcare organizations (see Blair & Fottler, 1990; Currie, Pouloudi, & Whitley, 2016), the literature does not address the stakeholders that set expectations for nurses' organizational roles. In this study, the purpose is to narrow this research gap by perceiving nurses' organizational roles and identifying the stakeholders that set their role expectations by analysing nurses' trade journal literature. The aim of this paper is to investigate, through a review of a nurses' trade journal, how nurses' organizational roles and related stakeholders' expectations are addressed in the published records. To be more specific, the research questions of our study are defined as follows:

1. What kind of organizational role expectations are set for nurses' within their own trade journal literature?
2. Which stakeholders, according to the trade journal literature, set organizational role expectations for nurses, and what are their locus and salience?

Our study applies the sociological process perspective and emphasizes the importance of expectations set by organizations (Olakivi & Niska, 2017; Postma Oldenhof, & Putters, 2015), as well as demonstrates how professions endeavour to adapt to these expectations (Noordegraaf, 2011). By examining stakeholder expectations, the study pursues to understand mechanisms that cause stability and change in the nursing profession and can help the profession to clarify nurses' identities, functions, and responsibilities. Nursing associations can apply the knowledge related to stakeholders' expectations while they evaluate whether these expectations should become part of professional repertoires (see Noordegraaf, 2011). In addition, nurse managers need to recognize these expectations when managing nurses' tasks and organization dynamics.

Background

Organizational role expectations

Whereas some of the extant studies have focused on the roles of nurses (see Jokiniemi, 2014; McGarvey, Chambers, & Boore, 2000; McKenna et al., 2008), the term "role" is seldom explicitly defined in this context. Often, this term seems to refer to different components or responsibility areas of nursing work (see Gibson & Bamford, 2001; McCarthy, Cornally, Moran, & Courtney, 2012), whereas in the organizational behaviour literature, a role refers to the behavioural patterns a person is expected to fulfil when occupying a certain position (see Robbins & Judge, 2010, p. 139).

Focusing on the organizational role to understanding certain work characteristics

---

[1] The nurse's role also includes aspects not explicitly related to organizational roles. For instance, nurses' involvement in discussions and decision-making in healthcare—both nationally and internationally—and their potential political activity (Arndt, 2003) are not explicitly connected to their organizational roles and therefore are outside the scope of this study.

is not a new approach. Particularly in the case of managerial work, there is a long tradition, originating from the seminal work of Henry Mintzberg (1973), of perceiving the different aspects of managerial work as roles. Sometimes these roles are perceived as more concrete activities (see Jokiniemi, 2014; Verschuren & Masselink, 1997) and sometimes more metaphorically (see Hatch, Kostera, & Kozminski, 2005).

As Verschuren and Masselink (1997) have noted, role expectations refer both to what should be done (tasks) and how it should be done (behaviour). While in some studies both tasks and behavioural expectations for nurses are combined, behavioural expectations are still more strongly linked to nurses' formal tasks (see Verschuren & Masselink, 1997) rather than their behavioural role expectations set by healthcare organizations' stakeholders.

Work tasks can originate, for instance, from legislation, such as the right to prescribe medicines or to dose them. Laws, moreover, define who has right to work as a nurse (Loversidge, 2013). In addition, nurses' own professional associations actively determine norms and regulations for nurses, such as ethical guidelines and codes (see Twomey, 2013). In addition to legislation procedures and job descriptions, such as the position of formal supervisor or the requirement of reporting adverse events in patient care, constitute formal expectations (see Mintzberg, 1979).

While nurses' work tasks obviously vary, for instance, across organizations, different specialty areas, hierarchical levels (McGarvey et al., 2000; Salmela, Eriksson, & Fagerström, 2011), positions, and country-specific legislation, some general nursing tasks can be identified (Evers, 2003). In Table 1, these common nursing work tasks are summarized according to Evers (2003), Gibson and Bamford (2001, p. 21−23), and Henderson (2011), and some specific examples related to each of them are provided.[2] As seen in Table 1, nursing work is wide-ranging, but nurses' main tasks are related to meeting patients' basic human needs (Durosaiye, Hadjri, Liyanage, & Bennett, 2018; Evers, 2003; Henderson, 2011).

Table 1
Common nursing work tasks areas with practical examples

Task area of nurses/role component	***Practical examples of the tasks***
Preventive tasks (clinical role component)	Monitoring symptoms and reactions (e.g., breathing) Detection of risks that can cause complications, diseases or disability
Educational tasks (education role component)	Providing instructions and information for patients on treatment, nursing care and patients' rights
Caring tasks (clinical role component)	Providing assistance in daily living, such as cleanliness, eating, clothing, sleep and rest Listening and providing emotional support for patients
Diagnostic and therapeutic	Carrying out therapeutic procedures and administering first aid

---

[2] Gibson and Bamford (2001) have identified research tasks as one of the role components of clinical nurse specialists. However, research tasks are not included in the general tasks of basic nursing work. Therefore, these are not included in Table 1.

tasks (clinical role component)	Collection of samples for diagnosis
Coordinative tasks (liaison and consultancy role component)	Consultation for colleagues and other healthcare professionals Delegation of nursing work and activities Coordinating patients' care
Reporting and administrative tasks (administration role component, consultancy role component)	Reporting observations and impressions about patient condition and treatment Participating in multidisciplinary team discussions about patients' care
Housekeeping tasks	Distributing meals Cleaning and maintenance of medical and nursing equipment

Organizational role expectations can also refer to stereotypes and cultural images of nurses (see Flinkman, 2014, p. 72). These, mostly informal, behavioural expectations refer to the way other actors and stakeholders, such as members of other healthcare professions, believe that a member of a certain profession should behave in a certain context (Robbins & Judge, 2010, p. 140). These are implicit social perceptions, such as attitudes and stereotypical expectations, as well as cultural images that set expectations for nurses' behaviour (Fagin & Diers, 2011; Flinkman, 2014, p. 72). Referring to the social perceptions associated with nursing, Fagin and Diers (2011) identified five metaphors—mothering, class struggle, equality, conscience, and intimacy—that create the milieu and setting for nursing work, for instance, in organizations. Fagin and Diers (2011) also note that the nurses themselves maintain the historical metaphor of Florence Nightingale. Table 2 summarizes the nursing metaphors according to Fagin and Diers (2011), Evers (2003), and Flinkman (2014) and illustrates some of their attributes.

Table 2
Nursing metaphors

Nursing metaphor	***Expectations towards and perception of the nurse role***
Mothering	Maternal types of behaviour: caring, nurturing, comforting Womanhood: warm, nice, and cordial Professional mother
Class struggle	Underdog: struggling to be recognized and approved Semi-profession Physicians' handmaid and assistant
Equality	Small social distance
Conscience	For physicians, nurses represent the feature of conscience, responsible for spotting any neglect or failure regarding patient care
Intimacy	Trusted peers: facing patients' vulnerability, hearing secrets
Florence Nightingale	Nurses' own expectations for their role: tough, canny, powerful, autonomous, heroic

Stakeholder perspectives of organizational roles

Since the seminal work of Freeman (1984), the stakeholder theory has gained considerable interest in various fields of the social sciences. The stakeholder theory has been increasingly applied also in analyses related to healthcare (see Currie et al., 2016). From the stakeholder theory perspective, a healthcare organization can be understood as a complex nexus in which nurses are the largest internal stakeholder group (see Currie et al., 2016; Marquis & Huston, 2006). However, adopting the perspective of nurses—instead of that of the organization—offers a somewhat different angle to this organizational role thematic. Although there are numerous definitions of stakeholders, in this study, stakeholders are understood according to Bryson's (2004, p. 48) classification, which defines stakeholders as an "extremely broad range of actors" such as individuals, groups, organizations, or institutions.

Stakeholder analysis is interested in who or what really counts and in what way (see Mitchell, Agle, & Wood, 1997). In this study, we focus on the locus (Blair & Fottler, 1990) and the salience (Mitchell et al., 1997) of stakeholders, as these two aspects are useful in grouping actors that have expectations regarding the organizational role of nurses and understanding the nature of their stake.

According to Blair and Fottler (1990), stakeholders can be classified into the following three groups according to their locus: internal, external, and interface. Internal stakeholders are those who operate within the borders of (healthcare) organizations, like management and other professional groups, and external stakeholders are those who operate within the broader organizational environment, like legislators and competitors. Interface stakeholders either operate simultaneously inside and outside the borders of the organization, such as members of the hospital board or operate mainly outside those borders but nonetheless influence the internal practices of the organization, such as professional associations.

In addition to the locus of stakeholders, it is essential to understand the nature of their stake—also known as stakeholder salience (Mitchell et al., 1997). Mitchell et al. (1997) determine the salience of stakeholders by analysing three stakeholder attributes: power, legitimation, and urgency. They define definitive stakeholders as those who possess both power (i.e., are able to bring about the outcomes they desire) and legitimacy (i.e., are considered to have the right to do so) and whose claims are urgent (i.e., their claims demand immediate attention). Dependent stakeholders are those who possess legitimacy and urgency but lack power. According to Mitchell et al. (1997), dominant stakeholders have power and legitimacy but not urgency, while those who have urgency and power but not legitimacy are dangerous stakeholders.

Data and method

The data of the study consisted of articles published in the *Sairaanhoitaja* journal. The journal is published in Finnish, and its title can be translated as *Nurse*. It is stated that the journal's aim is to focus on topical and central issues concerning nursing work and the nursing profession in general. As the purpose of the journal is to deal specifically with the themes associated with nurses and nursing on a practical level, as well as related issues from different perspectives, the journal highlights different dimensions of nurses' roles and thus was considered highly useful for the purposes of this study.

Nurse has been published by the Finnish Nurses' Association since 1927, and it is issued approximately eight to ten times per year. The journal's distribution in 2015 was around 40,000, and the measured readership in 2014 was over 77,000 (Sairaanhoitajat, 2016a), which is considered a relatively high number in a small country such as Finland. The journal is sent to all members of the Finnish Nurses' Association and can be considered the association's main tribune. Consequently, the journal has an agenda to promote nurses' matters and the nursing profession's development and visibility in society (see Sairaanhoitajat, 2016a; Sairaanhoitajat, 2016b.) Therefore, the articles do not merely report the perspectives of nurses but also reflect the agendas of the journalists, the editor, and the Nurses' Association. As a consequence for our empirical data, the stakeholders and their expectations are interpreted through a nursing lens, and data from other trade journals, such as physicians' trade journals, might have produced somewhat different outcomes. However, because professional associations are considered to significantly influence the development of professions (Noordegraaf, 2011), this data collected from the nurses' own trade journal can be considered purposeful.

The data were collected from the journal volumes published in 2014 and 2015, ending with the June 2015 issue (Issue 5), as the number of articles was already considerable. One author was responsible for gathering the data, while the analysis involved thorough discussions with all authors. Two of the authors have professional backgrounds in nursing, while one does not. This combination was considered useful as it enabled both "insider" and "outsider" perspectives in the analysis. Data gathering and analysis proceeded as follows.

In the first phase, every issue of *Nurse* was read thoroughly. *Nurse* covers different record categories, including editorial articles, news, reports, an at-work section, and a nurse-of-the-month section. Because all of these categories were included in the analysis, the total number of records was 232[3]. In the second phase, all records that were interpreted to either implicitly or explicitly address the nursing role were selected for further analysis. This resulted in 150 records.

In the third phase, the selected articles were analysed using content analysis. In this study, we were inspired by Graneheim and Lundman's (2004) approach to qualitative content analysis, which suggests that analysis can focus either on manifest or latent data content. Manifest content refers to the obvious and thus visible content of a text (what the text actually says), while latent content refers to the implicit and underlying meanings of a text and thus requires more interpretation and abstraction (Graneheim & Lundman, 2004). We focused mainly on the latent content, given that the nurse's role was mostly implicit in the data. Sometimes, however, the nursing role was also expressed explicitly in the text. For instance, when describing the formal tasks of nurses, the content was in many cases visible and obvious. Moreover, the actual term "role" appeared in the data several times. In some cases, it referred to the nursing role explicitly as it is understood in this study; for example, in one article, a nurse described her organizational role as that of an enabler and messenger. Moreover, the content analysis indicated that articles representing different data records were not systematically different from each other in depicting the organizational roles of nurses.

In the fourth phase of the analysis, the article phrases (or meaning units) that either explicitly or implicitly dealt with the nursing role were written down. This operation produced approximately 60 pages of text. The condensed meaning units were similar to the original meaning units but captured these using shorter expressions. The condensed meaning units were constituted by the content and included one or a few sentences. In the fifth phase, the meaning units were coded and then abstracted to higher-order categories. In the sixth phase, these categories were combined to form the overall themes (see Graneheim & Lundman, 2004), which were based on organizational role similarities. The coding framework is presented in Appendix.

While the data contained some articles where, for instance, patients or other actors described their (either implicit or explicit) organizational role expectations for nurses, the clear majority of the articles dealt with the nurses' own perspectives.

---

[3] *Nurse* contains several separate articles and article sections such as the News section that consist of several smaller items. However, in this study, these article sections are counted as one article.

Nevertheless, although nurses were discussing their own work in the articles, in most cases, the focus was not on their own role expectations but instead on role expectations set for them in the healthcare organization context.

In the seventh phase of the analysis, key stakeholders were identified from the meaning units. Some stakeholders, such as patients, emerged in the data constantly and explicitly, while others, such as the government and legislators, emerged more seldom and more implicitly. Those stakeholders that were central (either directly or indirectly) in the data were labelled key stakeholders (Blair & Fottler, 1990). Next, the key stakeholders were connected to the role expectations for nurses that appeared in the data. In most cases, stakeholders' expectations emerged in the data rather implicitly, and the actual terms of expectation appeared in the data only seldom. In the eighth phase, key stakeholders' expectations concerning nurses' organizational roles were further analysed for their salience. Following Mitchell et al. (1997), stakeholder salience was determined based on the power, legitimacy, and urgency of their claims, as is discussed in further detail in the Stakeholders setting organizational role expectations for nurses section of this article.

Types of organizational role expectations for nurses

According to Morgan (1986), metaphors create ways of seeing and shaping organizational life. We suggest, based on our empirical analysis in this study, that many of the nursing metaphors resonate with the organizational role expectations for nurses. However, the formal tasks and informal metaphors described in the extant literature do not adequately identify organizational role expectations. Instead, in nurses' own professional literature, organizational role expectations appear as manifold combinations of formal tasks and informal metaphors.

The empirical analysis of the data suggested five types of organizational role expectations for nurses. These originated from both formal and informal organizational role expectations and can be labelled as follows: "the alongside stroller," "the patients' advocate," "the reliable colleague and team member," "the expert and skills developer," and "the organizational underdog." Appendix illustrates the framework for the content analysis and provides examples concerning the organizational role expectations for nurses. The extracts presented were translated from Finnish into English by the authors.

As *the alongside stroller*, the central role expectation was for the nurse to provide emotional support to patients and their relatives. While many healthcare professionals naturally participate in a patient's care, the emotional support role was entrusted not only to mental health professionals (psychologists and psychiatrists) but also to nurses. The nursing role, in this case, was to share the patients' and relatives' burden. In the alongside stroller role, the nurse was expected to have good interpersonal skills and methods. When considering the nursing metaphors (see Fagin & Diers, 2011; Evers, 2003; Flinkman, 2014) introduced earlier in this article and in the case of this role, in particular, mothering types of behaviour clearly appeared in the data. In addition, formal caring tasks (Gibson & Bamford, 2001; Evers, 2003; Henderson, 2011) were part of this role (see Table 1). The analysis indicated that besides the metaphorical "strolling alongside" this role also manifested more concretely in nurses' work—nurses "walk along" the patient care pathway.

As *the patients' advocate,* the expectation was that nurses stood for patients' rights and ensured that each patient received the best possible care. In this study, this role was particularly evident in cases where a patient, due to his/her physical or mental condition, was unable to take care of him/herself. In addition, the nurse was expected to coordinate patient care and prevent possible malpractice and other undesirable outcomes. In addition to these preventive tasks, as the patients' advocate, the nurse was also responsible for educational tasks; nurses acted as counsellors to ensure patients receive the best care (see also Table 1). For example, in compiling a specific treatment testament (i.e., one's will to continue treatment in the case of serious illness, injury, etc.), the nurse's role was to ensure that the patient was aware of the actual meaning of the testament in different situations. In some cases, the nurse was expected to empower patients to take a more active role in their own care. While working as a particular patient's advocate, a nurse needed good interpersonal skills given that s/he had to alter his/her behaviour depending on the situation and the patient.

In the role of *the reliable colleague and team member,* the nurse was expected to act in a collegial manner that dignifies others' work, provides needed support, and ensures equal treatment of co-workers. In the context of this study, nurses were also expected to play this role in relation to other healthcare professionals, such as physicians and students. The importance of the role as the reliable colleague and team member was underlined by the fact that the Finnish Nurses' Association had compiled collegiality instructions for its members. In the data, the role of the nurse in healthcare organizations was above all described as the physician's work partner.

The fourth organizational role of nurses is that of an *expert*. Besides being an expert him/herself, a nurse is expected to develop and spread his/her expertise at the organizational level, as well as sometimes at the professional level, as a *skills developer*. The nurse was expected to guide and advise both students and recently graduated colleagues using his/her expertise and experience. As an expert, the nurse has to develop his/her theoretical and practical skills continuously. In some cases, this leads to formal qualifications in certain specializations such as cancer nursing. In the data, the role of expert also included the ethics and values that guided the nurse's role.

The fifth role—that of an *organizational underdog*—appeared in the data to be particularly related to compensation and salary. For instance, the data suggested that nurses received only limited compensation for their job task enlargements. In addition, this role appeared in the case of nursing students who were reportedly occasionally treated as organizational underdogs in the workplace. The role of organizational underdog aligns with the class struggle nursing metaphor (see Table 2; Fagin & Diers, 2011) and the fact that the nursing profession has traditionally been considered a semi-profession in healthcare organizations and thus inferior, particularly to the full professional physicians (Etsioni, 1969). While clearly evident in relationship to other organizational roles, the role of organizational underdog received somewhat less attention in the data.

The analysis showed that nurses' organizational role expectations in some cases overlapped and that a nurse often acts in two or more roles simultaneously. In addition, sometimes the organizational role, such as in the case of the skills developer role, could even be shared with a patient (Lynn, Hirschkorn, & Sainsaulieu, 2011) or praxis expert (i.e., with a patient who is educated as an expert in his/her own disease). The analysis also suggested that organizational roles varied according to task, organization, and specialization area. In other words, contingency factors (see McGarvey et al., 2000; Salmela et al., 2011) had an explicit effect on nurses' organizational roles. Organizational roles were also expected to develop throughout career phases. For instance, the role of expert and skills developer was expected to vary depending on the career phase. The analysis, moreover, indicated that the organizational role expectations of nurses are in constant flux. Task delegation from physicians to nurses and from nurses to care assistants and patients was particularly highlighted in the data. Additionally, the development of information and medical technology, in particular, seem to be key factors in changing and facilitating organizational role expectations for nurses (Godin, 2013).

Stakeholders setting organizational role expectations for nurses

In this section, we attempt to deepen the understanding of the nature of identified organizational role expectations by applying the stakeholder theory perspective to the analysis. In this study, we not only identify stakeholders in the data but in order to better understand stakeholders' expectations, we also analyse stakeholders in light of their salience (Mitchell et al., 1997) and locus (Blair & Fottler, 1990).

During the data analysis, we identified the following stakeholders: patients, patients' relatives, the Finnish Nurses' Association, physicians and other healthcare professionals (including nurses with different specialty areas), the work community (and the organization's management), other healthcare organizations, the media, educational organizations, the local authorities, and the government and legislators (including the European Union). However, while most of these stakeholders would be salient (Mitchell et al., 1997), some of them, such as the media, educational organizations, the local authorities, only appeared in the data on a few occasions. From the perspective of nurses' organizational role expectations, these stakeholders could thus be considered secondary stakeholders; however, this does not mean they would in any way be insignificant in defining the practices, priorities, and goals of healthcare organizations in general (Blair & Fottler, 1990; Mitchell et al., 1997). From the perspective of defining organizational role expectations for nurses, based on our data, these did not seem to have that much at "stake" compared to the key stakeholders. Based on the analysis, the key stakeholders (Blair & Fottler, 1990), from the perspective of organizational role expectations for nurses, were patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators (see Appendix).

With regard to stakeholder salience, our analysis suggests two types of stakeholders. Definitive stakeholders seem to have mostly formal role expectations, whereas dependent stakeholders seem to have informal role expectations (see Mintzberg, 1979; Mitchell et al., 1997; Robbins & Judge, 2010; Verschuren & Masselink, 1997). The key stakeholders identified as definitive stakeholders in setting organizational role expectations for nurses were the Finnish Nurses' Association and legislators. Patients, patients' relatives, and healthcare professionals other than physicians belong to the dependent stakeholder category, as they lack at least some power but nevertheless have urgent and legitimate claims concerning nurses' organizational roles.

Physicians and the work community can be considered to belong to both categories; they can be both definitive and dependent, depending on the situation. For instance, in some patient care decisions physicians are in a superior position to nurses. However, in allocating nurses' work time or in determining their ethical codes, for example, physicians are dependent stakeholders, as in these instances the nursing profession possesses more formal power and autonomy.

Based on what is said above, our analysis indicates that the organizational role expectations for nurses originate from legitimate sources. Accordingly, even though sometimes role expectations were not considered to be positive—as in the role of organizational underdog—from the perspective of the nursing profession, no role expectation identified in the data analysis seemed to originate from a source that could be labelled as dangerous. This means that the role expectations do not pose an immediate threat to the nursing profession and that the nursing profession can resist, for instance, coercion, which would be considered a direct threat (Mitchell et al., 1997).

Following Blair and Fottler's (1990) categorization, the identified key stakeholders form three different types of groups—internal, external, and interface. The first group in our analysis, physicians and other healthcare professionals (including nurses with different specialty areas), as well as the work community, are internal stakeholders, which means they are co-workers or operate inside the healthcare organization together with nurses.[4] Based on the data, physicians and other healthcare professionals set their expectations concerning nurses' roles within the organization mainly as reliable colleagues and team members, and as experts and skills developers. Physicians can be considered dependent, and occasionally also as definitive, stakeholders. As dependent stakeholders, physicians have profession-based informal legitimacy to guide the care process. As definitive stakeholders, formal legislation affords them the right to ultimately decide about a patient's care. Along with this right comes, for instance, physicians' role expectations for nurses as reliable team members and colleagues.

In the data, the work community referred to different facets of healthcare organizations. Typically, these facets were not explicitly defined. On those occasions that the work community was identified, it referred, for instance, to teams, organizational rules, and procedures. Sometimes the role expectations originating from the work community were more formal, as in the case of procedures and instructions concerning teamwork and responsibility areas in emergency situations. In these situations, the formal role expectations were related, for instance, to roles such as the reliable team member and colleague, as well as patients' advocate. However, in some cases, the work community also set more informal expectations, such as the nurse's role as an organizational underdog. Consequently, the work community as a key stakeholder can be salient both in dependent and definitive ways. Relating to rules and procedures, the work community (and the management as its manifestation) can be defined as a definitive stakeholder, while in the case of more informal expectations, as with the organizational underdog, the work community is a dependent stakeholder.

In the data, the second group, patients and their relatives, were nurses' customers who operated at the interface of the healthcare organizations.[5] While not actual members of these organizations, they are still not external to the organizations but inherent to their everyday operation (Bourgeault, Hirschkorn, & Sainsaulieu, 2011; Leemeijer & Trappenburg, 2016). Patients and their relatives are dependent stakeholders, as their claims possess legitimacy and urgency, but they typically lack the power to define expectations for nurses' organizational roles. Nevertheless, in the data, the needs of patients and their relatives were highly important for nurses, and it was part of nursing ethics to do the best to serve these customer groups. Patients and relatives mainly held expectations concerning the roles of alongside stroller and patients' advocate.

The third group, the nursing association and legislators, are external stakeholders: they operate outside the borders of the healthcare organization. The nurses' own professional association, both according to the data and theory (see Loversidge, 2013), defines organizational roles for nurses more profoundly than any other stakeholder. Accordingly, as suggested by Mintzberg (1979) in his seminal work, the coordination of professional bureaucracies, such as hospitals, in many ways take place outside institutional borders through professional associations. This happens, for example, when nursing associations publish recommendations that formally guide nurses' behaviour—just as the Finnish Nurses' Association has done in the case of its instructions for ethical guidelines (Ethical Guidelines of Nursing, 2014).

Professional control (or professional self-regulation) can be much stronger than formal managerial control (De Bruijn, 2011; Mintzberg, 1979). Being a part of a

---

[4] When healthcare professionals work together in networks or via the internet, they may be defined as external stakeholders.

[5] Blair and Fottler (1990) suggest that patients and their families are external stakeholders of healthcare organizations. We disagree and, similar to Parsons (1961) and Bourgeault et al. (2011), instead see patients and their families as recipients of healthcare services and thus operative members of healthcare organizations.

profession requires members to accept the values of the professional group (Abbott, 1988). Professional values and ethical principles are central to the nursing profession and are thus taught and internalized as early as during the nurses' training and indoctrination phase (see Lurie, 1981). Mutually shared ethical codes are also a tool for maintaining a profession's internal and external legitimacy (see Kitchener, 2002). Legislators set expectations for nurses primarily concerning their knowledge and competence requirements; along with these come the nurse's role as an expert and skills developer.

Conclusions and suggestions for future research

In the study, five different organizational role expectations for nurses were identified: "the alongside stroller," "the patients' advocate," "the reliable colleague and team-member," "the expert and skills developer," and "the organizational underdog." Furthermore, based on the analysis, there are seven key stakeholders that are particularly active in setting role expectations for nurses: patients and their relatives, physicians and other healthcare professionals, the work community, the nursing association, and legislators. All the mentioned stakeholders were important from the perspective of the organizational role expectations for nurses; however, the nursing association, legislators, and occasionally physicians and the work community were identified as definitive stakeholders. The organizational role expectations of these definitive stakeholders can be seen as mostly formal, whereas those of dependent stakeholders can be seen as informal.

The organizational role expectations identified in this study are not completely new. For instance, Evers (2003) has made somewhat similar identifications for nurses in his presentation of nurses' roles as complementary to that of physicians. However, compared to previous studies, this study identifies a range of expectations connected to each role in current nursing work and illustrates more comprehensively the set of nurses' organizational roles. Unlike the extant literature, this analysis provides empirical evidence of nurses' organizational roles based on professional nursing literature and thus offers a new perspective on the topic. This study also links the stakeholder perspective (Mitchell et al., 1997) and nurses' organizational roles (Mintzberg, 1979) for the purpose of highlighting the multiple sources of these expectations.

When professions are understood as changing systems (see Abbott, 1988; Muzio et al., 2013), it becomes important to identify and understand the expectations that stakeholders have towards a professional group. This study contributes to research literature on professions by introducing stakeholder expectations as a mechanism that can change nursing professionals' organizational roles. The extent to which professionals and professions adapt to these expectations is related to, for instance, professional associations. According to Noordegraaf (2011), professional associations can bring external expectations to professional education and therefore affect professional roles.

This study also contributes to the literature by expanding understanding of nursing roles using trade journal literature and by triggering a much-needed exploration of nursing roles that clarifies nurses' identities, functions, and responsibilities. Of course, this study is based on data collected from nurses' own trade journal, and one should perceive the results in light of this.

The results of the study can benefit, for example, nursing education, and can also be utilized in nursing management, especially when redesigning nurses' work tasks. It is important, both for educational and managerial purposes, to recognize the role expectations for nurses and the stakeholders behind them. This is also important from the perspective of the professional identity of nurses (Johnson, Cowin, Wilson, & Young, 2012). While this study describes stakeholders and their organizational role expectations specifically for the nursing profession, it is likely that other professions will also find food for thought and might consider identifying their own organizational role expectations derived from specific stakeholders.

In the future, additional perspectives could be gained by gathering supplementary data from other healthcare professionals' trade journals or by conducting observations and interviews with nurses or other actors who set expectations for nurses (such as patients or other healthcare professionals). It should also be noted that this study focuses on nurses' organizational roles and stakeholders' role expectations in the case of nurses conducting general nursing work. For future research, it may be useful to study nurse managers' and advanced practice nurses' roles separately. Furthermore, while reading the extant literature, the conceptual ambiguity of the term role in professional nursing became evident. We, therefore, suggest the importance of conceptual analysis in future research.

References

Abbott, A. (1988). *The system of professions.* Chicago: The University of Chicago Press.

Arndt, M. (2003). Political activity and the nurse—a professional duty? In T. Winn (Ed.), *Ethical and professional issues in nursing, perspectives from Europe* (pp. 72−96). Hampshire: Palgrave Macmillan.

Blair, J. D., & Fottler, M. D. (1990). *Challenges in health care management: Strategic perspectives for managing key stakeholders.* San Francisco: Jossey-Bass.

Bourgeault, I. L., Hirschkorn, K., & Sainsaulieu, I. (2011). Relations between professions and organizations: More fully considering the role of the client. *Professions & Professionalism, 1*(1), 67–86. https://doi.org/10.7577/pp.v1i1.150

Bryson, J. M. (2004). What to do when stakeholders matter: Stakeholder identification and analysis techniques. *Public Management Review, 6*(1), 21−53. https://doi.org/10.1080/14719030410001675722

Currie, W., Pouloudi, N., & Whitley, E. A. (2016). Entangled stakeholder roles and perceptions in health information systems: A longitudinal study of the UK NHS N3 network. *Journal of the Association for Information Systems, 17*(2), 107−161. https://doi.org/10.17705/1jais.00421

DeNisco, S. M., & Barker, A. M. (2013). *Advanced practice nursing: Evolving roles for the transformation of the profession.* USA: Jones & Barlett Learning.

De Bruijn, H. (2011). *Managing professionals.* Oxon: Routledge.

Durosaiye I. O., Hadjri, K., Liyanage, C. L., & Bennett, K. (2018). A matrix for the qualitative evaluation of nursing tasks. *Journal of Nursing Management, 6*(3), 274−287. https://doi.org/10.1111/jonm.12543

Ethical Guidelines of Nursing. (2014). *Assembly of the Finnish nurses association.* Retrieved from https://sairaanhoitajat.fi/artikkeli/ethical-guidelines-nursing

Etsioni, A. (1969). *The semi-professions and their organization: Teachers, nurses, social workers*. New York: FreePress.

Evers, G. (2003). The nurse's role: present and future. In W. Tadd (Ed.), *Ethical and professional issues in nursing, perspectives from Europe* (pp. 12−36). Hampshire: Palgrave Macmillan.

Fagin, C. M., & Diers, D. (2011). Nursing as metaphor. In D. J. Mason, S. L. Isaacs & D. C. Colby (Eds.), *The nursing profession: Development, challenges, and opportunities* (pp. 115−118). San Francisco: Jossey-Bass.

Flinkman, M. (2014). *Young registered nurses' intent to leave the profession in Finland—A mixed-method study* (Doctoral thesis). University of Turku, Turku.

Freeman, R. E. (1984). *Strategic management: A stakeholder approach.* New York: Cambridge University Press.

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge.* New York: Dodd, Mead & Co.

Gibson, F., & Bamford, O. (2001). Focus group interviews to examine the role and development of the clinical nurse specialist. *Journal of Nursing Management, 9*(6), 331−342.

Godin, M. (2013). Information technology for advanced nursing practice. In S. M. DeNisco & A. M. Barker (Eds.), *Advanced practice nursing: Evolving roles for the transformation of the profession* (pp. 307−330). USA: Jones & Barlett Learning.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105−112. https://doi.org/10.1016/j.nedt.2003.10.001

Hatch, M. J., Kostera, M., & Kozminski, A. K. (2005). *The three faces of leadership: manager, artist, priest.* Oxford: Blackwell.

Henderson, V. (2011). The nature of nursing. In D. J. Mason, S. L. Isaacs & D. C. Colby (Eds.), *The nursing profession: Development, challenges, and opportunities* (pp. 89−100). San Francisco: Jossey-Bass.

Jokiniemi, K. (2014). *Clinical nurse specialist role in Finnish health care,* University of Eastern Finland, Finland. Retrieved from http://urn.fi/URN:ISBN:978-952-61-1579-5

Johnson, M., Cowin, L.S., Wilson, I., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges. *International Nursing Review, 59*(4), 562–569. https://doi.org/10.1111/j.1466-7657.2012.01013.x

Kankaanranta T., & Rissanen P. (2008). Nurses' intentions to leave nursing in Finland. *The European Journal of Health Economics, 9*(4), 333−342. https://doi.org/10.1007/s10198-007-0080-3

Kitchener, M. (2002). Mobilizing the logic of managerialism in professional fields: The case of academic health centre mergers. *Organization Studies, 23*(3), 391–420. https://doi.org/10.1177/0170840602233004

Leemeijer, A., & Trappenburg, M. (2016). Patient centered professionalism? Patient participation in Dutch mental health professional frameworks. *Professions & Professionalism, 6*(2). https://doi.org/10.7577/pp.1474

Loversidge, J. M. (2013). Government regulation: Parallel and powerful. In S. M. DeNisco & A. M. Barker (Eds.), *Advanced practice nursing: Evolving roles for the transformation of the profession* (pp. 231−260). USA: Jones & Barlett Learning.

Lurie, E. E. (1981). Nurse practitioners: Issues in professional socialization. *Journal of Health and Social Behavior, 22*(1), 31−48. https://doi.org/10.2307/2136366

Lynn, I., Hirschkorn, K., & Sainsaulieu, I. (2011). Relations between professions and organizations: More fully considering the role of the client. *Professions & Professionalism, 1*(1), 67−86.

Marquis, B. L., & Huston, C. J. (2006). *Leadership roles and management functions in nursing: Theory and application*. Philadelphia: Lippincott Williams.

Mason, D. J. (2011). The nursing profession: development, challenges, and opportunities. In D. J. Mason, S. L. Isaacs & D. C. Colby (Eds.), *The nursing profession: Development, challenges, and opportunities* (pp. 3−81). San Francisco: Jossey-Bass.

McCarthy, G., Cornally, N., Moran, J., & Courtney, M. (2012). Practice nurses and general practitioners: Perspectives on the role and future development of practice nursing in Ireland. *Journal of Clinical Nursing, 21*(15−16), 2286–2295. https://doi.org/10.1111/j.1365-2702.2012.04148.x

McGarvey, H. E., Chambers, M. G. A., & Boore, J. R. P. (2000). Development and definition of the role of the operating department nurse: A review. *Journal of Advanced Nursing, 32*(5), 1092−1100. https://doi.org/10.1046/j.1365-2648.2000.01578.x

McKenna, H., Richey, R., Keeney, S., Hasson, F., Poulton, B., & Sinclair, M. (2008). The managerial and development issues of nurses and midwives in new roles. *Scandinavian Journal of Caring Science, 22*(2), 227−235. https://doi.org/10.1111/j.1471-6712.2007.00519.x

Mintzberg, H. (1973). *The nature of managerial work.* New York: Harper & Row.

Mintzberg, H. (1979). *The structuring of organizations: A synthesis of the research*. Engkewood Cliffs: Prentice-Hall.

Mitchell, R. K., Agle, B. R., & Wood, D. J. (1997). Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *Academy of Management Review, 22*(4), 853–886.

Morgan, G. (1986). *Images of organization.* Thousand Oaks: Sage.

Muzio, D., Brock, D. M., & Suddaby, R. (2013). Professions and institutional change: Towards an institutionalist sociology of the professions. *Journal of management studies, 50*(5), 699–721. https://doi.org/10.1111/joms.12030

Noordegraaf, M. (2011). Remarking professionals? How associations and professional education connect professionalism and organizations. Current Sociology, 59(49), 465–488. https://doi.org/10.1177/0011392111402716

Olakivi, A., & Niska, M. (2017). Rethinking managerialism in professional work: from competing logics to overlapping discourses. *Journal of professions and organization, 4*(1), 20–35.

Parsons, T. (1961). Sociological approach to the theory of organizations. In A. Etzioni (Ed.), *Complex organizations: A sociological reader* (pp. 32−47). New York: Holt, Rinehart & Winston.

Postma, J., Oldenhof, L., & Putters K. (2015). Organized professionalism in healthcare: Articulation work by neighbourhood nurses. *Journal of Professions and Organization, 2*(1), 61–77. https://doi.org/10.1093/jpo/jou008

Robbins, S. P., & Judge, T. A. (2010). *Essentials of organizational behavior*. New Jersey: Pearson Education.

Sairaanhoitajat. (2016a). *Faktat lehdestä* [Facts about the journal]. Retrieved from https://sairaanhoitajat.fi/jasenpalvelut/ammatillinen-kehittyminen/sairaanhoitajalehti/faktat-lehdesta

Sairaanhoitajat. (2016b). *Sairaanhoitajaliitto* [Finnish Nurse Association]. Retrieved from https://sairaanhoitajat.fi/sairaanhoitajaliitto

Salmela, S., Eriksson, K., & Fagerström, L. (2011). Leading change: A three-dimensional model of nurse leaders' main tasks and roles during a change process. *Journal of Advanced Nursing, 68*(2), 423−433. https://doi.org/10.1111/j.1365-2648.2011.05802.x

Tadd, W. (2003). Challenges and issues in nursing. In W. Tadd (Ed.), *Ethical and professional issues in nursing, perspectives from Europe* (pp. 1−11). Hampshire: Palgrave Macmillan.

Twomey, J. G. (2013). The role of codes of ethics in nursing's disciplinary knowledge. In S. M. DeNisco & A. M. Barker (Eds.), *Advanced practice nursing: Evolving roles for the transformation of the profession* (pp. 569−582). USA: Jones & Barlett Learning.

Verschuren, P. J. M., & Masselink, H. (1997). Role concepts and expectations of physicians and nurses in hospitals. *Social Science & Medicine, 45*(7), 1135−1138. https://doi.org/10.1016/S0277-9536(97)00043-9

Appendix

Stakeholders' organizational role expectations for nurses, their locus, and salience

Stakeholder	**Condensed meaning unit**	**Code**	Organizational role expectations	**Stakeholder locus**	**Stakeholder salience**
Physicians	We know each other´s ways of working and I can trust her. She takes a lot of responsibility for the patients. (Vol. 2014, issue 1)	There is confidence between the physician and the nurse.	Reliable colleague and team member	Internal	Dependent stakeholder and occasionally definitive
	Physicians work as trainers. Passing exams authorizes nurses to keep their own reception. (Vol. 2014, issue 6-7)	The nurse's organizational role is enlarging.	Expert and skills developer		
Other healthcare professionals	Nurses and other healthcare professionals work in close co-operation. There is mutual emotional and discussion support. (Vol. 2015, issue 3)	Nurses work in close co-operation with colleagues, and they support each other.	Reliable colleague and team member	Internal	Dependent
	Comprehensive treatment of the patient requires multi-professional co-operation with e.g., nurses, physicians, a nutritionist, and a social worker. (Vol. 2014, issue 9)	Comprehensive treatment results from multi-professional co-operation.	Expert and skills developer		
Work community	The advanced practice nurse nurse has time for the patient. S/he has time to explain any issues and provide patient guidance. (Vol. 2014, issue 9)	The nurse's job description is enlarged.	Alongside stroller	Internal	Definitive stakeholder and occasionally dependent
	The aim is to guide patients to the groups that serve their needs. We also have groups tailored for certain diseases. (Vol. 2014, issue 2)	The work community provides to patients the groups that meet their health needs.	Patients' advocate		
	When an intensive care patient is brought to the hospital, multi-professional teamwork proceeds fluently thanks to the organization's operational protocols. (Vol. 2014, issue 5)	The operational protocols of the organization support the nursing role as one of a reliable colleague.	Reliable colleague and team member		
	In addition to other tasks, nurses provide guidance in schools, day-care, and in meetings where the patients' matters are discussed. (Vol. 2014, issues 11−12)	The nurse provides expert guidance to various actors.	Expert and skills developer		
	There has been some debate about how job enlargement should manifest itself in nurses' salaries. (Vol. 2014, issue 9)	Compensation for increased accountability does not manifest in nurses' salaries.	Organizational underdog		
Patients	The patient expects a confidential and safe relationship with the nurse. (Vol. 2015, issue 1)	Nurse's interpersonal attitude in patient care	Alongside stroller	Interface	Dependent
	In the middle of the lunch break, a	The patient comes to the nurse	Patients' advocate		

	colleague comes to say that a patient is asking for the nurse. “The patient does not have reservations about his/her treatment but brings other worries to the nurse”? (Vol. 2014, issue 4)	with his/her worries.			
Patients’ relatives	Taking care of family members is part of the patients’ treatment. Relationships and interaction between family members are supported. (Vol. 2014, issue 4)	Nurses support patients’ relatives.	Alongside stroller	Interface	Dependent
	Loved ones can find decision making hard and may need the support of the nursing staff. (Vol. 2015, issue 3)	Relatives need support from nurses to make decisions.	Patients’ advocate		
Nursing association	The Nurses’ Association participates in a project creating a case manager model for patients that requires several health services. (Vol. 2014, issue 8)	Nurses’ Association is involved in developing the case manager model	Alongside stroller	External	Definitive
	Nurses have an important task as a profession. Nurses play a critical role in caring for patients and ensuring better healthcare. (Vol. 2014, issue 2)	The nursing profession’s task is to take care of patients and healthcare	Patients’ advocate		
	The Nurses’ Association asked a nurse to join a workgroup that would compose collegiality guidance for nurses (Vol. 2014, issue 3)	Nurses’ Association contributes to writing collegiality guidance for nurses.	Reliable colleague and team member		
	The Nurses’ Association created a new web service with the priority of providing interesting professional content for nurses. Nurses also play a role in creating this content. (Vol. 2014, issue 11–12)	Nurses create content in a professional web service.	Expert and skills developer		
Legislators	The upcoming law related to self-determination will cause challenges for the education and expertise of nursing staff. (Vol. 2015, issue 1)	The law of self-determination will change nurses’ expertise requirements.	Expert and skills developer	External	Definitive

&PROFESSIONS PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), e2298 http://doi.org/10.7577/pp.2298

Ursula Reichenpfader, Anette Wickström, Per Nilsen, Madeleine Abrandt Dahlgren, and Siw Carlfjord

Medi(c)ation Work in the Emergency Department: Making Standardized Practice Work

Abstract: Medication review, the systematic examination of an individual patient's medicines in order to improve medication therapy, has been advocated as an important patient safety measure. Despite widespread use, little is known about how medication review is conducted when implemented in routine health care. Drawing from an ethnographic case study in a Swedish emergency department and using a practice-based approach, we examine how medication review is practically accomplished and how knowledge is mobilized in everyday practice. We show how physicians construct and negotiate medication safety through situated practices and thereby generate knowledge through mundane activities. We illustrate the centrality of practitioners' collective reflexive work when co-constructing meaning and argue here that practitioners' local adaptations can serve as important prerequisites to make "standardized" practice function in everyday work. Organizations need to build a practical capacity to support practitioners' work-based learning in messy and time-pressured health care settings.

Keywords: Practice-based study, ethnography, practical knowledge, professional practice, medication review, implementation, patient safety

Ursula Reichenpfader,
Linköping University, Sweden

Anette Wickström,
Linköping University, Sweden

Per Nilsen,
Linköping University, Sweden

Madeleine Abrandt Dahlgren,
Linköping University, Sweden

Siw Carlfjord,
Linköping University, Sweden

Contact:
Ursula Reichenpfader,
Linköping University, Sweden
ursula.reichenpfader@liu.se

Medicines are the most commonly used therapies in health care, and the consumption of acute and chronic medications is increasing worldwide (World Health Organization, 2011). Although the availability of effective and safe drug treatments has had beneficial effects on the health of many patients, medication therapy has also been associated with negative health outcomes (Cadogan, Ryan, & Hughes, 2016). Quality of care and patient safety can be compromised when medicines are used or prescribed inappropriately, administered wrongly, or not monitored adequately. Prescribing or using inappropriate medications, that is, medicines without a clear clinical indication or not considered suitable for a given clinical situation of an individual patient, can result in ineffective drug treatment or medication-related problems (Leendertse, Egberts, Stoker, & van den Bemt, 2008). Nevertheless, medication appropriateness itself is a complex concept where several interconnected processes of selecting a particular drug have to be taken into account: the prescriber's clinical assessment of a patient's situation, an evaluation of the therapeutic aim, but also the accepted scientific evidence for that drug. Quality and safety of medication therapy, though, not only depend on these latter steps. Importantly, quality and safety are further entangled with activities of documentation where medical justification for a

Received:
13 Oct 2017

Accepted:
26 April 2018

specific medication is provided and is made accessible to others (Tully & Cantrill, 2006). This means that safer medication therapy is not only based on selecting the "correct" medication but equally rests on "correct" and up-to-date medication documentation (Kripalani et al., 2007).

Medication-related problems account for a considerable number of emergency department (ED) visits, many of which are considered preventable (Castro et al., 2013). Medication review, the systematic assessment of an individual patient's pharmacotherapy with the aim of improving therapy, has been suggested as a potentially relevant strategy to reduce medication-related harms (Christensen & Lundh, 2016). Medication review usually starts with a process called medication reconciliation whereby the patient's usual medications are identified and compared with a list known to the health care provider. Unintended discrepancies are reconciled and then included in an updated list used to assess medication therapy (Kwan, Lo, Sampson, & Shojania, 2013). Although hospital-based medication review was found to lead to a reduction of ED visits after discharge, it did not consistently improve clinically relevant health outcomes (Christensen & Lundh, 2016; Huiskes, Burger, van den Ende, & van den Bemt, 2017). Programs of medication review have been increasingly put into practice in various countries (Bulajeva et al., 2014), yet implementation into routine health care has proved to be challenging (van Sluisveld, Zegers, Natsch, & Wollersheim, 2012).

Little is known about how medication review really works (Sinnott et al., 2015). Uncertainties around the effectiveness of medication review as well as the difficulties to successfully integrate it into routine health care have prompted discussions about the complexity of medication review (Huiskes et al., 2017). Contributing to such complexity are, among others, the number of tasks and professional actors involved, the degree of patient involvement, and questions such as the optimal intensity and timing of conducting medication review. Difficulties to implement new practices or technologies in routine health care have been framed as accounts of clinicians' resistance against guideline- and protocol-driven care, viewed as too technical, standardized or "cookbook medicine" and not attuned to the contextualized nature of health care (Pope, 2003). We argue here that integrating a new way of working into everyday clinical routine requires a deeper understanding of the practice to be implemented but also of the dynamic context where implementation takes place. Thus, attention should be paid to how practitioners enact this practice and how they judge its workability in a given context (May, Johnson, & Finch, 2016). Rather than exploring difficulties in implementation with a focus on clinicians as resisting standardized practice, it should be examined how practitioners make such standards work in routine, messy practice situations. Conceiving standardization as a dynamic process where "localization and universality are inevitably intertwined" (Timmermans & Berg, 1997, p. 277), one should then look into how professional knowledge and working practices are re-configured when trying to make these standards work as "local universalities."

This article draws from a case example of local implementation of medication review in an ED at a Swedish university teaching hospital. In Sweden, in the case of medical emergencies or accidents, care is provided at hospital EDs with full 24-hour emergency services concentrated at the larger hospitals (Anell, Glenngård, & Merkur, 2012). Patient volumes and ED waiting times have increased, and there is a growing proportion of ED visits by elderly patients with complex conditions who require admission (Socialstyrelsen, 2014). Time targets for processing patients in Swedish EDs were introduced to reduce waiting times, and ED physicians report heavy workloads and lack of available hospital beds as significantly contributing to difficult work conditions (Bejerot, Gustavsson, Hasselbladh, Kankkunen, & Ekberg, 2017).

Medication review was introduced nationally in Sweden in 2012 as a measure to reduce inappropriate prescribing and preventable medication-related problems (Socialstyrelsen, 2012). According to binding national regulations, patients aged 75 years or older with five or more prescribed medications are entitled to receive medication review once a year in primary and ambulatory care, and when admitted to hospital. Regional guidelines in Östergötland are broader in scope in that medication review must be conducted for all patients irrespective of age or number of medications. Regulations and guidelines, though, offer few specifics of how assessment of medication appropriateness shall be done.

However, implementation in Östergötland aimed to establish "uniform procedures in order to reduce the risk of avoidable medication-related problems" (Region Östergötland, 2015). Efforts were made to provide shared medication lists within the electronic medical record (EMR) system to facilitate access to updated medication information within and across regions in Sweden. Yet, medication data are not automatically transferred between different regions, electronic medication lists are frequently incorrect, and patients often do not use these medication lists as an information source (Hammar, Ekedahl, & Petersson, 2014). Thus, it is crucial for patient safety that medication lists are verified and updated in each health care episode.

This article addresses an existing gap in the research literature in that it examines the practical, everyday doing of medication review using an ethnographic approach. A large number of controlled clinical trials evaluating the effectiveness of medication review with respect to subsequent health care contacts, morbidity and mortality have been conducted (Christensen & Lundh, 2016) but left issues of implementation unresolved (Viswanathan et al., 2015). In addition, aspects relevant to the delivery of medication review, such as physician-pharmacist collaboration, task distribution, or physicians' perceived competence in performing medication review have been previously explored (Hatah, Braund, Duffull, & Tordoff, 2013; Jubraj et al., 2015). Nevertheless, these studies used interview or questionnaire methods and were directed at cognitive and attitudinal factors of individual practitioners only. A focus on practical accomplishment brings to the fore the situated and processual character of a practice but also the normative dimension as practitioners' collective sense of appropriate practice (Geiger, 2009). Taking such a stance provides a broader perspective on how activities can be understood and analysed, going beyond cognitivist and rationalist views on doing and learning (Mahon, Francisco, & Kemmis, 2016). Thus, attending to the "seen but unnoticed, social and interactional resources" (Heath, Knoblauch, & Luff, 2000, p. 316) that practitioners draw upon in accomplishing everyday work can provide insights into how practices can be transformed and improved. In this article, we aim to analyse the practical knowledge necessary to perform medication review in the ED. We are particularly interested in analysing how medication safety is practically accomplished and how practices of medication review are being reproduced in everyday ED work.

Theoretical perspective: A practice-based approach

Practice theory has been described as consisting of a "broad family of theoretical approaches" (Nicolini, 2012) rather than being a unified theory (Schatzki, Knorr Cetina, & von Savigny, 2001). Nevertheless, practice-based approaches share various common assumptions, such as focusing on practices instead of individuals as the central unit when analysing social phenomena and viewing human activity as an ongoing and open event entangled with material arrangements (Nicolini, 2017). How actors define and organize the actions of a practice, their ideas of a practice's meaning, utility and legitimacy, in short, what they agree on that "makes sense to do" (Nicolini, 2012, p. 165), all hold a practice together. Researching a practice then implies not only attending to "what people actually do" but also to the specific historical, social, material and cultural context in which such doings are situated. Importantly, the context here is not conceived as a pre-given property but as emerging, dynamic and connected to the practices themselves (Nicolini, Gherardi, & Yanow, 2003). One of the several orientations within practice-based studies assumes the inseparable entanglement of knowledge with practice. Here, knowledge is transformed through its use in practice, where the knowing and the doing (of a practice) are relationally considered equivalent, as knowledge is activated and translated into a particular knowing through practices (Gherardi, 2011).

We have chosen to analyse medication review by focusing on the practical knowledge necessary to accomplish everyday work. Here, practical knowledge is understood as knowledge continuously constructed in normal work activities and as something which is recognized by or made recognizable to other participants in the practice. It is the knowing generated in performing a practice, a knowing-how-to-see, knowing-how-to-speak, and knowing-how-to-act (Gherardi, 2006, 2012b). Such a conception of practice emphasizes the situated, problem-oriented, experience-based and provisional character of human activity and posits learning and knowledge as unfolding over time *in* practicing. Knowledge is then not understood as simply pre-existing or residing in the head of individuals as an abstract possession. Knowledge, instead, is conceived as located in practices and activated through sayings and doings (Bruni, Gherardi, & Parolin, 2007). Practical knowledge, thus, concerns the "multiple methods of seeing, listening, reasoning and acting in connection with human and non-human elements" (Gherardi, 2009, p. 118); it is embedded in an institutional context, drawing on prior experiences, and constituted in how participants in the situation define, discuss and negotiate how the practice is being done appropriately (Gherardi, 2008).

The empirical project

A case study with an ethnographic approach was conducted in the ED of a large teaching hospital in the county council of Östergötland in Sweden. Ethical approval has been granted by the Regional Ethics Board (Dnr 2015/194-31). Ethnographic methods (Gherardi, 2012b) are often used in practice-based studies because they make it possible to appreciate everyday interactions and "practice as it happens" (Nicolini, 2012, p. 14). A case-study approach using ethnographic techniques with a "sensibility for practice" (Sedlačko, 2017, p. 47) seems best suited for studying practices. Such an approach upholds the principles of openness, immersion and reflexivity, while at the same time attends to people's doings and sayings and the materials used in practice.

Data collection

Between October 2015 and May 2016, the first author conducted the fieldwork and all interviews, undertaking about 160 hours of direct observation in all areas of the ED on 21 work shifts (day shifts but also several evening shifts on weekdays). The physicians shadowed (11 male, 10 female) reflected a wide a range of work experience in terms of duration of specialty training in emergency medicine and time worked at the ED. Fieldwork included informal discussions with ED staff. At the beginning of the shift, the researcher was assigned to a team by the ED charge nurse. Depending on the preferences of the physician of the assigned team, written or oral consent was obtained from the physicians shadowed, and oral informed consent was obtained from all other participants; participants received short written information about the study purpose and procedures. Open jottings in a paper notebook were made on site and further expanded into full fieldnotes on the same or subsequent day on the computer. Fieldwork not only included shadowing of physicians but also involved following material objects and tools that ED staff interacted with. After initial observations, the field researcher particularly focused on the artifacts that critically mediated ED medication work, such as the medication list (both in electronic and paper format), the EMR, but also the drug-interaction checker and other web-based clinical decision aids.

Additionally, semi-structured interviews with 13 ED physicians were conducted where participants were recruited to ensure diversity with respect to seniority, subspecialty and time worked in the ED. All 13 semi-structured interviews (mean duration of interviews 34 minutes; 7 ED specialist physicians, 6 at various stages of ED speciality training; 5 of the interviewees were previously shadowed by the first author) took place on hospital premises, in a room chosen by the physician, and were based on a broadly structured interview guide. All interviews (with the exception of one interview done during fieldwork directly after the physician's work shift) were conducted shortly after completion of the fieldwork phase. Interviews were digitally recorded and transcribed verbatim by the first author.

Data analysis

Data analysis was conducted by the first author with regular reflexive discussions among all authors. Throughout the research process, the first author kept a reflective journal describing experiences in the field, the researcher's reaction to the participants (personnel and patients), and also participants' reactions to the researcher. Writing and then sharing these reflections with the co-authors facilitated the development of critical awareness of the research process, particularly researcher–participant interactions during fieldwork and how these interactions might have affected data collection and interpretation. This involved recognizing tensions between the researcher role and the need to build and maintain rapport and trust with participants, making explicit the first author's assumptions prior to and when entering the field, but also reflecting on the field researcher's own position vis-à-vis the shadowed participants. Additionally, the first author engaged in regular meetings with the co-authors (one of them being a social anthropologist with about 15 years of ethnographic research experience) discussing fieldnotes, interview excerpts, conceptual maps, memos and analytic categories. Discussions about the methods of data analysis focused on how theoretical conceptions were developed, particularly how categories and relations between sets of data were generated. NVivo 10 was used for the initial and focused coding of the entire material after multiple readings of the data.

An interpretive, constructivist approach (Charmaz, 2014) with time spent in the field interspersed with periods immersed in the data was used. During two rounds of initial analysis, major categories and ideas (practices for identifying medication problems, constructions of risk and patient safety, generation of relevant knowledge, appraisal of own work, practices to prevent medication harm, professional responsibility) were created inductively and then iteratively interrogated by emerging concepts and the practice-theoretical constructs employed (Hammersley & Atkinson, 2007; Timmermans & Tavory, 2012). Particularly, the concepts of situated action of work practices and knowing-in-practice as elaborated by Gherardi (2006; 2012b) were used as analytical frames to investigate practitioners' own conceptions of medication safety and good medication practices. We particularly examined how these conceptions and understandings were connected to the objects used, own and others' actions performed, as well as the specific practice context. We focused on presenting fieldnote extracts to illustrate the findings discussed in this article. To this end, we selected instances that illustrated how physicians' knowing-in-doing medication review was organized when dealing with routine and non-routine problems in the ED. We found that the fieldnotes best captured the highly contextualized and situated nature of participants' sayings and doings when carrying forward a practice. Nevertheless, to a limited extent, we also present findings based on field observations as paraphrased text. The intention was to present concepts related to medication review practice that complement fieldnote extracts and which, although lacking the specificity and vividness of them, are still being true to the field experience. Finally, we also included physicians' "sayings in action" and embedded these verbatim passages in the narrative text (shown in double quotation marks). Again, we found these comments, made in informal field conversations (DeWalt & DeWalt, 2011), very relevant to researching practices as these were often made in direct connection to physicians' daily activities and, thus, tapped into the processual character of a practice.

Findings

Zooming in on how medication review is being practised in the ED, we first show the heterogeneous network in which the practical knowledge relevant to medication review is located. In the following subsections, three fieldnote extracts were chosen to illustrate how different elements of knowledge related to medication safety are connected "in-action" and how practical knowledge emerges each time anew.

It has to add up

Physicians exert some discretion with respect to the extent and depth of inquiring about a patient's medications and emphasize that not all patients they see in the ED would "need medication review." They acknowledge the "difficulty in specifying such need beforehand" and find it easier to define situations where medication lists are not "the main concern," usually patients with minor injuries. Conversely, patients with more complex conditions and those who might require hospital admission generally warrant a more thorough exploration to verify medications. The following account illustrates the special effort needed to obtain complete information about the medicines this patient was actually using.

> Dr N sees an elderly patient with abdominal pain. The patient, according to a note in the EMR, is a retired neurologist and has had several episodes of a urinary bladder infection. Asked by the doctor which medicines he had been taking, he insists, "Please, read it to me." Dr N checks her notepad and starts with the first few of the medications she had copied from the EMR, yet comes to a halt, "I have jotted down three different kinds of antibiotics from your record—have you taken all of them?" "Well, yes, I stopped the first one, and then tried two different antibiotics, but", he adds, "it did not get better… I thought I need something different now." On the way back Dr N comments, "He is self-medicating." She again checks the medication list on her computer, fetches the printout to double-check but still seems not convinced, "This does not add up… I can't figure out which of these (antibiotics) he took and for how long—I have to check again with him later." As the situation develops, the patient requires intravenous antibiotic therapy and in-hospital observation, so Dr N returns to the patient to verify medications for the second time. Finally, when dictating, she makes sure to refer to the patient as "a retired physician colleague" and lists all the medications she could establish, then pauses mid-dictation, "I usually do not mention this, but he was self-prescribing," then continues dictating. (Fieldnotes, January 2016)

Knowledge relevant in this situation resides in multiple locations: knowledge is anchored in the medical record and medication list, yet to a limited extent only. As this patient was self-prescribing, the parts most relevant to the situation—recent medication use and information on the course of the illness—had to be uncovered and reconstructed mainly in the patient-physician interaction. Thus, here, knowledge relevant for medication safety is not only distributed among these artifacts and the patient with knowledge on his actual medications; what makes it a skilful accomplishment and enactment of medication safety are the material-discursive practices in attending to what was actually *not* present in the record. This doctor assembled information obtained from the clinical presentation of the patient, notes in the medical record, and the patient's account of his own antibiotic use while also recognizing the gaps in the medical record and the discrepant medication lists. Here, practical knowledge is demonstrated by the physician's drawing on experience with self-medicating patients and her reacting to cues for action unfolding in the situation. The knowing-in-practice relevant to medication safety and medication review lies in how this physician critically interrogated the medical record, the medication lists, and the patient, hereby transforming the fragmented knowledge contained in the artefacts, or the "known," into a "knowing" (Bruni, Gherardi, & Parolin, 2007, p. 98) of how to obtain the best possible medication history in this situation. As stated at the beginning of this section, the in-depth inquiry of all patients about all medications is not considered doable in a busy ED environment. However, by making the "extra" effort so that medication information finally did "add up," this physician's practical accomplishment also shows the situated construction of medication risk, by identifying such a patient as "at risk" for a medication-related problem.

Illustrated, further, in the above account is the physician's hedging in the dictation by mentioning that the patient was a physician himself. ED clinicians do not express full confidence in the correctness of the medication information obtained, and given the episodic nature of their work, they are aware that they "never really know the patient." Faced with situations when patients are not quite certain about a specific medicine, physicians resort to a combination of clinical judgement and other validation strategies when deciding on approving a patient's medication list. Physicians then not only assess the face validity of a medication list by checking the drug therapy's plausibility given a recorded indication, but they also consider the date of a medication prescription and weigh up the credibility of the respective prescriber in a particular situation. Still, physicians stress the importance of "checking medications with the patient," not only because this helps them to produce an accurate medication list but equally so to "get a feel" of whether a patient is in control of and understands his or her own medications. Thus, physicians determined an individual patient's understanding of his or her medications through interaction with the patient *in* the practice of dealing with the medication list. This involved, for instance, using the list in some situations to assist patients in recalling their medications by reading out the drug names listed on the current medication list; yet, at other times when deemed appropriate, leaving the list and a pen to the patient and taking up such a list as edited by the patient in a medication discussion afterwards.

Similarly, as we will illustrate in the following subsection, a sensitivity for situational factors is also implicated in the practical knowledge required when assessing the appropriateness of medication therapy.

Checking medicines, checking patients

Medication review guidelines require physicians to assess a patient's medication therapy and provide individually tailored information to the patient. How medication safety is enacted in the ED, however, is shaped by the particular nature of emergency medicine practice with its focus on stabilizing and managing acute and potentially severe conditions. Thus, as exemplified in the following account, medication safety efforts focus on the problem at hand and take into account the organizational context in the ED where patients can stay and be monitored only for a limited period of time.

> After a brief handover at shift start Dr A sees a young female patient—she has given birth three weeks ago and is still breastfeeding—with acute renal colic symptoms; she was in extreme pain but feels better now after having received intravenous pain relief. It is agreed that she can be sent home with pain medication but shall return for further exams the next day. After double-checking whether an NSAID (nonsteroidal anti-inflammatory drug) is compatible with breastfeeding, Dr A writes a prescription. He then very thoroughly explains to the patient that she has to use the breast pump when taking the other medication,

> the one that contains codeine, an opioid. On our way back he explains “It’s always important to get a feel how reasonable a person is, how much they understand, I mean practically… I could see she was following what I was saying. So I’m confident to send her home now.” (Fieldnotes, December 2015)

This illustrates the practical knowledge at play or the knowing-in-practice as situated and competent knowing, “a knowing-how in situation” (Gherardi, 2012b, p. 206). In the above case, this entailed the physician assessing the patient’s clinical condition and linking decontextualized knowledge anchored in an artefact—the online information resource to check on drugs and breastfeeding, knowledge about the safety of a specific drug from the pharmaceutical database—with the knowledge learned “from experience and in experience” (Gherardi, 2012b, p. 25), that is, the sensible knowing of judging this patient’s ability to follow medication instructions. The latter knowledge was not something pre-existing or known to this physician; rather, it emerged as knowledge tied to the (inter)actions performed, and its mobilization also demonstrates the continuity of learning and practicing. The pragmatic stance, an orientation to problem solution, is evident in the above account and characteristic of practical knowledge; although patients with a similar condition might have required longer monitoring, this patient was considered safe to send home because it was possible to establish a sense of safety through interaction with the patient.

There are, however, further challenges to enacting medication safety. The difficulties ED physicians are confronted with when assessing medicines previously prescribed by health care providers outside the ED are illustrated in the following subsection.

Negotiating good practice

One of the main objectives of medication review is to identify medication-related problems, such as the use of potentially inappropriate medicines. Yet, ED physicians are very cautious about interfering with potentially problematic medications in everyday busy work. Put simply, not interfering with a patient’s medications in non-acute situations is often considered legitimate practice, and, therefore less acute or more long-standing medication issues often cannot be addressed. Yet, as the following account shows, there are legitimate causes that warrant taking action.

> Dr J, a junior resident, is seeing a young female patient who came to the ER with a suspected allergic skin reaction. Although no medical conditions or diagnoses are documented in the EMR, a lot of medicines are recorded on her medication list. Unsure of how to proceed, Dr J needs to discuss this patient with the senior specialist and comments to her, “Look, she has an old lady’s medication list.” The list contains sleeping pills, antidepressants and sedatives; the patient also takes a daily dose of a diuretic (a water pill). Asked by the specialist why this patient is taking such a drug without a documented indication in the patient record, the resident just replies, “You know, I didn’t even want to get into too much details with her … all the other medications were complicated enough to talk about.” Dr J then reviews all medications listed, discusses this again with the specialist and returns to the patient. During a longer conversation with the patient, Dr J learns that the patient is in close contact with her primary care physician and currently in the process of reducing her psycho-active medications; Dr J later documents her conversation with the patient and her recommendation to cut down and discontinue some of those problematic medications. When Dr J returns to the team room, Dr A, the specialist, comments, “We have to bring such things up, I know that other doctors here would just have only taken care of the main complaint and would have let her go. But she is so young; one has to try.” (Fieldnotes, December 2015)

The above account illustrates the modalities of two discursive practices, “talk in practice” and “talk about practice” (Gherardi, 2012a, p. 30), as further resources through which a practice’s performance is reproduced. While talk *in* practice occurs as exchanges between participants in collaborative work or when giving instructions, talk *about* practice refers to practitioners’ talk when the practice itself becomes the object of discourse. As the situation developed, the specialist mobilized narrative discourse by recounting how she dealt with “patients’ problematic medication use.” More specifically, she emphasized that “as an ED physician, one is not risking undermining the trust relationship between the patient and the physician, like in primary care” when dealing with uncomfortable situations. Thus, the practical accomplishment also rests on the competent use of “reflexive and argumentative discursive practices” (Gherardi, 2012b, p. 130) through which the specialist legitimized professional authority and accountability and on the ways how physicians understood and negotiated the implicit and formal rules regulating the practice in that situation. In talk about practice, the implicit rules “of doing or not doing things in the ED” were mobilized, eventually turning them into the practice’s “normative infrastructure” (Gherardi, 2012b, p. 132), a resource that supports a practice. At the same time, by talking about dealing with long-standing medication problems—typically not considered ED business—the specialist also put forth the affordances of the ED as a favourable setting as well as the professional competencies necessary for “being straightforward with the patient” and, thus, being capable of managing potential medication-related problems in the ED.

Moving beyond the above account and looking at other instances of managing suspected medication-related problems, talk in and about ED practice was also connected to knowledge based on formal rules embedded in diagnostic algorithms and ED treatment procedures. This would, for example, involve the team nurse proceeding with the triage protocol and checking with the physician which laboratory tests to order. The practitioners then subsequently engaged in discussions about the expected consequences of these tests, which, finally would result in a physician’s making the planned course of action explicit to others, often referring to a particular clinical algorithm. Talk in and about practice also developed when a physician sought advice from a senior ED specialist or consultant from other disciplines. Thus, talk constituted in practice made it possible to follow how knowledge unfolded in routine work situations. In addition, it made visible how professional competencies related to medication work were negotiated and how practices and competencies were bound up with protocols and rules intended to order or standardize the practice.

Conversely, theorizing through talk *about* practice was less evident in inter-professional contexts. Interpretation of observational data suggests that meanings of a practice were not exchanged between physicians and nurses in certain situations. Brief physician-nurse exchanges in instances when a medication list had to be reviewed and authorized before a patient’s admission to a ward revealed different understandings of the practice task and its competent performance. Here, physicians were often prompted by a nurse to “just sign the list,” whereas physicians, thereby deliberating their own practice, tried to make their doings accountable and emphasized the consideration required before approving such a list. Physicians, later, expressed frustration as they felt that the “complexity of reviewing medications” was lost on the nurses. Similarly, talk *about* practice was absent when team members at the start of each shift briefly discussed how to go about reviewing patients’ medication lists, hereby co-constructing what was considered “a patient at risk” and what was falling “inside the practice.” Usually, it was determined by the physician whether, for example, all patients’ medication list should be reviewed or only lists of specific patients. Nevertheless, as physicians would provide no explanations of their judgments, their understandings of appropriate candidacy for medication review were not made accessible to nurses. Although this was not further explored in this article, not sharing this knowledge, such “stickiness” of knowledge (Brown & Duguid, 2001) could be understood as practitioners not fully sharing a practice.

Discussion

In this article, we analysed the practical knowledge involved when performing medication review in the ED and how practices of medication review were being reproduced in everyday work. Viewing practice as an epistemic-normative construct (Rouse, 2001), what becomes reproduced as a practice is what is made recognizable to others as "accepted ways of doing and performing things" (Geiger, 2009, p. 133). We showed how ED physicians skilfully mobilized different forms of knowledge through participation in the practice. In doing so, the constructed they situated practice boundaries of medication review as well as negotiated the competencies to perform it appropriately. Subsequently, we will discuss the modalities identified that stabilized or reproduced the practice of medication review.

Firstly, the practice of medication review was reproduced through "silent legitimization" (Bjørkeng, Clegg, & Pitsis, 2009, p. 150), such as through the absence of sanctioning when physicians did not conduct medication review "according to the guidelines." Such silent legitimization was upheld by physicians' following the "accepted ways of doing things" in the local ED and in emergency medicine as a specialty. Contributing to the reproduction of medication-related practices, thus, was the professional vision of ED clinicians in how they understood events as a professional community and then transformed them into answerable problems (Goodwin, 1994). Here, the logic of standardized performance was at odds with the characteristics of a working environment with great time pressures, frequent non-routine situations and high patient variability with respect to symptom severity. Thus, ED physicians—often implicitly—engaged in constructing the practice's boundaries, establishing what was falling inside or outside medication review practice in a specific ED situation. This was exemplified in how physicians went about defining the "need" for medication review. Similarly, they adapted the conduct of medication review according to clinical judgements of a patient's risk for medication-related problems, for instance by modifying the thoroughness and duration of certain medication review components when asking about and documenting a patient's medications. These constructions of risk, "locally and contextually filled with practical meanings" (Gherardi, 2006, p. 227), focused on medication complexity, narrow therapeutic range drugs, and on patients with multiple conditions. Thus, ED physicians' medication review practices were not standardized in the sense of performance uniformity or conformity to guidelines. Rather, physicians practically constructed risk for medication problems where what counts as a relevant medication-related problem was shaped by what was considered answerable in the ED. Working around the medication review guidelines in certain situations, therefore, was at times legitimized as still being true to the "accepted ways of doing things" in the ED, accommodating the need to practice according to an individual patient's medical needs.

Secondly, medication review was reproduced by discursive practices where practitioners constructed medication review activities, such as how to identify, investigate or manage a suspected medication-related problem. Particularly in talk *about* practice (Gherardi, 2012a), such as shown in the specialist's taking up a young patient's problematic medication use, normative understandings of "good practice" were activated discursively through storytelling by the senior specialist. In talking about practice, practitioners negotiated the boundaries of what falls "inside" the practice of medication review, but also how to perform it competently in the ED. Talk about practice was conducive to learning within the community of ED physicians through practitioners' own theorizing about a practice, that is, their own practical reasoning about what makes medication review work or appraised their own work. Such theorizing often occurred "in the midst of practice and as a mundane conversation" (Gherardi, 2012a, p. 31), at times almost in passing, arising for example in the course of clinical supervision which attests to the significance of situated, practical knowledge through participation in everyday work. That practices and competencies were "negotiated" between professionals meant that situated meaning was made accessible to each other. Also, there was evidence of different inter-professional understandings of “good” or legitimate medication review practice, specifically of medication review activities where practice understandings were not established or exchanged. It should also be mentioned that not all practitioners had equal positioning, as talk in and about practice was essentially framed within a medically dominated discourse and within clearly delineated jurisdictions where physicians have the ultimate responsibility for conducting medication review and prescribing decisions.

Thirdly, we showed how materiality was involved in reproducing the practice where people and non-human actors were doing things together as a collective accomplishment. This meant that the practical knowledge was embedded in the community of ED clinicians, interacting with each other and the patient, as well as with multiple material entities (such as the medical record, the medication list, clinical decision support tools, drug databases) and organizational rules. Understanding practice as a phenomenon where non-human actors are “doing things together” with human actors shifts attention to the ways material entities act together with rules and discourses as mediators of social actions. Illustrated in the example with “an old lady’s medication list,” the formalized knowledge contained in artifacts such as the diagnostic algorithm for a patient presenting with suspected allergic reaction skin, privileged particular steps for a diagnostic work up. Nevertheless, mediated by talk about an ED physician’s unique position to tackle uncomfortable medication problems, competencies, and the sense of what it takes to be an ED physician were skilfully mobilized into the practice. The collective accomplishment of such medi(c)ation work, then, lies in the everyday practices of assembling these mediators so that medication safety can be achieved.

Lastly, the above discussed material-discursive practices were instrumental not only in reproducing medication review in routine work but also in adapting work practices to the local context. This is of practical relevance since adapting practice components in order to increase the fit between an intervention and its context can lead to improved outcomes when implementing a novel practice (Kakeeto, Lundmark, Hasson, & von Thiele Schwarz, 2017). Here, we showed how practitioners through material-discursive practices both enact and challenge the “script” (Akrich, 1992) ingrained in the medication review guidelines. Importantly, many of this script’s elements, the envisioned goals and purposes of medication review, the hypothesized mechanism and the conditions under which it works, as well as the actions set out for effective accomplishment, figure only implicitly in the guidelines. We argue here that practitioners’ local adaptations can serve as important prerequisites to make standardized practice function in everyday health care work. However, this requires a less traditional notion of standardization of medical care, one that accentuates its ongoing and co-constructive character (Ellingsen, Monteiro, & Munkvold, 2016). Thus, rather than viewing ED physicians’ deviations from the guidelines as resistance to top-down prescribed procedural standards, we understand their tweaking of and tinkering with these standards as efforts to align practice as prescribed in the guidelines with local contingencies on site and profession-specific standards of appropriate practice. Using our empirical case, we showed how ED physicians adapted practices by incorporating messy, less systematic, and less formal practices in order to make medication review locally workable.

Conclusions

We have made visible how ED physicians mobilize different forms of knowledge in “practicing” medication review in everyday work. We showed the important role of material-discursive practices and of silent legitimization in reproducing and adapting medication review, but also in learning within the community of ED practitioners.

Engaged in their ED practices, physicians implicitly and explicitly constructed medication risk and medication safety, established what defines "good" medication review practice and negotiated how it is competently performed. Both, workplace learning and implementation strategies need to better take into account such practical knowledge and the variability of practice in messy and time-pressured health care settings. Future research should explore how practitioners accomplish to integrate formalized, rules-based knowledge with practical knowledge to identify and manage medication-related risks and how these knowledge practices can be made accessible to other health professionals so that learning can materialise.

References

Akrich, M. (1992). The de-scription of technical objects. In W. E. Bijker & J. Law (Eds.), *Shaping technology/building society: Studies in sociotechnical change* (pp. 205–224). Cambridge and London: MIT Press.

Anell, A., Glenngård, A. H., & Merkur, S. (2012). Sweden: Health system review. *Health Systems in Transition, 14*(5), 1–159.

Bejerot, E., Gustavsson, M., Hasselbladh, H., Kankkunen, T. F., & Ekberg, K. (2017). Occupational control on drift—national and local intervention in clinical work at emergency departments. *Professions & Professionalism, 7*(1). https://doi.org/10.7577/pp.1765

Bjørkeng, K., Clegg, S., & Pitsis, T. (2009). Becoming (a) practice. *Management Learning, 40*(2), 145-159. https://doi.org/10.1177/1350507608101226

Brown, J. S., & Duguid, P. (2001). Knowledge and organization: A social-practice perspective. *Organization Science, 12*(2), 198–213. https://doi.org/10.1287/orsc.12.2.198.10116

Bruni, A., Gherardi, S., & Parolin, L. L. (2007). Knowing in a system of fragmented knowledge. *Mind, Culture, and Activity, 14*(1–2), 83–102. https://doi.org/10.1080/10749030701307754

Bulajeva, A., Labberton, L., Leikola, S., Pohjanoksa-Mantyla, M., Geurts, M. M., de Gier, J. J., & Airaksinen, M. (2014). Medication review practices in European countries. *Research in Social & Administrative Pharmacy, 10*(5), 731–740. https://doi.org/10.1016/j.sapharm.2014.02.005

Cadogan, C. A., Ryan, C., & Hughes, C. M. (2016). Appropriate polypharmacy and medicine safety: When many is not too many. *Drug Safety, 39*(2), 109–116. https://doi.org/10.1007/s40264-015-0378-5

Castro, I., Guardiola, J. M., Tuneu, L., Sala, M. L., Faus, M. J., & Mangues, M. A. (2013). Drug-related visits to the emergency department in a Spanish university hospital. *International Journal of Clinical Pharmacy, 35*(5), 727–735. https://doi.org/10.1007/s11096-013-9795-7

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd Edition). London: SAGE Publications Ltd.

Christensen, M., & Lundh, A. (2016). Medication review in hospitalised patients to reduce morbidity and mortality. *Cochrane Database of Systematic Reviews,* 2, CD008986. https://doi.org/10.1002/14651858.CD008986.pub3

DeWalt, K. M., & DeWalt, B. R. (2011). Participant observation: A guide for fieldworkers (2nd Edition). Lanham, MD: Rowman & Littlefield.

Ellingsen, G., Monteiro, E., & Munkvold, G. (2016). Standardization of work: Co-constructed practice. *The Information Society, 23*(5), 309–326. https://doi.org/10.1080/01972240701572723

Geiger, D. (2009). Revisiting the concept of practice: Toward an argumentative understanding of practicing. *Management Learning, 40*(2), 129–144. https://doi.org/10.1177/1350507608101228

Gherardi, S. (2006). *Organizational knowledge: The texture of workplace learning.* Malden, MA: Wiley-Blackwell.

Gherardi, S. (2008). Situated knowledge and situated action: What do practice-based studies promise? In D. Barry & H. Hansen (Eds.), *The Sage handbook of new approaches to organization studies* (pp. 516–527). London: Sage. https://doi.org/10.4135/9781849200394.n89

Gherardi, S. (2011). *Organizational learning: The sociology of practice.* Italy, Europe: Blackwell Publishing.

Gherardi, S. (2012a). Docta ignorantia: Professional knowing at the core and at the margins of a practice. *Journal of Education and Work, 25*(1), 15–38. https://doi.org/10.1080/13639080.2012.644902

Gherardi, S. (2012b). *How to conduct a practice-based study: Problems and methods.* Cheltenham, UK/Northampton, MA, USA: Edward Elgar. https://doi.org/10.4337/9780857933386

Goodwin, C. (1994). Professional vision. *American Anthropologist, 96*(3), 606–633. https://doi.org/10.1525/aa.1994.96.3.02a00100

Hammar, T., Ekedahl, A., & Petersson, G. (2014). Implementation of a shared medication list: physicians' views on availability, accuracy and confidentiality. Int*ernational Journal of Clinical Pharmacy, 36*(5), 933–942. https://doi.org/10.1007/s11096-014-0012-0

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd Edition). London New York: Routledge. https://doi.org/10.1002/9781405165518.wbeose070

Hatah, E., Braund, R., Duffull, S. B., & Tordoff, J. (2013). General practitioners' views of pharmacists' current and potential contributions to medication review and prescribing in New Zealand. *Journal of Primary Health Care, 5*(3), 223–233.

Heath, C., Knoblauch, H., & Luff, P. (2000). Technology and social interaction: The emergence of "workplace studies." *British Journal of Sociology, 51*(2), 299–320. https://doi.org/10.1111/j.1468-4446.2000.00299.x

Huiskes, V. J. B., Burger, D. M., van den Ende, C. H. M., & van den Bemt, B. J. F. (2017). Effectiveness of medication review: A systematic review and meta-analysis of randomized controlled trials. *BMC Family Practice, 18*(1), 5. https://doi.org/10.1186/s12875-016-0577-x

Jubraj, B., Marvin, V., Poots, A. J., Patel, S., Bovill, I., Barnett, N., … Bell, D. (2015). A pilot survey of junior doctors' attitudes and awareness around medication review: Time to change our educational approach? *Eur J Hosp Pharm Sci Pract, 22*(4), 243–248. https://doi.org/10.1136/ejhpharm-2015-000664

Kakeeto, M., Lundmark, R., Hasson, H., & von Thiele Schwarz, U. (2017). Meeting patient needs trumps adherence: A cross-sectional study of adherence and adaptations when national guidelines are used in practice. *Journal of Evaluation in Clinical Practice, 23*(4), 830–838. https://doi.org/10.1111/jep.12726

Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. *JAMA, 297*(8), 831–841. https://doi.org/10.1001/jama.297.8.831

Kwan, J. L., Lo, L., Sampson, M., & Shojania, K. G. (2013). Medication reconciliation during transitions of care as a patient safety strategy: A systematic review. *Annals of Internal Medicine, 158*(5 Pt 2), 397–403. https://doi.org/10.7326/0003-4819-158-5-201303051-00006

Leendertse, A. J., Egberts, A. C., Stoker, L. J., & van den Bemt, P. M. (2008). Frequency of and risk factors for preventable medication-related hospital admissions in the Netherlands. *Archives of Internal Medicine, 168*(17), 1890–1896. https://doi.org/10.1001/archinternmed.2008.3

Mahon, K., Francisco, S., & Kemmis, S. (2016). *Exploring education and professional practice: Through the lens of practice architectures*. Singapore: Springer.

May, C. R., Johnson, M., & Finch, T. (2016). Implementation, context and complexity. *Implement Sci, 11*(1), 141. https://doi.org/10.1186/s13012-016-0506-3

Nicolini, D. (2012). *Practice theory, work, and organization: An introduction.* Oxford, UK: Oxford University Press.

Nicolini, D. (2017). Practice theory as a package of theory, method and vocabulary: Affordances and limitations. In M. Jonas, B. Littig & A. Wroblewski (Eds.), *Methodological reflections on practice oriented theories* (pp. 19–34). Cham, Switzerland: Springer. https://doi.org/10.1007/978-3-319-52897-7_2

Nicolini, D., Gherardi, S., & Yanow, D. (2003). Introduction: Toward a practice-based view of knowing and learning in organizations. In D. Nicolini, S. Gherardi & D. Yanow (Eds.), *Knowing in organizations: A practice-based approach* (pp. 3–31). Abingdon, United Kingdom: Routledge.

Pope, C. (2003). Resisting evidence: The study of evidence-based medicine as a contemporary social movement. *Health, 7*(3), 267–282. https://doi.org/10.1177/1363459303007003002

Region Östergötland. (2015). *Slutrapport: Rätt läkemedel* [Final report: The right drug]. Linköping, Sweden. Retrieved from http://vardgivarwebb.regionostergotland.se/pages/206591/Slutrapport.pdf

Rouse, J. (2001). Two concepts of practices. In T. R. Schatzki, K. Knorr Cetina & E. von Savigny (Eds.), *The practice turn in contemporary theory* (pp. 198–208). London: Routledge.

Schatzki, T. R., Knorr Cetina, K., & von Savigny, E. (2001). *The practice turn in contemporary theory.* London: Routledge.

Sedlačko, M. (2017). Conducting ethnography with a sensibility for practice. In M. Jonas, B. Littig & A. Wroblewski (Eds.), *Methodological reflections on practice oriented theories* (pp. 47–60). Cham, Switzerland: Springer. https://doi.org/10.1007/978-3-319-52897-7_4

Sinnott, C., Mercer, S. W., Payne, R. A., Duerden, M., Bradley, C. P., & Byrne, M. (2015). Improving medication management in multimorbidity: Development of the MultimorbiditY COllaborative Medication Review And DEcision Making (MY COMRADE) intervention using the Behaviour Change Wheel. *Implementation Science, 10*(132). https://doi.org/10.1186/s13012-015-0322-1

Socialstyrelsen. (2012). *Ändring i föreskrifterna och allmänna råden om läkemedelshantering i hälso- och sjukvården* [Changes in the provisions and general guidelines on medication management in health care]. Stockholm, Sweden.

Socialstyrelsen. (2014). *Väntetider vid sjukhusbundna akutmottagningar* [Waiting times at hospital-based emergency departments]. Retrieved from http://www.socialstyrelsen.se/publikationer2014/2014-12-4

Timmermans, S., & Berg, M. (1997). Standardization in action: Achieving local universality through medical protocols. *Social Studies of Science, 27*(2), 273–305. https://doi.org/10.1177/030631297027002003

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory, 30*(3), 167–186. https://doi.org/10.1177/0735275112457914

Tully, M. P., & Cantrill, J. A. (2006). The validity of explicit indicators of prescribing appropriateness. *International Journal for Quality in Health Care, 18*(2), 87–94. https://doi.org/10.1093/intqhc/mzi084

van Sluisveld, N., Zegers, M., Natsch, S., & Wollersheim, H. (2012). Medication reconciliation at hospital admission and discharge: Insufficient knowledge, unclear task reallocation and lack of collaboration as major barriers to medication safety. *BMC Health Services Research, 12*(170). https://doi.org/10.1186/1472-6963-12-170

Viswanathan, M., Kahwati, L. C., Golin, C. E., Blalock, S. J., Coker-Schwimmer, E., Posey, R., & Lohr, K. N. (2015). Medication therapy management interventions in outpatient settings: A systematic review and meta-analysis. *JAMA Internal Medicine, 175*(1), 76–87. https://doi.org/10.1001/jamainternmed.2014.5841

World Health Organization. (2011). *The world medicines situation report 2011* (3rd Edition). Retrieved from http://www.who.int/medicines/areas/policy/world_medicines_situation/en/

& PROFESSIONS
PROFESSIONALISM

ISSN: 1893-1049 Volume 8, No 2 (2018), e2017 http://doi.org/10.7577/pp.2017

Richard Gäddman Johansson and Ulla Hellström Muhli

Developing Care Professionals: Changing Disability Services in Sweden

Abstract: In Sweden, professionalization projects in disability care services are currently being undertaken in order to differentiate and establish a professional identity for professionals within care work. The aim of this paper was to analyse the experiences of care workers' meaning of the professionalization process concerning their occupation and their occupational identity in relation to tasks they perform in front-line contacts with persons with intellectual and developmental disabilities at respite care service homes. Semi-structured interviews were conducted with ten care workers. The meaning of the professionalization projects is an ongoing process of a connected mission, meaning that the care work is performed in close contact with care receivers and that it takes place within an informal and free framework, predicated on a logic of possessing a particular kind of "care-feeling."

Keywords: Professionalization, new professionals, care worker, respite care service home, intellectual and developmental disabilities

In Sweden, professionalization projects in disability care services for persons with intellectual and developmental disabilities are currently being undertaken with multiple objectives: (1) ensuring competence levels and promoting skills development, (2) promoting higher status for the care work performed within disability care services, (3) ensuring future recruitment to these services, and (4) replacing the diversity of occupational titles currently in use in order to achieve a single area of competence and expertise within these disability care services at an undergraduate level. Hence, municipalities across Sweden, which are responsible for implementing the national social policy of disability care services, have begun shifting to and adopting the shared titles of *Support Assistant* and *Support Educator* (e.g., City of Stockholm Social Services, 2013; The Act on Higher Vocational Education, 2009). Support Assistant is a vocational title based on relevant Swedish upper secondary school education, while Support Educator is a title based on completed education at a Swedish vocational college (The Act on Higher Vocational Education, 2009). However, both Support Assistants and Support Educators work within respite care service homes provided for persons with intellectual and developmental disabilities, which is a branch of disability care services regulated by the Swedish *Act Concerning Support and Service for Persons with Certain Functional Impairments* (LSS, 1994).

These ongoing professionalization projects can be described as processes of specialisation of expertise and knowledge within new professions (Brante, 2013, 2014).

Richard Gäddman Johansson,
Uppsala University,
Sweden

Ulla Hellström Muhli,
Uppsala University,
Sweden

Contact:
Richard Gäddman Johansson,
Uppsala University,
Sweden
richard.johansson@soc.uu.se

Received:
20 April 2017

Accepted:
24 April 2018

The term *new professions* means newly emerging occupations comparable to professions such as social workers, nurses and teachers, but which are not fully considered as "professionals" in regard to special characteristics (Etzioni, 1969). These new professionals represent a new generation of professions which have arisen from the development of welfare systems and higher education reform in 1977, and which have been systematically organised and integrated into universities (Brante, 2013). Support Assistants and Support Educators are—like nurses and social workers—considered as new professions, although the latter two in Sweden have up to three and a half years of university education as a basis for their profession.

In this paper, we adhere to the description of the word profession/s according to Abbott (1988, p. 117) as "organised groups of individuals who do different things in different workplaces for different clients." The meaning of the word professionalism, however, has to do with an occupational value and consequently with the trust lay-people place in professional workers (Evetts, 2014).

According to the occupational value aspects of professionalism, Thomas Brante means that the new professionals perform a certain type of work that is necessary for society to function well; for instance, by offering care services of high quality to persons with intellectual and developmental disabilities. Furthermore, Brante (2014) also puts forth that these new professionals are spearheads to the future by facilitating possible inventions and innovations in different areas. The new professionals thus have both integrative and differentiating or innovative functions in society that are of social significance. Literature has emphasised care workers as being those who realise the socio-political goals of an inclusive community for persons with intellectual and developmental disabilities (Lewin, 2011). These care workers are also likened to the ultimate cutting edge of politics and can be described as the medium through which national, regional and organisational ideas and objectives are transformed into practices and actions in the care services being provided (Hewitt & Larsson, 2007; Lewin, Westin, & Lewin, 2008).

However, the above reasoning does not problematize how care workers within disability care services in general, and at respite care service homes in particular, can raise their professional status and position in order to be innovative and offer care services of high quality. The reasoning also lacks sociological aspects of how the care work relates to the knowledge system and its organisation around the profession. The reasoning also lacks aspects of how economic and institutional rationality governs the logic of quality of life, ethics, dignity and human perception (Larsen, 2016). The question of how the care workers themselves perceive their role in this professionalization process has been raised to an even lesser extent.

When it comes to care workers' status, Abbott (1988) means that professional status reflects the degree of involvement with the knowledge system around which the profession is organised. He states that "[t]he more one's professional work employs that knowledge alone—the more it excludes extraneous factors—the more one enjoys high status" (Abbot, 1998, p. 118). He states that the front-line professionals who make the first professional contacts with clients are generally at the bottom of status rankings within their professions because they work in environments where professional knowledge must be compromised with client reality (Abbot, 1988). This distinction is relevant to the professionalization process, even if the distinction is not new. It can be recognised from the early development of modern medicine and the medical specialisations, which have affected professional group organisation (Freidson, 2007; Pinell, 2011).

This paper, however, is limited to the ongoing process of professionalization within a particular initiative or care service arrangement provided for persons with intellectual and developmental disabilities in Sweden, namely the organised stay at respite care service homes. In this context, the concept of professionalization is regarded as the process of achieving the status of profession (Evetts, 2014). Hence, we ask how care workers themselves understand and make meaning of (1) their occupation and (2) their occupational identity in relation to the tasks they perform in front-line contacts with persons with intellectual and developmental disabilities.

These questions are of relevance since the occupational group of care workers are expected to meet and concretise these professionalization processes. These questions are also of relevance for the professions and professionalism in general, in that the professions are social phenomena placed in a certain context, in this case, the political goals of the Swedish welfare development. Thus, the type of professionalization process in this specific context is primarily a product of the state's political will, rather than a product based on discovery-driven innovations (Brante, 2013).

Swedish disability care services based on social policy

The professionalization process taking place within disability care services for persons with intellectual and developmental disabilities in Sweden is based on social policy, namely the Swedish *Act Concerning Support and Service for Persons with Certain Functional Impairments*, or *LSS* (1994). This law assumes the approach of giving everybody an opportunity, organised on the basis of the tax-financed Swedish welfare model within the open market economy. A corresponding tax-funded welfare model can be found in the UK and in other Nordic countries (Edebalk & Svensson, 2005; SOU 2002:31 d2). This is unlike the situation in Germany, for example, where the financing is based on mandatory insurance (SOU 2002:31 d2).

The LSS law in Sweden is reframed from a human rights perspective of full participation and equality, developed by international bodies like the UN and EU (Tøssebro, 2016). Disability is a worldwide phenomenon and has existed throughout western history at the intersection between the particular demands of a given impairment, society's interpretation of that impairment, and the larger political and economy-related context of disability (Braddock & Parish, 2001). Thus, disability is situated within the larger social context, while impairment is a biological or physical condition.

LSS is a law of rights, meaning that it only applies to a limited part of the total population in Sweden. This limited population includes (1) persons with developmental disabilities, autism or autism-like conditions, (2) persons who have significant and permanent intellectual disability after brain damage acquired through external violence or physical illness during adulthood, and (3) persons who have other long-lasting impairments (physical or mental) which are not due to processes of so-called 'normal ageing', provided they are large enough to cause significant difficulties in daily life and thus give rise to an extensive need for support and service (LSS, 1994).

According to LSS, respect for individual autonomy, integrity and equality in social life should form the basis for all professional interventions (LSS, 1994; SoL, 2002; Swedish National Board of Health and Welfare, 2007).

There are, however, a variety of obstacles to the professionalization processes taking place. Firstly, in the current situation, the undergraduate new professionals do not count as formally belonging to the group of more Parsonian (1951/1991) or ideal-typical professional occupations. These ideal-typical professionals are defined as being autonomous carriers and providers of socially sanctioned, abstract knowledge systems that give them the ability to perform actions which are perceived as difficult, skilled and valuable to the public or their clients (Brante, 1988, 2009; Freidson, 2007). The new professionals within care work are simply not yet deemed to be independent in their professionalism as fully-fledged professionals able to independently control their work based on science and proven experience, even though the field of knowledge-based disability care work has grown in relation to its historical framework of welfare policy (Pinell, 2011; Tøssebro, 2016).

Secondly, at the level of practical care work, this distrust is expressed in negative expectations regarding the ability to fulfil the law's intent and the perceived risk of deficiencies in the provision of care and in the interaction between new professionals within disability care work and service users as a result of, among other things, insufficient knowledge about intellectual and developmental disabilities (e.g., Mörk & Strand, 2012). In providing care services for persons with intellectual and developmental disabilities, it is not deemed sufficient for the new professionals within care work to simply be generally decent people capable of showing empathy, compassion and a desire to do good (Lewin, 2011). Rather, specified knowledge including good understanding of the core values and main objectives of LSS is held to be indispensable in this kind of work (Andersson, 2005; Laursen, Plos, & Ivarsson, 2009).

This discussion points to the crucial dimension of the professionalization process in relation to specialised knowledge in the work of new professions and the knowledge base of experts that also concerns new professionals within care work at respite care service homes.

Respite care is made up of temporary accommodation at a residential care facility for predetermined periods, rotated with periods at home (Swedish National Board of Health and Welfare, 2002; IVO, 2016). Respite care refers to children, adolescents and adults. However, the data collected in this study is limited solely to respite care for children and adolescents. Respite care service homes as an LSS initiative has two main purposes: (1) to provide a change of environment for the persons making use of the care services, and (2) to provide a period of relief for the care recipient's family members, who commonly act as informal carers (Askeheim, Bengtsson, & Bjelke, 2014). In this regard, these homes also serve as a workplace for new professionals within care work at respite care service homes, who perform the care work in order to meet these purposes during the service users' stay.

Method

In this study, we have chosen to approach the problem area described above from a sociological-hermeneutic perspective. By studying how new professionals within care work at respite care service homes create understanding and meaning when providing care to persons with intellectual and developmental disabilities, we have aspired to illustrate and produce an account of that which may otherwise remain latent in the background and thus run the risk of remaining (more or less) unnoticed or not reflected upon (Ödman, 2007). The hermeneutical approach has to do with human understanding and description. In this case, the new professionals' own perspective on the occupation and their occupational identity in relation to tasks they perform in front-line contacts with persons with intellectual and developmental disabilities at respite care service homes, and thereby the approaches, expectations and skills which have become a concern of the Swedish welfare state (e.g., City of Stockholm Social Services, 2013).

Procedures and data

Qualitative interviews were used to elicit care workers' experiences and meaning-making. The data was then analysed using a hermeneutic mixed deductive and inductive method (Føllesdal & Walløe, 2000). This kind of sociological-hermeneutic perspective enables detailed analyses to be undertaken of (1) the meaning of the care work as experienced (inductively) within the context of daily work, and (2) social interaction with the care recipients as well as (3) with representatives of the disability care system at respite care service homes. The analysis was also performed within the framework of the theory of social construction with emphasis (deductively) on how meanings of phenomena are not necessarily inherent in the phenomena themselves but rather develop through interactions in a social context (Berger & Luckmann, 1967).

The data corpus consists of ten interviews (10 hours of recorded interview material in total) with an equal number of new professionals from both private and municipal care providers (Table 1), in the county of Stockholm in Sweden. The participants included in the study consisted of eight women and two men, all of whom worked at a respite care service home at the time the interviews were conducted, and all of whom had worked in these types of care services for a period of 5 to 17 years. Six of the participants indicated that they either currently or previously held other positions of work parallel to their employment at respite care service homes. Some of the informants were married and had children. The scope of the participants' services ranged from part-time (50%) to full-time (100%). A common feature was that all of the participants worked a mixture of times on weekdays and weekends, with varying intensity according to a varied but regular work schedule. When it came to educational background, there was variety in level (graduate, undergraduate) and range; from different forms of nursing (assistant, childcare, psychiatric) to cultural studies and teaching.

Table 1
Overview of participant information

	Private respite care service homes	Municipal respite care service homes	n=
Female participants	5	3	8
Male participants	2	-	2
Working part-time (50%) at respite care service homes	1	-	1
Working between part and full time (51-99%) at respite care service homes	4	1	5
Working full time (100%) at respite care service homes	2	2	4
Working in other jobs alongside respite care service homes	5	1	6

The managers at eleven respite care service homes were provided with information about the study, and they then informed potential candidates about the possibility of participating in the study. An information letter describing the purpose of the study was sent to those who expressed an interest in participating.

All of the interviews took place at the time and place of the participant's work at the respite care service homes except for one, which was conducted at the participant's home. The interviews maintained a semi-structured format based on an interview guide consisting of a number of open-ended questions pertaining to the participants' understanding and experiences of (1) their occupation, (2) their professional identity in relation to the tasks they perform in front-line contacts with persons with intellectual and developmental disabilities, and (3) reasons for pursuing and deciding to continue working at a respite care service home. Each interview was conducted in an informal open dialogue, thus allowing the interviewees to answer in many different ways, and the interviewer to ask follow-up questions (Holstein & Gubrium, 1995).

Ethical aspects were emphasised in accordance with the Helsinki declaration of

1975, as revised in 2008 (WMA, 2008) and the Swedish Act on vetting the ethics of research that involves humans (The Ethical Review Act, 2004). The interviews were tape-recorded and transcribed verbatim (Linell, 1994).

Analysis of data

The analysis was performed (deductively) within the framework of social constructionism (Berger & Luckmann, 1967). However, the analysis focused on how experiences were understood and what meaning they were given as described by the care workers (inductively). This method interprets hermeneutics as a method used on meaning-carrying material created from the insider's view, exploring how the care workers come to understand and live with their care work in situ at respite care service homes (Schütz, 1967).

The hermeneutic approach is a constant movement between a part of a text and the contextual whole of which it is part. This method describes the hermeneutic spiral in the form of circles that touch the researchers' understanding, the participants' meaning-making and the meaning of the text (Ödman, 2007). In this study, the movement between a part of the text and the contextual whole was to fit the part and the contextual whole into each other in order to form a meaningful unit. The analysis process can be depicted as moving along sequences of the following stages.

- The interviews were transcribed and read thoroughly several times in order to obtain an overall representation and a comprehensive view of the material.
- The different parts of the text were coded with the first reflection on various categories related to the interview guide. This was done in order to provide a descriptive account of the manifest meaning content.
- The different parts of the text were re-read and coded with a second reflection relating the various themes included in the theoretical framework. This was done in order to interpret the latent meaning content.
- Attempts were made to organise the text's manifest and latent meaning content in thematic groupings of meaningful units.
- The final categorisation involved making connections between the thematic groupings and the contextual whole in order to develop a coherent account and main interpretation of how new professionals within care work understand and give meaning to the professionalization process concerning (1) their occupation, and (2) their occupational identity.

Results

The results from the analysis of the meaning-making by the new professionals are summarised in Table 2 and presented in the form of a theme, two categories, and four sub-categories.

Table 2
The research findings presented as theme, categories, and sub-categories

<table>
<tr><td colspan="2"><i>Theme</i>
The meaning of the professionalization projects is an ongoing process of a connected mission whereby the care work is performed in close contact with persons with intellectual and developmental disabilities and takes place within an informal and free framework that necessitates a particular kind of “care-feeling.”</td></tr>
<tr><td><i>Categories</i></td><td><i>Sub-categories</i></td></tr>
<tr><td rowspan="2">The meaning of the occupational group of care worker at respite care service homes is understood as a kind of</td><td>informal formality</td></tr>
<tr><td>non-monetary exchange</td></tr>
<tr><td rowspan="3">The meaning of being a new professional within care work at respite care service homes is understood as demanding a certain degree of</td><td>compatibility</td></tr>
<tr><td>professional platform</td></tr>
<tr><td>professional discretion</td></tr>
</table>

Making meaning of the professional occupation of care worker

The meaning of the occupational group of care worker at respite care service homes is presented here in the form of two main sub-categories: (1) informal formality and (2) non-monetary exchange.

Informal formality. The professional occupation of care worker at respite care service homes is depicted as a special kind of occupation, whose work drastically differs from more regular forms of labour. In contrast to “regular jobs,” which are understood by the care workers in terms of being static, routine-bound and constraining for the individual, performing care work is portrayed as being inherently dynamic, free-flowing, and liberating. These meanings are constructed around the practical tasks and relationships of inter-subjectivity with the persons with intellectual and developmental disabilities created in the context of respite care service homes, which appear to be closely reminiscent of those generally performed and held within the private sphere and confines of the personal household. The formal mission of providing care work at respite care service homes thus takes on an aura of informality and is exemplified by one care worker as follows:

> It is a very homey environment because we cook the food ourselves and we sit and eat together with the kids and everything like that. So it, and we don’t have any breaks, so it is not like anyone is running away like, that’s enough now I am going to be by myself, and such. So like it becomes a very homey environment, it is hard to explain these things like (laugh) it feels a little like home, too. (Participant 6)

As suggested in the quote above, providing this occupational group’s care work is constructed with a meaning of being home-like, and the tasks being performed by the care workers create a (formal) work context reminiscent of a more (informal) home-like milieu. Relationships among care workers at respite care service homes—as well as between care workers and residents—are depicted as being of a more intimate nature that enables the carers to meet the residents and understand their life-world, which in turn provides care workers with a sense of being part of an extended family. In this way, the boundaries between and the meanings created in relation to the public and private spheres, between the formal and the informal aspects of providing care, become blurred and are not as readily distinguishable as is understood to be the case in other more “regular” professional occupations.

Non-monetary exchange. Along with being understood as a kind of informal formality, performing care work at respite care service homes is also depicted as offering the occupational group of care workers something other than simply monetary reward in exchange for their labour. In contrast to conceptions of "regular jobs," which the care workers conceive as being tedious and repetitive in essence, performing care work at respite care service homes promotes a vivid sense of engagement and personal development. It also brings forth a form of "life-force" or "energy" for the new professionals within care work that is characterised by a sense of excitement, affinity, joy, and love. This is expressed in the following ways:

> But the salary, like had it been for the salary then I wouldn't have stayed here. Because I know that I can get higher salary by changing [to a respite care service home in an adjacent municipality]. And it's like, it's not for the money you stay. So no, then I would have probably, had it been for the money then I would have switched a long, long time ago. (Participant 6)

> Wow, wow, wow you can live on that for several days. I succeeded there in making contact with that person. That's what it is, and then, that is that which you also get. Often from these people you like get a lot of love and warmth or whatever you call it, too. (Participant 2)

As suggested by the two quotes above, performing care work at respite care service homes is constructed with a meaning of offering the new professionals "something else," something more meaningful in terms of human values, rather than just monetary rewards. In this regard, the care work itself is understood to offer something that is deemed to be meaningful and important to both the residents and the care workers, as opposed to "regular jobs" which are conceived to be more detached from the personal lives of the individuals who perform them.

Making meaning of being a new professional within care work

The meaning of being a new professional within care work at respite care service homes is presented here in the form of three sub-categories: (1) compatibility, (2) professional platform, and (3) professional discretion.

Compatibility. Being a new professional within care work is depicted as demanding a certain degree of compatibility between the individual, on the one hand, and the different tasks and organisation of shifts and scheduled working hours, on the other. The care workers see themselves as possessing and maintaining a particular set of characteristics and attitudes, which make them especially suited to providing care services to persons with intellectual and developmental disabilities, and this is expressed as follows:

> I don't know how to express this, but I think … that I have a kind of personality. And it, and that personality, is that I do my thing and such. And then maybe I don't care about the organisation and managers. And that personality is also good when engaging with our youngsters and such because that is also important in our work and such. (Participant 3)

It is also suggested that being a new professional within care work at respite care service homes is not understood to be an overarching identity category, superseding all others, but rather to be compatible with other occupational identities or affinities. As previously stated, the participants said that they had other jobs alongside their employment at respite care service homes. This was portrayed as predominantly positive since it allows the care workers to make their care work provision an integrated part of their lifestyles and enables them to live their lives more broadly.

Professional platform. Being a new professional within care work at respite care service homes is depicted as involving the creation and maintenance of a kind of common professional platform. This platform functions as both a starting point and a guiding principle for the care workers providing care. This platform may comprise a description of the care recipients' wants and needs as well as the mission statement of respite care service homes in general (as expressed through LSS). Cooperation is depicted as important when it comes to the provision of care work, although in this context the term cooperation does not necessarily mean performing in uniform according to predetermined methods of best practice, rather, the care workers highlight the importance of coordinating their individual performances in a complementary fashion. By establishing a common point of reference in terms of a starting point and guiding principle for the care provided, the new professionals are afforded a certain degree of freedom, which may alleviate some of the pressure and strain otherwise associated with reconciling one's personal and occupational identities. This is exemplified as follows:

> In some way when you are a group of workers, everyone is like individuals, but somewhere you have to have a common platform where you stand. Otherwise, I believe it becomes really difficult if the service users have to adapt to us the whole time. To our personal, like, personalities. I don't know, maybe it could work, but it would be much more strenuous. (Participant 4)

As suggested in the quote above, the creation and maintenance of a common professional platform as the basis for the care being provided by the occupational group at respite care service homes functions as a form of mediator between one's different identities when interacting with care recipients. Moreover, this quote also suggests that this professional platform may serve as a point of reference, not only for new professionals within care work but also for individual care recipients as well, thereby reducing any potential relational strain related to repeated interpretational and adaptive work on behalf of the latter. Being autonomous and self-determining in one's role as a care worker is thus to some extent depicted as being contingent on having a common point of reference on which one can lean back and be guided by in the provision of care services moving forward.

Professional discretion. In addition to the aspects of compatibility and the creation and maintenance of a professional platform as described above, being a care worker is also depicted as involving great amounts of occupational freedom and autonomy. Care workers as an occupational group are in a sense portrayed as being autonomous and self-determining. For one thing, they appear not to be bound to a specific spatial location. When providing care, the care workers are not perceived to be strictly bound to the concrete context of the respite care service homes, but rather they are free to participate in and experience a wide variety of social and communal activities taking place outside of the given workplace together with care recipients on a regular basis. Furthermore, new professionals as an occupational group within care work are understood to be in charge of making decisions pertaining to the performance of specific tasks and, as a result, the meaning of what providing care entails and how it is done is to an extent left up to their professional discretion. This is expressed as follows by a care worker:

> That's what I like about this freedom. How do we make plans for a weekend? It's up to us ourselves. There's no one else who has opinions on this and that, and we don't have to be fifteen [people] that need to reach consensus. Instead, we are a small group that have, yeah, are in control. A sense of independence. I find that

> very important and that's something I think we all benefit from. (Participant 1)

From the quote above, it is suggested that care workers are given a lot of leeway when it comes to control and making decisions regarding the care services provided at respite care service homes, and this is constructed as a predominantly positive meaning in relation to the given occupational identity. However, the professional discretion of care workers is not understood to be absolute. Although depicted as providing certain degrees of freedom to the care worker, the ways in which the care services are organised is also constructed with a parallel meaning of a more negative nature. Objects or events, perceived to be hindrances that limit the possibilities to exercise one's professional discretion such as, for instance, rigid organisational structures or budgetary restrictions, dictate the degree of freedom afforded the care workers. While depicted as having a potential negative impact on the performance and provision of care, this also suggests that new professionals within care work are not perceived as fully autonomous and self-determining actors entrusted with supervising and regulating their own practices.

Theme: An ongoing process of a connected mission

The meaning of the professionalization process is an ongoing process of a connected mission whereby the care work is performed in close contact with persons with intellectual and developmental disabilities and takes place within an informal and free framework that necessitates a particular kind of "care-feeling."

More precisely, the most important understanding and meaning-making of the occupational group as new professionals within disability care work seems to be a sense of informal formality and non-monetary exchange derived from providing care services at respite care service homes. When it comes to the meaning-making of occupational identity in relation to the tasks they perform in front-line contacts with persons with intellectual and developmental disabilities, it is manifested in the data material as compatibility between the care workers and the work, having a sort of common professional platform which, once established, acted as a foundation upon which they could exercise a form of professional discretion. From this, it is suggested that the care workers characterised the specific nature of the professionalization process within disability care practices as an ongoing process that occurs in close contact with the care recipients at respite care service homes. It is a process that, as indicated by the five sub-categories mentioned above, takes place within an informal and free framework. One aspect of this close care work is directed towards the care workers themselves, namely that a certain aptitude is required on the part of the care worker in order to be suitable to provide the expected care services. This aptitude can be depicted as having a particular concern for people. This kind of meaning-making illustrates the perceived prerequisites for providing care and ensuring good quality of life for persons with intellectual and developmental disabilities, as stated in the social policy objectives for LSS. This meaning-making also shows the logic that the care workers act upon when providing care.

The new professionals as an occupational group within care work also highlight themselves as having a specific type of character, namely a special kind of interest in challenges, and properties that make it possible to address the different challenges faced when providing care. These challenges consist of managing a situation in which the tasks are not completely obvious, but where the care workers have to think about how the tasks should be performed. This challenge is exemplified as follows:

> Yes, uh no, but yeah I think I am a bit the person that, yes, like being challenged by some of these kinds of things. This will be something new to bite into (laugh) or what to say and uh, think about like that. (Participant 2)

Overall, the key issue here about the specific nature of understanding the professionalization process within disability care services is to have “a feeling for caring” and “a genuine interest in people.” The term “care-feeling” is used to describe these feelings. The specific nature of this understanding is, however, related to a base of personal characteristics and not to an explicit knowledge base. The analysis thus shows that the importance of having “care-feeling” also means, as mentioned previously, for the occupational group of care workers to get close to the residents, both physically and emotionally. Furthermore, it means to actively create and maintain close relationships, to interpret and respond to the residents’ state of mind, to manage conflict and violent situations, and to provide support when it comes to the residents’ personal hygiene. These listed skills require a specific kind of practical knowledge and training and are, therefore, understood in this context to represent a kind of expertise within disability care.

Discussion

From the data we can see the following: Firstly, the new professionals within care work emphasised the importance of establishing a common professional platform in order to successfully provide care services at respite care service homes. This kind of result is also supported by Ahnlund and Johansson (2006). Secondly, in their accounts, the new professionals depicted themselves as being autonomous and self-determining in their care work, at least to a certain extent. This was related to the informal nature of the tasks performed at, and the general context of, respite care service homes. Thirdly, the intimate relationships and inter-subjectivity (Berger & Luckmann, 1967; Schütz, 1967) that develop between care workers and care recipients were perceived to facilitate a form of exchange which was understood as being different from that which takes place in more “regular” forms of wage labour. This, in turn, was related to the compatibility between the properties and attitudes that characterise the individual care worker and the content and organisation of the work involved in providing care services. However, having “care-feeling” or a particular concern for people in general, and for persons with intellectual and developmental disabilities in particular, is understood as the logic upon which the new professionals in care work act when providing care. It is worth noting that this kind of guiding logic was not found in the study by Ahnlund and Johansson (2006).

The new professionals within care work stressed the importance of having a kind of specialised and socially sanctioned knowledge base in the form of a common professional platform. This platform is seen as a point of reference that functions both as a starting point (knowledge pertaining to the needs of individual service users) and guiding principle for providing care services at respite care service homes. Within the context of their work, cooperation through the coordination of complementary performances is depicted by the care workers as the preferred course of action. In this regard, however, the care workers do not view the care work they perform as being founded on a uniform knowledge base consisting of predetermined methods of best practice. Rather, this knowledge base is conceived to be much more varied, dynamic, individualised and readily adapted to and coordinated with the skills and competencies of those with whom one has to collaborate at a particular time and place. This description of knowledge use is similar to what Abbot (1988) describes, namely that professional knowledge must be compromised with the client reality. This recognition of knowledge would thus be explained to be the reason for the occupational group’s low status.

New professionals within care work are to an extent autonomous and self-determining in their role and work performance at respite care service homes. However, in contrast to Parsonian ideal-typical conceptions of professions, which understand professional autonomy as stemming from a long and highly regulated educational process (e.g., Brante, 1988, 2009; Parsons, 1951/1991), the autonomy and self-determination afforded to new professionals is instead suggested to be related to the informal or personal character of respite care service homes and caregiving more generally. From the analysis, it is suggested that the intimate relationships developed between care workers and care recipients facilitate a form of non-monetary exchange that is perceived as being differentiated from more "regular" forms of wage labour. The thing that is being exchanged in return for the care services rendered is a vivid sense of engagement, personal growth and development. This exchange is depicted as being meaningful for care recipients and care professionals alike, and as something which is not attainable when performing more "regular jobs."

This non-monetary exchange appears to be related to the notion of compatibility between, on the one hand, the characteristics and attitudes of individual care workers and, on the other hand, the content and organisation of the work involved in providing care at respite care service homes.

Conclusions

Firstly, the analysis showed that similar to more established professions, which to some extent are founded upon a socially sanctioned knowledge base, the importance for new professionals as an occupational group within care work to establish a common professional platform was highlighted in order to successfully provide care at respite care service homes.

However, the contents of such a platform were not explicitly specified but were instead only vaguely mentioned in terms of the possible effects they have on the perceived quality of the care workers' performance. Secondly, the occupational group of new professionals within care work are depicted as being, at least to some extent, autonomous and self-determining when it comes to organising and providing these care services, due in part to the informal nature of the particular tasks and general context of the work at respite care service homes, thus suggesting the importance of striking a balance between the public and private spheres. Thirdly, it has been suggested that the close relationships that develop between care workers and care recipients are of the utmost importance when providing care at respite care service homes, since they are seen as giving rise to forms of exchange that benefit both parties in ways other than, and even explicitly differentiated from, monetary rewards. What this suggests is that, although the common professional platform is depicted as important in order to provide care to persons with intellectual and developmental disabilities well, seemingly even more important is the notion of possessing a form of intrinsic "care-feeling" or "sense for caring" related to one's own person, in order to be able to provide the necessary care services at all.

The professionalization projects that are currently taking place within Swedish disability care services including respite care service homes pose some important issues pertaining to the possible ramifications of such projects:

- Whatever benefits that may be attributed to the existence of a common professional platform or socially sanctioned knowledge base that serves as a starting point and guiding principle for care provision at respite care service homes, it is unclear what the impact might be of an organisational order which downplays (and even discourages) the maintenance of close relationships between care workers and care recipients.
- As long as it is not understood as a strictly formal/public concern nor a mainly informal/private concern by the occupational group of care workers themselves, the provision of care at respite care service homes is currently a form of balancing act along the blurred boundaries between the two.
- There seems to be no easy way of telling just how professionalization projects aimed at typifying and routinizing certain aspects of the work at respite

care service homes might change the way in which new professionals of the occupational group within care work perceive their occupation and occupational identity in the future.
- It is difficult to predict how professionalization processes will affect the dynamics of the occupational group of care workers' relationships and engagements with care recipients at respite care service homes in the future.

As shown, substantively, this study offers an excellent example of achieving a better understanding of the subjective dimension (which is the figure in this study) of a professionalization project of an occupational group of care workers. Behind the subjective dimension is a backdrop to which this subjective dimension should be reflected, namely different interests in the professionalization process.

At a national level, we can interpret interest in concretising the political goals of social rights for persons with intellectual and developmental disabilities, as well as controlling an increase in costs within the framework of the market-based model of New Public Management. However, this concretisation is not a simple transfer of political goals but rather contains implications for disability care service institutions as a whole, for the disability care work and for processing.

At the local municipality level, the underlying motives are to ensure the quality of services and control implementation (Askeheim et al., 2014; Edebalk & Svensson, 2005). At the group and individual level, the interest is that care workers as a professional group are given a certain kind of freedom and a lot of leeway when it comes to control and making decisions regarding the care services provided, despite rigid organisational structures and budgetary restrictions.

Theoretically, we have learned that this freedom is an aspect of the meaning of the word professionalism and has to do with the trust and value (Evetts, 2014) placed in the occupational group that gives meaning in relation to the occupational identity. Through this meaning-making, a broader understanding of the profession and professionalism has thus been explicated in order to also contribute knowledge to the literature on professions and professionalism in general. However, it is difficult to comment on experiences of the professional position in relation to other occupational groups and how they are valued on the scale of high-low status professions (Freidson, 2007) solely on the basis of this study.

For practical considerations, the findings from this study are of more than just academic interest. They also indirectly shed light on the care recipients, who can take advantage of the care workers' expertise of practical knowledge and interest in the human aspects and in caring for others. It would be valuable for facility heads and politicians to be aware of how the occupational group of care workers should be supported in their professionalization endeavours and become aware of how the organisation can reasonably contribute to designing two new professions.

References

Abbott, A. (1988). *The system of professions.* Chicago: The University of Chicago Press.

Ahnlund, P., & Johansson, S. (2006). Omvårdnadsutbildning som mål eller medel? Om legitimitetsproblem och kunskapssyn [Nursing education as objectives or means? About legitimacy problems and knowledge-related approaches]. *Socialvetenskaplig tidskrift, 3*, 212–227.

Andersson, U. (2005). *Rätt person på rätt plats* [The right person in the right place] (Report 2005/3). Härnösand: Research and Development Västernorrland, FoU.

Askeheim, O. P., Bengtsson, H., & Bjelke, B. R. (2014). Personal assistance in a Scandinavian context: Similarities, differences and developmental traits. *Scandinavian Journal of Disability Research, 16*(S1), 3–18. https://doi.org/10.1080/15017419.2014.895413

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin Books.

Braddock, D., & Parish, S. (2001). An institutional history of disability. In G. L. Albrecht, K. D. Seelman & M. Bury (Eds.). *Handbook of disability studies* (pp. 11–55). London: SAGE. https://doi.org/10.4135/9781412976251.n2

Brante, T. (1988). Sociological approaches to the professions. *Acta Sociologica, 31*(2), 119–142. https://doi.org/10.1177/000169938803100202

Brante, T. (2009). Vad är en profession? Teoretiska ansatser och definitioner [What is a profession? Theoretical approaches and definitions]. In M. Lindh (Ed), *Vetenskap för profession* [Science for profession] (pp. 15–34). Borås: Högskolan i Borås.

Brante, T. (2013). The professional landscape: The historical development of professions in Sweden. *Professions & Professionalism, 3*(2). https://doi.org/10.7577/pp.558

Brante, T. (2014). *Den professionella logiken: Hur vetenskap och praktik förenas i det moderna kunskapssamhället* [The professional logic: How science and practice join together in the modern knowledge society]. Stockholm: Liber.

City of Stockholm Social Services. (2013). *CARPEbladet—Samverkan inom funktionshinderområdet mellan kommuner i Stockholms län* [CARPE flysheet—Cooperation in the field of disability between municipalities in Stockholm County]. Stockholm: City of Stockholm Social Services.

Edebalk, P. G., & Svensson, M. (2005). *Kundval för äldre och funktionshindrade i Norden: Konsumentperspektivet* [Customer choice for the elderly and disabled in the Nordic region: The consumer perspective] (TemaNord 2005:507). Copenhagen: The Nordic Council of Ministers. https://doi.org/10.6027/tn2005-507

Evetts, J. (2014). The concept of professionalism: Professional work, professional practice and learning. In S. Billett, C. Harteis & H. Gruber (Eds.), *International handbook of research in professional and practice-based learning* (pp. 29–56). New York: Springer. https://doi.org/10.1007/978-94-017-8902-8_2

Etzioni, A. (1969). *The semi-professionals and their organization: Teachers, nurses and social workers.* New York: Free Press.

Freidson, E. (2007). *Professional dominance: The social structure of medical care.* New Brunswick: Aldine Transaction.

Føllesdal, D., & Walløe, L. (2000). *Argumentasjonsteori, språk og vitenskapsfilosofi* [Argumentation theory, language and philosophy of science]. Oslo: Universitetsforlaget.

IVO (Health and Social Care Inspectorate). (2016). *Hem för viss annan heldygnsvård—"Korttidsboende"* [Home for certain other whole-day care—"Short term stays away from home"]. Stockholm: IVO. Retrieved from http://www.ivo.se/tillstand-och-register/sol-tillstand/hem-for-viss-annan-heldygnsvard-korttidsboende/

Hewitt, A., & Larson, S. (2007). The direct support workforce in community supports to individuals with developmental disabilities: Issues, implications, and promising practices. *Mental Retardation and Development Disabilities Research Reviews, 13*(2), 178–187. https://doi.org/10.1002/mrdd.20151

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Thousand Oaks: SAGE. https://doi.org/10.4135/9781412986120

Larsen, K. (2016). Paradokser om stat, sundhedsvæsen, professioner, viden, sygdom og sundhed: Om faktorer der sikrer status qou—i et samfund der hylder forandring og udvikling [Paradoxes about state, health care, professions, knowledge, illness and health: About factors that secure status quo—in a society that honours change and development]. *Social Kritik, 148*(3), 16–31.

Laursen, E., Plos, K., & Ivarsson, B. (2009). Yrkeskunnande och kompetensutveckling i arbetet med vuxna individer med utvecklingsstörning—ett vårdperspektiv [Professional know-how and competence development in the work with adults with developmental disabilities—a care perspective]. *Vård i Norden, 29*(1), 19–23. https://doi.org/10.1177/010740830902900105

Lewin, B. (2011). *För min skull för din skull eller för skams skull? Om LSS och bemötande* [For your sake, for my sake or for embarrassment's sake? About the LSS and engagement]. Lund: Studentlitteratur.

Lewin, B., Westin, L., & Lewin, L. (2008). Needs and ambitions in Swedish disability care. *Scandinavian Journal of Disability Research, 10*(4), 237–257. https://doi.org/10.1080/15017410802410068

Linell, P. (1994). *Transkription av tal och samtal: Teori och praktik* [Transcription of speech and conversations: Theory and practice]. Linköping: Linköpings universitet.

LSS. (1994). *Lag 1993:387 om stöd och service till visa funktionshindrade* [Act Concerning Support and Service for Persons with Certain Functional Impairments]. Retrieved from http://rkrattsbaser.gov.se/sfst?bet=1993:387

Mörk, E., & Strand, H. (2012). *LSS-undersökning 2012. Kan kommunerna leva upp till LSS?* [LSS survey 2012: Can the municipalities live up to LSS?] (FUB report 1/2012). Retrieved from http://reclaimlss.org/lss-undersokning-2012.pdf

Parsons, T. (1951/1991). *The social system*. London: Routledge.

Pinell, P. (2011). The genesis of the medical field: France, 1795-1870. *Revue Francaise de sociologie*, *52*(S), 117–151. https://doi.org/10.3917/rfs.525.0117

Schütz, A. (1967). *The phenomenology of social world.* Evanston: Northwestern University Press.

SoL. (2002). *Socialtjänstlag 2001:453* [Act on Social Services]. Retrieved from http://rkrattsbaser.gov.se/sfst?bet=2001:453

SOU 2002:31 2d. (2002). *Vårdsystem i andra länder* [Healthcare systems in other countries]. Retrieved from http://riksdagen.se/sv/dokument-lagar/dokument/statens-offentliga-utredningar/sou-2002-31-d2_GQB331d2

Swedish National Board of Health and Welfare. (2002). *Kommunens stöd till anhörigvårdare—anhörigas erfarenheter och synpunkter* [Municipal support to family carers—family members' experiences and opinions]. Stockholm: Ministry of Health and Social Affairs.

Swedish National Board of Health and Welfare. (2007). *Lag om stöd och service till visa funktionshindrade—LSS* [Act concerning support and service for persons with certain functional impairments—LSS] (Report 2007, 114–49). Stockholm: Ministry of Health and Social Affairs. Retrieved from https://www.socialstyrelsen.se/publikationer2007/2007-114-49/documents/2007-114-49_200711429.pdf

The Act on Higher Vocational Education. (2009). *Lag 2009:128 om yrkeshögskolan* [Act on Higher Vocational Education]. Retrieved from http://rkrattsbaser.gov.se/sfst?bet=2009:128

The Ethical Review Act. (2004). *Lag 2003:460 om etikprövning av forskning som avser människor* [Act concerning the Ethical Review of Research Involving Humans]. Retrieved from http://rkrattsbaser.gov.se/sfst?bet=2003:460

Tøssebro, J. (2016). Scandinavian disability policy: From deinstitutionalisation to non-discrimination and beyond. *ALTER, European Journal of Disability Research, 10*, 111–123. https://doi.org/10.1016/j.alter.2016.03.003

WMA (World Medical Association). (2008). *World Medical Association declaration of Helsinki, ethical principles for medical research involving human subjects*. 59th WMA General Assembly, February 10, 2011, Seoul. Retrieved from http://www.wma.net/en/30publications/10policies/b3/17c.pdf

Ödman, P-J. (2007). *Tolkning, förståelse och vetande: Hermeneutik i teori och praktik* [Interpretation, understanding and knowledge: Hermeneutics in theory and practice]. Stockholm: Nordstedts Akademiska.