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Coping with Crises: A Neo-Classical View on Professions

Abstract: The classical view in the sociology of professions is rooted in Parsons' work. By using the term "profession," this view tries to distinguish a class of occupations that serves a specific function in society. As is well known, such a functional view in the sociology of professions came under attack in the 1970s, when professionalization processes were increasingly analysed in terms of interests and power. In this article, we have pointed out the theoretical and empirical relevance of a line of thought that emerged in the 1980s in the German-speaking academic world. It has revitalized a functional approach based on research into the interaction between professionals and their clients. The general idea that has emerged is that research into the microstructures of professional action could reveal a societal function that would explain the particular institutional features ascribed to professions.

Keywords: Professionalization, functionalism, professional-client interaction, revised theory of professionalization, objective hermeneutics

The sociology of professions witnessed major shifts that were deeply interwoven into the history of modern society itself. Previously, professions were of central importance in sociological thought, with Parsons (1968) considering them the most important single complex of modern society. Functionalism, which dominated sociology for most of the mid-20th century and was closely related to Parsons' work, referred to professions' functions in society in order to explain the traits that differentiated them from other occupations, for example, their autonomy in controlling their occupational performance. This view was largely replaced in the following decades by research into professional action, which focused on the question of how an outstanding and in some sense "professional" status would be achieved in a given field of action. To explain the creation of a professional status, not only careful and detailed studies of the realities of professional action were conducted. The described processes of professionalization were analysed chiefly in terms of interest and power (Macdonald, 1995). Thus, whereas the first approach was apt to justify the privileged status of professions in society, the latter questioned its legitimacy.

Today, discussions about professions take place in a quite different constellation. Now, the sociology of professions has to deal with the epochal changes that accompany deep transformations in the system of occupations and the organization of work (Broadbent, Dietrich, & Roberts, 1997; Olgiati, Orzack, & Saks, 1998). These developments are indexed by catchwords such as "blurring boundaries," "flexibilization," "marketization," and "managerialism." Consequently, the focus of empirical research has become increasingly unclear. On the one hand, it is highly questionable

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whether a thing such as a "profession" still exists in the Parsonsian sense (for example, Parsons, 1951, 1968). On the other hand, a growing number of occupations seem to strive towards a vague concept of "professionalism." In this situation, some authors tend to broaden the research scope to include all kinds of expert labour (for example, Evetts, 2003, 2011), whereas others want to restore a more narrow and analytical concept of professionalism (Brante, 2010; Olgiati, 2010; Sciulli, 2010). Here, we focus on an approach that can be located within this field of attempts to reorganize the sociology of professions and is so far little known beyond the German-speaking academic world, namely, the revised theory of professionalization (RTP), which was developed by Oevermann (cf. 1996) and refined by the research of his students. This approach allows the restoration of an analytical core of the professionalism concept besides power strategies, social closure, and staging. Specific to this approach is a synthesis of theoretical reasoning that is closely connected to the older idea of functional explanation, as well as a more recent style of empirical research into professional action that is related to the "ethnographic turn" in the social sciences: that is, the detailed and often sequentially proceeding analysis of "what people really do." In the following sections, we first outline the RTP, which we think is the most advanced version of an approach that links sociological functionalism to the detailed study of human interaction. After briefly introducing objective hermeneutics, which is the kind of methodology connected to the RTP, we provide an example of a professional interaction. With respect to an ethnographic approach, we ask what can be observed in interactional data. Will there really emerge just a struggle for professional status, or is there a professional ethic at work that goes beyond questions of power and interest? Can this ethic be connected to a special kind of service that in terms of the RTP would have to be characterized as coping with crises? Finally, we point out the RTP's achievements and impacts and relate them to actual topics in the sociology of professions.

Architecture of the revised theory of professionalization

The last decades of the 20th century have experienced fundamental shifts in modern society. Closely connected to them, the mode of reflexion on modern society has changed, which also applies to the styles of explanation that can be found in sociology. Modern society is no longer considered a product of a long history of rationalization, which is deeply rooted in European culture but having emerged from mutable constellations of power. This transformation is reflected in the decline of structural-functional thought and the rise of a broad intellectual movement, which have led to a completely new understanding of sociological research. According to this understanding, sociologists should no longer describe abstract patterns of social order in terms of shared norms and values and make them intelligible by explaining their functions in a well-ordered society. The proper subject of research is now understood as what people really do, described in quite specific terms as a contextualized activity in which social reality is achieved in ongoing communication that takes place within changing fields of power (Keller, Knoblauch, & Reichertz, 2012). Nevertheless, in the German-speaking academic world, a research tradition exists, which does not fit into this picture. The increasing interest in a detailed analysis of the appearances of human interaction is not opposed to a functional view of society but related to it. Social reality is not explained as being constructed in and by everyday activities. It is the emerging structure of interaction that is to be explained, which should imply identifying the needs of human life that are addressed in this kind of interaction. Although acknowledging the idea of functional explanation, such an approach implies important differences from a "classic" functional view. The assumed functions are not considered fulfilled in the first place by institutions as basic parts of society (cf. Münch, 2003, pp. 18-19; Schwinn, 2013, p. 36) but in spontaneously emerging interactions, which then become institutionalized.

With respect to the sociology of professions, such a view would require identifying the basic needs of human life that are the focus of those occupations that can be called professions from a sociological perspective. It would also necessitate explaining why responding to these needs leads to a process of structure formation, which can be described as "professionalization" and results in "professionalism" as the institutional framework of professional work. The idea that professions deal with existential problems of human life is of course not specific to the RTP (for other examples, see Olgiati, 2010; Stichweh, 1996, 1997). In this connection, it is often assumed that professionals have to tackle the complexity of the problems of people who need help or should be "transformed" by the interaction between professionals and clients. It is also supposed that in such a context of interaction, it is not enough to apply formal knowledge. An example of a more detailed empirical research into professional action that focuses on the complexities of the interaction itself between professionals and their clients is the approach taken by Schütze (1996) and his followers. An important argument, in this case, is that professional action has to deal with contradictory orientations. The basic assumption is that members of such occupations for which such contradictory orientations are typical have to develop special qualities. What is necessary for such contexts of action seems to be a special habitus that allows coping with contradictory orientations. This way, we arrive at a general idea of how professionalization processes might work; dealing with a special kind of problem is assumed to be linked to special requirements of action that can set into motion a professionalization process.

The RTP is the most elaborate and influential theory of professionalization that has been developed along these lines of argument. With its "revised" attribute, its connection to the now classical sociology of professions, represented by authors such as Marshall, Parsons, and Goode should be indicated. The theory's basic claim is to remedy a shortcoming of the old functional view of professions, which gave the opportunity for the power approach to gain ground that is, ascribing a function to professional autonomy without explaining how autonomy is linked to the special kinds of problems that professionals cope with in their everyday work. In contrast to related approaches (such as those of Olgiati, 2010; Schütze, 1996; Stichweh, 1996), it is specific to the "revised theory" that the problems tackled in the occupations related to concepts such as profession, professionalization and professionalism are derived from a general theory of human cooperation and experience. Furthermore, the theory is combined with a specific methodology of sequential analysis of human interaction that should allow for the reconstruction of the structure formation processes that are induced by dealing with these problems. Finally, the theory is explicitly linked to a more traditional sociology of professions by the claim that it answers the old problem that the structural functionalist theory failed to answer satisfactorily (that is, why are there occupations in the modern society whose performance is not controlled by the logic of administration or the market (cf. Marshall, 1963)?

A basic distinction of the theory is that between crisis and routine (cf. Oevermann, 2016). As it might suggest, the term "crisis" does not refer to the state of being in despair. It indicates the fundamental fact that human action does not just mean pursuing a target by using appropriate means, as expressed in the usual theories of action. It always implies being confronted with alternative options to act, which demand a selection among them. For Oevermann, this aspect of human action (being forced to select) should be perceived as the basic fact of human existence that constitutes experience, which he refers to with the old philosophical term "praxis." This has implications for the proper empirical analysis of human activities themselves. Studying them as praxis would mean reconstructing a history of ongoing selections in a specific method of sequential analysis of human interaction (cf. Maiwald, 2005; Wernet, 2014).

Selections, so the argument continues, do not occur incidentally. They are motivated by convictions deeply rooted in experience or by a belief in the advantages of one of the available options (Oevermann, 2006). In the first case, basic experiences

in life do establish a preference for certain choices; in the second one, the selected option has to prove itself by leading to success in life. Having previously resulted in success, a similar selection would occur in a similar situation. This way, a routine or a habit of life emerges. In the ongoing development of a human being, these routines or habits comprise a habitus, to use Bourdieu's term (see Bourdieu 1985), which is a product of a complex history of interrelated selections that have appeared fruitful. Since this history of selections is different from individual to individual and from group to group whose members act together, the resulting habitus are different from one another. This has implications for the proper understanding of the notion of crisis itself. As a habitus forms as a result of the ongoing selection among options, a crisis emerges when a fixed way of life is challenged by the failure of an established routine or by new opportunities that open up and demand selection. Thus, a crisis should always be perceived as a moment in an ongoing process of individuation—another important technical term in the theory.

Nevertheless, human beings cooperate with one another. Thus, in real life, no isolated agent struggling for his or her own life has to select among the different options open to him or her, but humans as social beings several agents that are coping with the problems of life in a given context of cooperation. In social life, a crisis emerges when a fixed way of living together is challenged, and in this respect, it seems possible to distinguish among different types of such crises. According to Oevermann (cf. 1996, pp. 88-95), in the context of human cooperation, only three basic crises of existential importance occur, and they do so in the attempt to maintain (a) a shared understanding of reality as the basis to be able to intervene successfully in the world, (b) a consensus on the norms of living together, and (c) the integrity of a person, a couple, a family or the representatives of an organization that is placed in such a context and has to meet social expectations.

Given this typology of basic crises, the question arises about what kinds of occupations emerge in the ongoing process of functional differentiation that contributes to the resolution of the issues. Clearly, the following three vocations that are of great importance in the sociology of professions fit well with that theory: science, law and medicine. Science can be linked to the need to achieve a shared understanding of reality as the basis of being able to act in the world. Law can be related to solving conflicts about the norms of living together. Medicine can be associated with the integrity of an ill person who has to meet social expectations. The theory of crisis not only allows for the ascription of social functions to the activities of coping with crises, but it also establishes assumptions about their particular character. It is assumed that those who perform these activities react in a specific way to these crises; they cope with them vicariously, or to be more precise, they at least make aspects of these crises the business of their own occupational group. This has important implications. First, someone who makes a crisis his or her own business does not just perform affective neutral routines but gets involved in affectively charged communication—in the intellectual struggles of his or her time, as in science; in the resolution of a dispute between two parties and within a community whose peace is endangered, as in law; and in the life of a person, a couple or a family (among others) who needs help, as in medicine and the other fields of therapy.

Second, when a crisis always emerges in a process of ongoing individuation, then vicariously coping with it implies doing so in a case-specific manner. Thus, when someone makes that crisis his or her own business, he or she has to realize the case-specific constellation where that crisis has emerged. The intellectual struggles of an era should be tackled to continue the given history of ideas in a compelling way that restores a shared world view. The resolution of disputes should take into account the individual viewpoints of the parties, as well as the changing interests of the community whose peace is endangered. Helping a person, a couple, a family and others who have to meet social expectations implies understanding their problems in the context of the course of their own lives.

In this connection, a further conclusion should be drawn. When someone is constantly coping with crises on behalf of others and thus gets involved in affectively charged communication and is forced to cope with such crises in a case-specific manner, then this would also lead to an individuation process and the formation of a habitus of that person. The emerging habitus would be specific in two respects. It would be due to the specific type of crisis to be dealt with in a particular profession, as well as to the individual history of a professional's vicarious coping with the crisis. Thus, for the RTP, the formation of the varying habitus of professionals is an important field of research.

Finally, vicariously coping with crises does not mean tackling them as a gifted individual but as a member of an occupational group that claims knowledge about how to identify the right explanation for a phenomenon, the right judgement in a legal case or the appropriate treatment of an ill person. Thus, vicariously coping with crises implies handling them methodically on the basis of the occupations superior knowledge and ongoing discourse on how to answer the questions that arise in dealing with a not yet fully comprehended reality.

To return to a more conventional sociology of professions, the vocations that should be called professions would have to be distinguished from other vocations by a sociologically defined criterion, and it would have to be explained in sociological terms why they are special with regard to the methods of control of occupational performance. There are vocations that imply more than the application of knowledge (that is, coping with the crises that can emerge in every context of human cooperation); other vocations do so in a special way (that is, vicariously). Why then can these vocations be considered special in terms of the methods of control of occupational performance? Here, the theory offers a simple answer. The different methods of control of occupational performance are assumed to be intrinsically linked to the structure of interaction of different kinds of vocations. According to this view, the sociology of professions should not deal with different methods of occupational control in the first place but with different structures of interaction, which bring forth peculiar methods of control due to very different criteria of quality. For example, acting in an administrative context calls for methods of checking whether the action is in accordance with the formally defined directives that constitute an administrative regime. Acting in a market requires methods that ensure the provision of those particular products and services that consumers demand. Political decision-making brings forth methods that link them closely to the reactions of the audience that is to be convinced. Vicariously coping with crises would require methods of control that guarantee that an ongoing process of individuation is continued on the basis of sound, case-specific judgements and interventions by the members of a profession. Thus, in the context of the action through which crises are handled vicariously, it seems mandatory that the quality of the required service can only be controlled by the ongoing discourse of the professionals themselves. Therefore, professional autonomy is not just an ideology for securing unjustified privileges.

In the following sketch of an analysis of professional action, we want to show how the special structure of interaction that can be described as vicariously coping with a crisis can be reconstructed in a detailed sequential analysis of interaction.

Methodological implications of the RTP's theoretical basis

Before we present our empirical example, we highlight the methodological implications of the theoretical framework underlying the RTP. Giving this framework the ethnographic turn leads to a specific way of dealing with "ethnographic data." The turn to what people really do does not just imply describing the observable practices of everyday life but analysing the sequential order of acting together. The analysis of this sequential order should not be understood as reconstructing the formal pat-

terns of types of action following each other but reconstructing the patterns of selection (that is, explaining what could have been done in a given situation and why that option was chosen and not another). This seemingly simple procedure turns out to be quite complex in real research because there are always many processes of individuation at work.

Take the following case of a doctor-patient interaction. The habitus of that particular doctor is expressed, on the one hand, and that of the particular patient, on the other hand, but both sides do interact with each other. Thus, a peculiar case-structure of doctor-patient interaction is an emergent pattern that results from the meeting of two particular strands of history. Even more important with respect to the RTP, the emergent pattern of interaction is not just the result of an encounter between two established habitus. The starting point of that particular type of interaction is a crisis that challenges such an established habitus—being ill or at least worried about one's health does imply that a fixed way of living in accordance with social expectations is questioned. This is true in the first place for the ill person himself or herself but then, also for the person who becomes involved by vicariously coping with that state of illness. Thus, in the kind of interaction in question, we might find an emergent pattern, not just due to the meeting of two different habitus but also to a challenge that might lead to their more or less serious transformation. As a result, we can sum up that the theoretical framework underlying the RTP leads to a specific understanding of the method of sequential analysis that is characterized by the following operations: explaining alternative options, hypothesizing about the motives for selecting a particular option, reconstructing the development of these motives in the social history of individuals, reconstructing the emergent pattern of interactions as a meeting of different strains of such a history and detecting the forces of human life that recreate the openness of history by challenging the fixed ways of life at a certain time. At least, a remark on methodology is apt to be added here. Most studies conducted according to these methodological principles have worked with ethnographic data in which people talk. This is not just an artefact of the availability of audio-recording machines that have supplied social scientists first of all with transcripts of spoken language. It is due to the assumption that language is a special medium of action through which the optionality of human action is generated (see Leber & Oevermann, 1994, pp. 384-385).

Empirical reconstruction of the normative order of professional action

As shown in the previous section, the RTP's starting point of a professionalism process is considered the praxis of coping with crises on behalf of others. The most suggestive case of such praxis is, of course, that of an ill person who consults a doctor. The basic need is a search for help in a situation of suffering, which creates the pressure of suffering (*Leidensdruck*). The interaction between a professional and his or her client has the character of a working alliance (*Arbeitsbündnis*) in which both sides cooperate to treat the ill person. In this section, we illustrate these theoretical assumptions with an example taken from an investigation by a sociologist who wanted to analyse the structure of medical practice beyond the market rules (Rychner, 2006).[1] Now, what can be observed in such an interaction between a client and a professional? What really happens in such an interaction? What kind of theory is suggested by the data? Is a description of professional action in terms of domination

[1] For a detailed analysis, see Rychner (2006, pp. 68-117). The use of the data and the summary of the analysis took place with the friendly support of the author, Marianne Rychner. We translated Rychner's transcript into English.

and staging of competence or of a process in which a social world is "constructed" really fruitful, or does it prove a reconstruction as an ongoing *process of individuation*, due to *coping with the challenges of life*, to be more realistic? If we follow the second course of analysis, do we find hints that the interaction really starts with a *crisis*? Is that crisis really tackled *vicariously*, that is, is there really more than a mere application of routines? Does vicariously coping with such a crisis have the implications described in the theory? For example, does a call for help imply an *affective loaded communication* that *creates a bond between a professional and a client*, beyond the kind of interaction that can be found in administrative or business contexts? To what extent does coping with crises create a habitus that triggers an interaction *beyond mere self-interest or a struggle for status* and corresponds to what is described in the older sociology of professions as a *professional ethic*?

For ease of understanding, we want to start with some contextual information. Around the time of her research, the researcher generated an idea of being ill. When collecting her data, she had attended a fair for health services and had her pulmonary functions checked up, which was "diagnosed" as an obstructive pulmonary disorder. She found the same information on the University of Zurich website. Consequently, she became really worried about her health and made an appointment with her physician, who knew about her research. The researcher asked him whether an audio recording of the meeting would be possible. Due to this quite unusual context, at the beginning of the transcribed sequence, the frame of the situation was unclear. For the physician, the meeting was framed as a research interview. However, the researcher herself wanted a consultation.

The transcript begins in mid-sentence. "R" represents the researcher/patient; "H" denotes the physician.

> R: I don't know [with a slight drawl].
> H: What do you mean? [2 secs pause]. What do you assume?

The beginning of this interaction was not recorded. Nevertheless, it can be assumed that the physician wants to know how long the meeting would take. This conversation would, of course, be very unusual for *a situation in which a patient was consulting a doctor*. How long such a consultation would take would be up to the physician, not the patient, but it would make sense in the context of a *research interview.* Thus, in this case, it can be conjectured that the physician supposes that such an interview should be conducted with him.

> R: I would say 20 minutes.
> H: 20 minutes? Then I quickly have to call my daughter [H dials a number on the phone].
> R: Okay [1 sec pause]. Otherwise, we could also postpone it. It is not that urgent.

It is also extremely inappropriate for a doctor to call his daughter during a consultation with a patient. Again, it can be easily explained in the context of the assumed interview. Nevertheless, the doctor's answer is puzzling; 20 minutes constitutes quite a short time for a research interview. The answer makes sense if we assume that H, in fact, has no time at all. R's reaction to H's announced phone call does not fit into the interview frame. By introducing her proposal to postpone with the term "otherwise" (*sonst* in German), R indicates that there are possibly more important reasons that might contradict the proposal. It is unclear what these reasons might be because postponing would be in H's interest. Moreover, by saying "It is not that urgent," she presupposes a frame of interaction in which urgency matters. However, this would not fit the interview situation. In such a context, a few days more or less would have no consequence. R realizes that the doctor is obviously involved in private affairs and under time pressure. Nevertheless, the way she formulates the offer indicates that for her, the situation is more complex.

R's answer allows for an explication of the norms of medical practice. On the one hand, she refers to the norm that the physician should pay full attention when there is a health problem, but she does not want to receive help without good reason. The patient has the right to medical treatment in an urgent case even if the physician is occupied with private matters. On the other hand, the complementary norm is not to presume an emergency when it is not the case (Rychner, 2006, p. 76). If there is no urgency, the patient has to wait within the consultation time, when another patient needs the doctor's help more, as well as outside the consultation time, when the doctor is involved in private affairs. R operates in this field of tensions.

> H: I've still a pile of, yet a pile of work, and [1 sec pause] I am just attending a seminar tomorrow [uh-huh, yah, yah], and still, I have to by the ton [approximately 5 secs pause], and I should cook dinner for my two daughters [3 secs pause]. I cannot do more than one thing at a time [yah], and today has just been a muddle.
> R: Yah.
> H: But… until when do you need it, then?
> R: That is, that makes, that is, does not really matter.

H makes it quite clear how absorbed he is by private matters, and it is also obvious that he still defines the situation as an appointment for a research interview, which he refers to by using "it." R, in turn, clarifies that there is no hurry with regard to the interview.

> R: I have indeed [yah] a real health problem that I have because of all that [yah], but anyway, the scientific, the record, that I need [yah], that [yah] isn't urgent.

R now explicitly refers to the difference between research and medical practice. There is something else—a health problem concerning her. When she begins to talk about her health problem, H's attention immediately shifts to R. He communicates this by accompanying R's utterance by repeatedly saying "yah," indicating that he understands.

> H: And right now you have a health problem?

H starts to clarify the situation. He takes up R's assertion of having a real health problem and asks whether it is acute. Thus, he offers an opportunity to open up a consultation for which the presence of a problem is essential. Under normal conditions, this is simply presupposed in a patient's visit to a doctor. Here, the doctor has to provoke R to take the position of a patient. With his question, a special space for communication opens in which a present *crisis* can be articulated ("Do you have a problem *right now*"?) Thus, an opportunity for an *affectively charged communication* is provided, creating a *bond between the doctor and the patient*. He makes himself available for coping with the crisis of his counterpart, against the interests he had made quite clear immediately before.

> R: I have a health problem that has arisen from my scientific [laughs slightly sheepishly] research [yah] and that simply lends itself to me being able to record [yah, yah] a real consultation, which otherwise would be very difficult [yah, yah]; that's how it is.

R gives a confirmative answer to H but also explains how this health problem is entangled with her research. Thus, she re-establishes the basic ambiguity of the situation. As a consequence of her explanation, the situation becomes ambiguous again in a symptomatic manner.

> H: Yah, and now the question is, well, I would still be happy in a way if we could postpone it, but I don't know [yes, we can indeed] whether it is for you, eh [interrogatively]?

H proceeds to try to clear up the situation; for him, the uncertainty of whether or not it is acute has to be removed.

> R: I can just tell you the diagnosis quickly, and then you can say how severe it [yah] or…

Again, R refuses to make the decision and tries to delegate it to the doctor. She suggests that being a patient is not a question of her suffering but of the doctor's expertise and ability to judge how urgent it is. How does H react to R's persistent refusal to take a position?

> H: The diagnosis [partly inquiring, partly stating; 1 sec pause] that you make? Or where?

At this point of the interaction, the situation has been transformed; H is no longer concerned with making a decision but with R's problem itself. He reacts in an irritated manner and makes the oddity of a patient confirming a diagnosis a subject. To express it pointedly, by her avoidance strategy, R has provided an occasion for intervention. She has produced a "symptom" that provokes a "clarification." Here, H is vicariously coping with R's crisis in two respects. He implicitly reminds her about the doctor's authority to make the diagnosis but also forces her to correct her attitude about herself and her state of health.

Next, R tells in great detail how her so-called diagnosis occurred. We skip this lengthy passage and enter into the analysis again at the point of the conversation when the doctor explicitly asserts that the situation has been changed.

> R: That is that, what the physiotherapist gave me. Well, now, we can also some other time still…

After her narration of the history of the "diagnosis," she once again offers to postpone the consultation. For R, the question of whether to postpone or to proceed does not seem answered yet. However, for H, the decision has already been made.

> H: No! No no no, now we have started; you have arranged that cleverly; now, we are already in the middle of it.

He fiercely rejects the repeated offer to postpone. For him, the situation has been irreversibly transformed when an acute problem that is related to health arises and becomes the focus of the interaction. The initial lack of clarity is once again a theme in his reply by presuming that R has been following a strategy to get him involved in the consultation. It would be illuminating to analyse his reply in more detail. In fact, *he* has clarified the situation and established the consultation, which implies a working alliance. Nevertheless, he attributes agency to R ("you have arranged that cleverly").

To summarize this brief analysis, the interaction of R and H transforms itself from an unclear situation to a consultation, against his personal interests and governed by his medical habitus. According to the frame of a research interview, the physician has a strong preference for postponement. However, at the moment when R's health concerns are put on the table, quite another normative structure begins to operate. According to this structure, it would be impossible to postpone due to R's supposed need for medical treatment. This transformation is even more impressive in this situation because the physician is tired from a busy day and wants to cook a meal for

his daughters. What the example should have shown is that here, similar to all sorts of professions, a specific ethic is at work that is more basic than simply "doing being a professional" and that is triggered by a real crisis, which in the RTP is considered the starting point of every professionalization process.

Achievements and specific perspectives on actual discussed topics

In the previous sections, we have sketched a research approach that implies a particular understanding of such terms as profession, professional action, professionalization and professionalism. We have also offered an impression of how theory construction and empirical work are connected to each other. The scope of research is, of course, much broader than this short example suggests. An important aim of the research over the last decades has been to overcome the bias regarding the professionals' interactions with their clients in order to cover all kinds of professional activities. There have been studies on the professionalization of the members of the legal profession, whose client is considered a legal community as a whole (regarding lawyers, see Wernet, 1997; regarding judges, see Maiwald, 1997). Other studies have focused on the professionalization of scientists and artists, whose client is considered even more abstract—humankind who is committed to a universalistic culture (concerning scientists, see Franzmann, 2012; Münte, 2004; concerning artists, see Ritter, 2011). Even in the classical field of professional-client interaction, the structure of interaction has proven to be much more complex than the physician-patient example suggests (see Scheid, 2016 for teaching; Becker-Lenz, Busse, Ehlert, & Müller-Hermann, 2009 for social work; Schmidtke, 2006 for architecture; Münte, 2016 for mediation).

Due to the anthropological foundation of the approach and its interest in the problem of coping with crises, there is a research bias towards what is considered the core of professional action (that is, how professionals cope with crises). Nevertheless, this is only part of what professionals do; they are also involved in professional politics and regulative bargaining. These fields of activities are of course significant in the context of the sociology of professions, and the RTP establishes an unusual view of them. According to this approach, the research focus is not on the explanation of successful social closure (for example, the neo-Weberian approach described by Saks, 2010); the entire professionalization process would have to be explained in terms of both function and power. What would have to be studied is how professionals develop an implicit theory of their work, how this theory is codified in professional discourse and how a profession's representatives act highly strategically in a given field of power to secure what they think is an appropriate organisational and regulatory frame for their work.

Although such institutionalization processes have not been the focus of interest, some studies deal with these questions. Maiwald (1997) tries to show how the process of the professionalization of judges occurs in the context of the Prussian reform of the legal system. Citing the example of the foundation of the Royal Society, Münte (2004) demonstrates how the institutionalization of modern science follows a professionalization pattern that cannot be explained in terms of interests and power alone. Jansen (2011) provides a similar reconstruction of the foundation of the National Academy of Science in the USA. Franzmann, Jansen, and Münte (2015) describe the relationship between nation building and the formation of the science profession from the RTP perspective.

The approach that has been outlined also opens up quite specific perspectives on central themes in recent debates on professionalism. Here, we focus on two topics of growing importance—the problem of occupational autonomy and the increasing interest in the governance of occupational performance. Whereas in the 1970s and the

1980s, the sociology of professions was engaged in the critique of the assumed "ideology of professional autonomy," being confronted with deep changes in the world of labour, scholars since the 1990s have become increasingly active in studying how professionals react to new regimes of occupational control and processes such as marketization and managerialism in order to secure their "professional identity." From the RTP perspective, quite particular questions would have to be asked in this respect. First, there would be a need to study how professionals under such regimes cope with those crises that are assumed to be the focus of their vocation. The central question would be whether the idea of vicariously coping with them can be defended against the challenges of marketization and managerialism or whether an adaptation process is set in motion that might affect or even transform the structure of occupational action itself.

A broader interest in the governance of occupational performance is closely related to the study of marketization and managerialism processes. Governance research (cf. Benz, Lütz, Schimank, & Simonis, 2007) investigates all the varieties of mechanisms that allow human activities to be steered towards their desired outcomes. In this research context, professional self-control can be viewed as one mechanism, among others, that is relevant to the control of occupational performance (Schimank, 2013). This implies an important shift in the debate on professional self-control. The question is no longer whether professionalism as a specific mode of control is essential to some occupations and not to others or is an ideology for securing a privileged position in society. This confrontation is to be replaced by empirical research into the real effects of different regimes of occupational control with regard to an occupation's desired achievements. This shift is reflected in the sociology of professions by the distinction of professionalization processes that are driven by the interests of the professionals themselves or the interests of managers who try to govern their organizations by using a discourse on professionalism (cf. Fournier, 1999). From the RTP standpoint, these developments would have to be described differently. According to this theory, the mode of control that should be called "professionalism" is intrinsically linked to the particular pattern of action. Understood as vicariously coping with a crisis, professional action implies control, not as a mechanism initialized from the outside but as inherent in a community that claims responsibility for dealing with life's existential problems in a methodical manner and on a scientific basis.

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& PROFESSIONS PROFESSIONALISM

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

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

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

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

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

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

Outline of the problem

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expanding the focus by applying Günther's logic of reflection

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The lived body, community, and society

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

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

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

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

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

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

Professions as arrangements of self-conditioning observational positions of reflection

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

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

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

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

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

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

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

First crisis of modern medicine

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

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

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

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

Second crisis of modern medicine

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

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

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

The body as a non-trivial machine

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

Technology

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

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

Functional systems of society

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

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

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

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

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

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

Organizations as constituting the problem and the solution

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

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

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

The professional as a polycontextural lived body

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

Preliminary conclusion

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

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

The future of professions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Proliferations and Vulnerabilities: Hybridization of Professionalism in the Field of Cancer Medicine

Abstract: In cancer medicine, particularly in drug research and development, structural changes in professionalism can be observed as examples. This field is characterized by a strong tension between social expectations concerning the control of existential risks to health, on the one hand, and strong commercial interests of a shareholder value-driven industry, on the other hand. Based on a qualitative empirical analysis, two subfields within the field of cancer medicine are reconstructed. One of these subfields—colon cancer therapy—could be interpreted as representing a renewal of the knowledge-power nexus. The pattern of the other subfield—brain tumour research—refers to a much more vulnerable professionalism. Both fields are characterized by development in professional work, which could be described with the hybridization concept. Therefore, the contrast between the two empirical examples presented still challenges the theoretical interpretation of contemporary professionalism.

Keywords: Professionalism, hybridization, medical profession, structural change, pharmaceutical industry

During an international cancer conference in the autumn of 2015, a music video was shown on screen, in which the Belgian singer Stromae broached the threat of cancer. In the black-and-white film clip, he writhed in torment while creepy claws slowly approached. It can happen to anyone; the question is solely (as asked in the song's title): Cancer—*quand c'est?* [Cancer—when will it happen?]. The much-awarded pop song elaborately conveys the perception of the disease, summarized with the term "cancer." While modern medicine seems to have mastered the grave dangers to health in western industrial societies, cancer still poses a basic threat to life that arises from the frightening idea of a latent menace and endogenous cell growth, becoming independent in a hostile manner.

For the cancer specialists who had gathered at the conference in Vienna, this piece of pop music contained a welcome recognition of their work. The song is about human suffering and the urgent need for new medical cures and drugs to end this misery. At the same time, Stromae's impressive performance has been effective in advertising for the pharmaceutical industry, which is involved in oncological research. Thus, cancer research does not only refer to a relevant social problem and a medical challenge, but it is also a profitable business. Drugs for treating cancer are sold at high prices, but more importantly, the approval of promising active ingredients to fight cancer leads to a rapid increase in the stock prices of pharmaceutical groups.

Because of the entanglement of medical relevance and commercial importance,

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the field of cancer medicine is particularly interesting for the sociology of professions. On the one hand, aspects of structural changes in professionalism can be observed. On the other hand, the tension between social expectations and commercial interests, which characterizes this field, challenges the classic conception of professionalism, as well as more recent interpretations. Now, within the scope of this paper, I discuss the results of a study on cancer medicine. Recent interpretations of professionalism, especially the thesis of "hybridization" (Noordegraaf, 2007), theoretically lead the analysis. It describes a new mixture of the classic professionalism and (new) work requirements, which are traditionally alien to professions and result from commercial or organizational interests. Against this perception, transformation would directly be accompanied by de-professionalization and would sooner or later lead to the decline of professions. The hybridization concept supposes that professions need to evolve according to social change, and up-to-date theoretical concepts are required, which can capture these changes appropriately. Cancer medicine is suited for the purpose of this proposition. It covers experimental research, as well as the medical care of seriously ill patients, and are therefore two sources of unpredictability that resist technocratic standardization and economic calculation. Furthermore, the field of cancer medicine is also structurally changing with great dynamics. Especially, the junction of medicine and pharmaceutical industries and the related dependency on the corporate control that is oriented towards the shareholder value play a significant role.

In this article, I aim to scrutinize the hybridization phenomenon, showing that it actually characterizes professionalism's adaptation to a changing environment. Cancer medicine is an ideal field for studying the contradictions and the variations of this development. However, as two empirical examples illustrate, hybridization can have many faces, and the ambivalence between power and vulnerability is still key to understanding contemporary professionalism.

In the following sections, I discuss the structural transformation of professions and the changes in professionalism behind this development. Next, I consider the expansion of the notion of professionalism and the thesis of hybridization as representative of recent interpretations in the sociology of professions. Regarding colon cancer and brain tumour research, hybridized manifestations of professionalism in the field of cancer medicine are then reconstructed. Within the tension between existential risks to health and shareholder value, a new knowledge-power nexus and more vulnerable professionalism are carved out. In the last section of this article, I reflect on what consequences can be derived from these observations for the theory of the sociology of professions.

Relational or substantial change?

The classic professions had successfully defended themselves against reforms for a long time. Only in the course of rebuilding the welfare state institutions during the end of the 20th century had they faced pressures to change. Especially in the European sociology of professions, the facets of this transformation (which has occurred over the last decades) have been the subjects of intense research. The theoretical approaches and concepts based on these developments are on a middle-range level and mainly systematize changes in the organization and control of professional work. On the one hand, the consequences of the so-called new public management and new governance principles have come into focus (Evetts, 2009; Langer, 2012). They have brought along requirements—especially regarding transparency and the cost efficiency of professional services—that do not correspond to the traditional model of professionalism. On the other hand, the relation between "profession" and "organization" has been reflected on in a fundamentally new manner (Muzio & Kirkpatrick, 2011). The different logics of control, as presented by Freidson (2001), are analysed in new, mixed proportions beyond the conventional patterns. For example, clinicians

have always operated within the bureaucratic structures of hospitals, but now, the novelty is that they increasingly have to accept managerial tasks, as well as organize medical services based on economic aspects.

This development has to be situated in the context of more profound changes. Questioning the institutional privileges of the classic professions not only accounts for the structural alteration of professionalism. The development and reproduction of professionalism as a resource for dealing with the core problems of society have also come under pressure, "from the outside" as debated under the keyword "de-professionalization" and in a substantial manner, too. This affects social conditions, as well as the knowledge base of professional work. The diagnosis of the transformation from the industrial to the so-called information society or knowledge society provides the socio-theoretical background for explaining this change. Although "knowledge society" might not be a sufficient term from a social theory perspective, it consequently sums up some general trends in the field of interest.

Particularly at the structural level, the transformation of the educational system in western industrial societies is essential. In the course of the generally increased access to education, the sealing off by professional elites has become more permeable, and the internal structure of professional groups has turned more heterogeneous. Professions do not solely recruit candidates from the educated classes anymore, and passing on professional roles across generations is no longer the custom. Moreover, professions experience a greater inflow from the middle class so that social homogeneity has been loosened, and competition within their respective labour markets has increased.

Another important societal transformation, which has contributed to the structural changes in professionalism, is digitalization and its corresponding access to information. Additionally, it is both directly and indirectly linked to the phenomenon of consumerism and the expansion of market-based regulations of professional services. The traditional model of professional services implied an explicit asymmetry, derived from the vulnerability of clients and the superiority of professional experts. However, it is now claimed that the devout respect for professional expertise (e.g., as expressed in the phrase "demigod in white," referring to a medical practitioner) has been replaced by increased decision-making power of clients and consumer sovereignty. Professionals are therefore required to develop new strategies for generating trust and commitment and interacting with their clients.

The knowledge bases of professional work itself have changed as well. Considering the accelerated advancement of scientific knowledge production, Kraemer and Bittlingmeyer (2001) cite the temporalization of knowledge. This development is enhanced by an increased awareness that knowledge itself has to be grasped as a product of social construction and should, therefore, be viewed as relatively dependent on the concrete and mutable contextual conditions. Nonetheless, the instability of specific knowledge bases originating from this situation opposes the strategies of demarcation and monopolization that have traditionally been practised by the professions. Noordegraaf (2007) expresses the issue this way,

> Once, things were simple. Classic professions … were able to deliver tangible, relatively simple services with clear added value. They were able to get a rather stable grip on content and criteria.… Nowadays, such strong professionalism is hard to attain.… Which problems must be tackled, as well as which criteria must be used to judge problem-solving, is ambiguous in both technical and ethical respects.…When professional methods such as therapeutic or didactic methods are used, it is also unclear which methods are effective and which are not; it is also unclear what is effective and what is not. (pp. 769-770)

In sum, professions and the sociological analysis of professionalism are confronted with modifications in relation to social change, as well as with quite substantial challenges of professionalism. Hence, in the following sections, I focus on the field of

cancer medicine after presenting how these developments are sociologically conceptualized. As mentioned, cancer medicine is characterized by structural changes in relation to societal transformations. Furthermore, cancer medicine is characterized by the paradox of professional knowledge as being powerful and vulnerable at the same time, which might be equally important for an understanding of contemporary professionalism. It is powerful as long as it can prove its ability to solve societal problems. It is vulnerable because these problems' main attribute is that they are not completely solvable; for example, people still die from cancer. Within a constellation that could be described as "hybridized" (the subject of the next section), the inherent tension between professional power and vulnerability becomes more obvious and structurally relevant.

Hybridization and professionalism as discourse

Approaches from the sociology of professions, which take up the previously described developments in a constructive manner, emphasize the relationality of professionalism and societal development. Professionalism is thereby less defined as a distinct form of controlling labour and rather described by its embeddedness within bureaucratic structures, organizational rationalities and interdisciplinary communities of practice. Overall, between professional work and the changing contextual conditions, direct interactions can be stated. Out of the attempts at theoretical conclusions, Evetts' (2011) analysis of the discursive turn of the concept of professionalism, as well as the diagnosis of hybridization, has gained special attention (see also Gourdin & Schepers, 2011; Noordegraaf, 2007).

Evetts (2011) suggests that classic professionalism, as referring to an occupational group in the Durkheimian (Durkheim, 1993) sense of an epistemic or a moral community ("occupational professionalism"), still exists. Moreover, a cultural and symbolic extension of the idea of professionalism is assumed. The "discourse of professionalism," also described by Fournier (1999), can be interpreted as a reaction of the contemporary transformation of capitalism, which is characterized by tertiarization and facets of the emergence of knowledge societies. The "appeal of professionalism" would, therefore, serve as an ideological tool in the service sector, which indeed relies on self-governance in the Foucaultian sense but is still more or less distant from enabling an autonomous professional practice. Here, Evetts (2009) introduces the term "organizational professionalism" to characterize a type of professional practice that demands specialist knowledge and self-dependent action but decisively stays obligated to the interests of an employing company or organization.

Hybridization describes the entanglement between professionalism, on the one hand, and requirements and constraints, which traditionally lie outside the professional area of responsibility, on the other hand (Noordegraaf, 2007). This concept does not refer to the inflationary rhetorical use of the term professionalism in contexts that are only seemingly liable to professional standards; rather, hybridization refers to classic professional work that now turns out as increasingly dependent on external interests and evaluation. The emphasis of the analysis thereby lies in overcoming the classic model of professionalism, which equates the latter with an all-encompassing structural autonomy. Besides, the influence of the criticism of professionalism might have affected this interpretation. The conflict-oriented and power-sensitive debate had its starting point in the late 1970s, in reaction to the earlier relatively schematizing and rather affirmative interpretations of professions. Instead, a critical glance was cast on the monopolization of responsibilities and the ideology of professional altruism, partly by highly detailed historical studies (Johnson, 1972; Larson, 1977). The professionalization of the established occupational groups has been reconstructed as a strategy of social exclusion and collective upward mobilization, which could only be achieved at the price of depreciating, subordinating, and discriminating against other occupations (e.g., care work versus medicine). Following the interpretation that professional autocracy under the guise of autonomy

did not prove itself historically, new findings take up the structural transformation as a logical consequence of social transformation and potential advancement.

The hybridization concept does not solve the contradiction between professionalism and market constraints or organizational interests, but these contradictions are considered within contemporary professional work. Hybridized professionalism not only has to incorporate professional knowledge and the corresponding moral and ethical responsibilities, but it also has to justify its effort in an adequate and balanced manner (Brint, 2006). Instead of the "third logic" of controlling work (Freidson, 2001) that comprises closure and autonomy, professionals are integrated into organizations that require verifiable professional performance and therefore operate with more or less elaborated forms of evaluation. In contrast to the discussion in the 1990s on the crisis of professions, hybridization is not interpreted as de-professionalization but as a realistic and contemporary form of professionalism. However, professionals are trusted to cope with the modified demands. Instead of a polarized interpretation implying either "pure professionalism" or ideologically disguised subsumption, tackling ambiguities and negotiating compromises characterize hybridized professionalism in particular.

The key to dealing with the structural transformation here is perceived in an active self-contextualization, which has to be integrated into the professional self-conception. Thus, it is in the nature of professional work to handle complex, paradoxical and partly unsolvable demands. Professional per se is characterized by a high amount of reflexivity because theoretical knowledge can never be transferred directly in the concrete individual case but presumes a systematic setting in relation to different forms of judgement. It refers to societal or rather collective problems occurring in a most complex, individual (by situational and contextual influences) and overdetermined manner that should be processed accordingly. This attribute of professionalism is now conferred on the modified framework conditions and needs to be extended correspondingly to these newer interpretations. Therefore, professional and ethical standards not only have to be followed but often have to be explained, vindicated and made transparent. Nonetheless, it is assumed that professionals with the intellectual and the methodical resources to reflect on the manifold manifestations of societal problems in individual cases should also be able to deal with altered and possibly conflicting requirements to a certain degree.

In both approaches, the struggle for control is moved from the structural to the symbolic-cultural level. It is referred to as the rhetoric of normative control, which does not remain entirely without effect but leads to the enforcement of selected, soft and subtle standards in particular.

> The importance of controlled content should not be overemphasized, as strict substantive and institutional control is hard, if not impossible, to accomplish because times are ambiguous and because professional work is inferential and experimental. Instead, it should focus on new connections between work and organizational action, and outside worlds, as well as on how these connections are made meaningful. (Noordegraaf, 2007, pp. 775-776)

This "fuzziness" also affects the relation between individual professionals and the professional community. Hybrid professionalism is characterized by "patterns of fragmented association" instead of stable and homogeneous groups (Noordegraaf, 2007, p. 781). While Evetts critically examines the use of the discourse of professionalism for strengthening corporate identities to effectively control professionals, Noordegraaf emphasizes the structuralizing potential of professional identity.

Professionalism today can therefore also be understood as "a search for … appropriate work identities … that can be used for coping with trade-offs between individual demands, professional claims, and organizational action" (Noordegraaf, 2007, p. 780).

Overall, these new interpretations react to the structural transformation without

abandoning the concept of professionalism. Nevertheless, the thesis of hybridization also demonstrates that professionalism has slipped into a defensive position. In the following section, I further discuss the interpretation of hybridization with regard to a field, which on the one hand is dominated by the ideal-typical profession of medicine but on the other hand, does not provide a refuge for pure professionalism by any means. Hybridization shapes the entire field and therefore enables a reconstruction of different forms of professionalism under these conditions.

In between professionalism and shareholder value—the field of cancer medicine

To examine the hybridization of professionalism, the field of cancer medicine proves itself to be particularly appropriate. I present empirical examples from a recent research project funded by the German Research Association. The study's methodological approach was based on a combination of ethnographic observations, expert interviews and in-depth interviews with doctors involved in the pharmaceutical industries` research. Observations were made basically at conferences and symposia in the field of cancer medicine. Expert interviews were conducted with medical professionals, such as researchers in tumour clinics or representatives of foundations and professional organizations. In-depth interviews, conducted as problem-centred interviews, built the core of the study. Therefore, open narrations within a thematic frame provided an inside look into the subjective intentions and the structural circumstances of the interviewees' decisions to change their positions from clinical medicine or academic research to the pharmaceutical industry.

Although cancer research is highly internationalized, the empirical study focused mainly on Germany. The observations and all interviews were transcribed. The evaluation of the empirical material followed the grounded theory approach; selected episodes were also sequentially analysed. The actors` experiences as medical managers were interpreted with regard to the biographical context and the structural developments in cancer research. Furthermore, the combination of different qualitative materials (observations and interviews with experts and medical managers) allowed reconstructing different syndromes of hybridized professionalism. I briefly discuss two of these syndromes.

Despite significant medical progress over the past decades, cancer still poses a major threat to health. The development of new medicines and diagnostic and treatment methods are proximately interlinked with the actual medical care. If therapies that have been used to date fail, medical practitioners and patients alike rely on the involvement of pharmacological studies, hoping for the success of newer substances and treatments. Cancer research is extremely laborious, costly and in Germany, financed mainly by the pharmaceutical industry. Public funding is scarce and reserved exclusively for fundamental research. The symbiotic relationship between the pharmaceutical industry and the field of medicine (Light, 1995) is particularly true for the domain of cancer research. While the pharmaceutical industry benefits from the trust in the medical profession, medicine profits from pharmacological innovations to maintain its reputation as a knowledge elite (Light, 1995). Economic relevance, on the one hand, and the importance of public health, on the other hand, coalesce into a unique mélange in the field of cancer medicine. If a pharmaceutical company succeeds in pushing a new active substance through the national and international regulatory bodies, its stock-market prices will be affected even before it earns revenues from the drug sales. Rumours about a promising new drug will already result in increasing market rates.

At the same time, the internal organization of the pharmaceutical industry has changed over the last two decades, especially regarding the development of active oncological ingredients. Considering certain general health risks (such as hypertension, high cholesterol levels or indications such as attention deficit

hyperactivity disorder), the industry's influence severely dominates societal perceptions of problems and medical treatment (diseases are effectively generated), whereas in the field of cancer medicine, the industry is actually much more subjected to scientific research (David, Tramontin, & Zemmel, 2009). The reciprocal dependency has been intensified by the biomedical approach, which serves as a basis for the most recent diagnostic and therapeutic achievements. While the conventional development of active substances still resembles the classic industrial value chains, the biomedical method works on a project basis and involves the kind of organization that integrates the principles of human medicine right from the start (Fuchs, 2001). Biomedical substances are rather developed theoretically, with their efficacy based on targeted precision. Therefore, the patient or rather, the molecular biological analysis and classification of the tumour, is taken as a starting point of treatment. In this context, antibody therapy, which has contributed to the promotion of disease control in certain areas of indication, can be taken as an example. To develop new active substances with this approach and succeed in their registration, entire businesses, especially start-ups with the relevant biomedical expertise, have been purchased by pharmaceutical companies (Orsenigo, Pammolli, & Riccaboni, 1999). Beyond this, the industry has intensified its efforts to recruit oncology specialists. Hence, these hired medical professionals are neither (as assumed in the past) graduates attracted by money nor practitioners who failed in clinical practice but are often very skilful and experienced specialists.

Whether cooperating within the scope of clinical studies or as the so-called medical managers in pharmaceutical companies, doctors practising in the field of cancer medicine have to be familiar with the rules of the industry, organize their research projects in an economically reasonable manner and take into account commercial interests. Professional roles oscillate between science, medical practice and managerialism and thereby intersect systematically. In other words, the historical symbiosis of the pharmaceutical industry and profession has merged into a hybridized field. Tensions and contradictions between medical and bureaucratic–commercial orientations are not cancelled, but they are not necessarily triggered by the boundary between professionalism and organization. In fact, new combinations, alliances and lines of conflict may arise. Now, based on empirical findings, different pathways within this generally hybridized constellation can be reconstructed.

Contrasting constellations of hybrid professionalism

The development cycle of a new active substance takes at least 12 years from the first laboratory attempts to approval. According to the pharmaceutical industry, the expense for every new drug is estimated at several billion euros. Hence, high drug prices in the field of cancer medicine are justified with investment costs (not with their material production costs, for instance). Although companies do profit from each successful approval, the biomedical turn in oncology entails economically ambivalent preconditions. In accordance with molecular biological diagnostics, treatments have become more target oriented, aiming at a smaller number of patients in the sense of "stratified medicine." Therefore, diseases within the oncological complex, which have a high prevalence, are of considerably higher economic interest. Since better opportunities for financing and sophisticated research proposals are provided, the chances of securing a solid reputation in the medical profession are better in a field of high prevalence compared to research on rare or more specified health risks. Regardless of how it is objectified, successfully developing a new substance or treatment is essential for success in both professional and commercial spheres. Thus, in the arena of oncology, different constellations arise. This can be exemplified by comparing the colon cancer and the brain tumour research fields.

The indication area of colon cancer is rated as an epidemic disease (according to the German Cancer Research Center at the Helmholtz Association (DKFZ, 2016),

every seventh case of cancer is related to the intestines, with about 60,000 new diseases nationwide in 2014). Nonetheless, considerable progress has been made in colon cancer therapy over the last 10-15 years. The survival rates have risen, and the quality of life has also generally improved under treatment. Medication functions more effectively, there are fewer side effects, and the intensity of medical surgery has been reduced accordingly. At the same time, diagnostics have been refined, and the population has been sensitized towards participating in prevention programmes promoted by healthcare policies. That is why colon cancer therapy offers very high chances of success for both medicine and industry. Despite the overall increased life expectancy, the demand for oncological therapies will not decline due to the disproportionate cancer incidence in the population. Thus, it can be assumed that in the field of colon cancer, the contradiction between medical and commercial interests is evened out (at least on the surface). Medical researchers are coerced to design their research projects in accordance with commercial purposes, but professional interests meet the interests of the pharmaceutical industry to a relatively far extent.[1]

In contrast, brain tumour research represents a rather marginalized field in cancer research. In 2012, only 7000 people who were newly taken ill with malignant tumours had been reported in Germany. The disease is medically challenging and rapidly leads to massive impairment of health and the quality of life. It is particularly drastic for the patients because a brain tumour affects not only the body but the whole personality. At the same time, medical interventions on the brain are risky; surgeries particularly require extraordinary precision and are inevitably life threatening. There had been therapeutic achievements in some subcategories of the indication area of brain cancer in the past; nevertheless, it is still rated as incurable in most cases.

Therefore, this field turns out to be academically and economically much less promising than that of colon cancer. The medical challenges are nonetheless extensive. Apart from the technical challenges of working on the sensitive and delicately structured brain, the psychological burden for physicians is exceptionally high due to the severe consequences of even the smallest mistakes or sloppy work. Moreover, successful interventions will probably not effectively prevent patients' suffering and death. Experimental drug therapies offer hope for therapeutic progress but still require comprehensive research. Due to the small size of the target group, the industries' commercial interest in this therapeutic area is limited. Research and development are promoted by new health policies to a certain extent, allowing simplified licensing procedures for new drugs targeting the so-called orphan diseases. However, mostly, the only reason for investing in drug development in such a small market is the application of already existing substances on diseases that have so far not been included in the drug approval.

Therefore, these two constellations within cancer medicine differ fundamentally from each other. The colon cancer constellation reflects a kind of virtuous circle, wherein the dependency on commercial interests does not seem to imply a hindrance to professionalism. A more profound empirical insight reveals that thereby, professionals have to accept compromises as well, but this does not impair their professional reputation. In comparison, brain tumour research is structurally shaped like a vicious circle. The disease is rarer yet particularly frightening since it is accompanied by much pain and an impairment of personality and is still claimed to be incurable and lethal. Although some public funding is allocated for this disease, the research relies on industry support because of the expensive patented substances in use. Compared to the colon cancer constellation, it seems less promising to build a professional career on specializing in this therapeutic area. It is also much more difficult to acquire industry sponsorship for research in this field.[2]

[1] Source: Interview with a clinical doctor and researcher at a regional tumour centre.
[2] Sources: Interviews with an expert and the chairman of a public funding committee.

Both fields are structurally characterized by hybridization and the mutual interdependence of professionalism and pharmaceutical companies. Regarding the type of professionalism arising from this constellation, contrast is revealed as well. In analogy with the depicted structural requirements, this contrast can be described in two phenomena—as the renewal of the knowledge–power nexus and as vulnerable professionalism.

A new knowledge–power nexus?

To capture the hybridization phenomenon more precisely, I explain it with an ideal–typical contrast, exemplified and fathomed by the colon cancer and the brain tumour research fields. First, I reconstruct colon cancer research as a (re-)institutionalization of hybridized professionalism.

Within the German scientific community of oncological research, the so-called working groups have been established, bringing together medical professionals and industry representatives for periodic symposia, workshops and conferences. Colon cancer research herein forms a major group, uniting reputable scientists and large companies involved in cancer research. Apparently, hybridization has reached a level of institutionalization and closure in this field; even potential internal conflicts and competitions among members will be resolved within the working group.

An empirical example involved the case of a dispute about a national study investigating a new therapy strategy. The debate focused on the treatment of patients with metastasized colon cancer by administering medication which includes different antibodies. The study had been designed as a comparative type and should have proven a new active substance's superiority over the established combination of drugs. The study effectively failed to reach its self-imposed goals, and only a subgroup of the patients participating in the study had gained advantages from the new therapy. Some of the patients even died earlier than would have been expected from the standard therapy. Nevertheless, the findings were presented as medical progress and ascertained as a new therapeutic standard.[3,4]

The conflict culminated when the findings were supposed to be presented at an annual conference of the working group. The company that had developed the standard medication until then (thus a competitor of the particular study's sponsor) prevented the presentation of the results by an interim injunction. At that point, the working group had a controversial discussion on the proper conduct, the evaluation of the results and the adjustment of the treatment guidelines.[5] The dispute resulted in an appeal to the ethics commission, and briefly, the pragmatic consensus among the clinical doctors involved in this study, other medical professionals and the pharmaceutical corporations became questionable. At issue was nothing less than a euphemistic portrayal of the research results and a default of scientific standards, a prestigious professor who probably made promises for obtaining sponsorship and last but not least, a competition between two major companies. Nonetheless, just a little later, the study's results were published in a positive manner, stressing the medical progress against the threat of cancer, even touted as one of the most important achievements of the year in cancer research, whereas the disputes behind the scenes remained invisible outside of the working group.[6]

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[3] Tumours are diagnostically differentiated by their molecular structure and therefore react unequally to the antibody treatment. For the subgroup with a better result under the new medication, this medication is now listed as standard therapy in the treatment guidelines.

[4] Sources: Observations at a symposium; interviews with a director of a tumour clinic, a biomedicine expert and a medical manager.

[5] Source: Observations at a symposium.

[6] Sources: Documentation of the ethics commission evaluation; observation at a cancer medicine congress.

The important point in interpreting this phenomenon lay with the structural fastening of the connection between medical professionalism and company interests. A marketing slogan by the pharmaceutical industry—"The best medicine is research" (*Forschung ist die beste Medizin*) (Verband forschender Arzneimittelhersteller, 2011)—symbolized the legitimation of this alliance. As long as the promise to society that cancer would be fought by any means could be demonstrated by successful research, the contradictions in the relationship between profession and commerce in this field of research could be concealed.

Regarding the professional self-conception, structural hybridization seemed to come along with a discourse of pure professionalism in this field. Despite this contradictory setting, the actors tended to adhere explicitly to the ideology of traditional professionalism. The medical leader of the mentioned study, who had been criticized for withholding the negative treatment results, justified his decision by reiterating his unquestionable responsibility as a medical doctor for the well-being of his patients.[7] Complementary to the retaining of traditional role sets, the medical managers working alongside the industry in this field also insisted on the different roles of doctors and managers. They referred to their motivation to carry medical progress forward as well but viewed themselves in the positions of communicators, leaders and organizers.[8] Career opportunities on both sides of the cooperation between the pharmaceutical industry and the medical profession appeared very promising. The corporate careers of three of the interviewed medical managers advanced within two years. Overall, the subfield of colon cancer was characterized by hybridization but already developed a new framework that stabilized and sheltered the group from internal and external criticisms. At the same time, traditional roles were defended, at least at a discursive level.

Vulnerable professionalism

For the field of brain tumour research, no comparable establishment could be stated. Notwithstanding the German working group and regular expert meetings at the national level, international networks were more important. The case of a surgeon, who was hired by a pharmaceutical company after performing several roles in research and medical practice, illustrated how far this subfield within the arena of oncological research was also representative of the hybridization of professionalism. He was contracted to support the process of the indication extension of an antibody for a specific type of brain cancer up to the legal approval. Deeply affected by the experience that patients could not be healed from their torturous illness and confronted with the limits of standard therapies, the surgeon adopted the role of medical manager. His designated goal for accepting this position in a pharmaceutical corporation was the regular provision of this antibody for patients. He had observed improvements for patients when this drug was used in experimental therapy approaches. His new position in the pharmaceutical industry seemed to him an opportunity to apply his professional knowledge more successfully and even in a more satisfying manner.[9]

The characteristics of hybridized professionalism, as described by Noordegraaf (2007), were thereby met in an ideal manner. He engaged in the project management of the company, explained the medical backgrounds to the different decision-making bodies, worked with an interdisciplinary team, acknowledged the company's commercial interests and reflected on his work situation as a reasonable compromise. His professional self-conception was stabilized by the subjective envisioning of limited alternatives in the fight against brain cancer and especially through a network of

[7] Source: Observations at a symposium.
[8] Sources: Interviews with medical managers.
[9] Source: Interview with a medical manager.

colleagues from industrial research and from medical practice, which encouraged him to follow that direction and to try to improve the situation of the disease-ridden patients.

According to his own interpretation, the interviewee did not attain his goal. The main reason was that the company's marketing department insisted on a broader definition of the indication field. It was stated that the costs of the approval procedure would be too high for the very small scope of application planned for the drug. Not even the warnings about the risks of a further extension of the indication would bring the company's strategy on track again. The approval procedure failed. Although the company offered him a new position in another project, the surgeon returned to medical practice.[10]

This case reflected the hybridization of professionalism in cancer medicine, as well as in the example from the field of colon cancer. However, it showed a different pattern of hybridized professionalism. Research on active ingredients in the field of brain cancer would depend on industry sponsorship, not only for funding large studies but also in the case of experimental research because the producers should at least provide the active substances. The hiring of a brain surgeon for the project on indication extension by the pharmaceutical company and his subsequent resumption of medical practice also showed a historically new permeability of the boundaries between industry and profession.

Differing from the colon cancer research field, in which profession and industry potently merged, the constellation of brain tumour research was defined by a vulnerability of professionalism, reinforced rather than qualified by hybridization. Thus, both examples resembled each other in that the medical development tended toward the direction of minimizing the target collectives of patients, while the industry constantly bore in mind the enlargement of the sales market. Nonetheless, in the case of the actual colon cancer study, this conflict was solved behind closed doors, while the results were presented to the public as an utter success in the fight against cancer. In the other case, the indication extension of the antibody for treating brain tumours, medical expertise conflicted with the mechanisms of business management and led to the project's failure.

This case of the brain surgeon took up the core argument of classic professionalism theories in as much as the problem (the severe disease of brain cancer) guided action. In the issue at hand, it even substantiated his willingness to abandon his professional role as a medical practitioner and to adopt another, the functional role of a medical manager. Instead of the powerful aspects of professionalism, its vulnerability was revealed. The interviewee described difficult surgical interventions on the brain and mentioned that he had "screwed up people" when he was unable to remove a tumour without injuring the healthy tissue despite his extreme efforts.[11] The confrontation with the limits of existing therapies explained his openness to the requirements of industrial project management. On the other hand, he neither understood nor accepted technocratic thinking, particularly of his colleagues in the corporation. Thus, he came into conflict with the company's marketing division, which was not susceptible to medical arguments.

According to these observations, an ideological discourse of professionalism paradoxically appeared to apply to the prestigious professor in the field of colon cancer rather than to the brain surgeon in the role of a medical manager. While the professor rejected fallibility by referring to his undeniable professional obligation for patients' well-being, the brain surgeon turned out to be resistant to the company's internal and external ideological appeals.

[10] Source: Interviews with a medical manager and a biomedicine expert.
[11] Source: Interview with a medical manager.

Conclusions

High hopes in new therapeutic treatments to fight the menace of cancer correspond to equally heightened profit expectations of the pharmaceutical industry concerning the development of new active substances. Patients are particularly reliant on a functioning system of medical care, but economies of scale and shareholder value also play important roles in this field of medicine. Medical professionals in this context are confronted with both interests regardless of their cooperation with the industry as clinicians and scientists or direct employment by the industry. Thus, the field of cancer medicine provides comprehensive materials to fathom the transformation of professionalism.

Cancer as a life-threatening disease reveals the paradoxes and the discrepancies that historically accompany professions, which only now, in the course of the recent structural changes, particularly come into focus. The core question, also regarding the examples discussed above, is how key problems of society can be processed appropriately, respecting scientific, technical and socio-cultural conditions. In times of accelerated knowledge production and growing complexity, one stand-alone discipline cannot achieve this anymore. Especially because knowledge can no longer be perceived as a stable good but has to be viewed as a constantly developing resource, an interdisciplinary cooperation among professions and new conceptions of professionalism are needed. Instead of monopolizing and piling knowledge, professionals are required to engage in processes of continuous knowledge creation and questioning.

However, professionalism that embraces these developments loses its hegemonic character. To express it differently, a paradox of the structural changes in professionalism is that modernization and broadening the principles of professionalism result in shrinking latitudes. This contradiction becomes particularly obvious in framework conditions, which are regulated to a high degree in a technocratic manner and are objectified by mostly quantitative criteria. Listed pharmaceutical companies not only operate under economic principles to design commercially successful developments of active substances, but economic efficiency criteria have also become independent. Thus, aiming solely at the contradiction between the different logics of profession and organization would fall short of the goal. Rather, the rise of neoliberal ideology reveals its consequences, not only for the health system but for society in general. The suspension of the sanctity of the classic professions could be understood as progress from a power-sensitive perspective, with the mono-professional way of processing increasingly complex societal questions being outdated. On the other hand, if economic quantification is set as the ultima ratio, as is the case with management doctrine, and is uncritically adopted as a means for increasing efficiency, experimental and qualitative approaches are at a disadvantage. Working with complicated problems (which will remain challenging and usually will not be solved without compromises) is characteristic of professional work but not very popular in a shareholder value economy based on calculable investment and a definite success. Both empirical cases illustrate that despite the actors' efforts to reach an arrangement with the industry, they cannot assert professional arguments and medical criteria against the predominance of one-dimensional economic measurements. The urgency ascribed to the development of new therapies for cancer treatment serves as a decisive legitimation for the pharmaceutical industry, but the formula of "good medicine also being good business" withholds the fact that scientific progress presupposes long-term developments and does not function with the logic of short-term, cost-benefit calculation.

What then is the lesson to learn from these empirical findings for the sociological debate on professions and professionalism? It had been a struggle for decades to overcome the historically specific, androcentric and hegemonic concept of professionalism, which seemed impervious against any modernization. Actually, fundamental changes in the arena of professional work have now taken place, and

an inflationary use of the term 'professionalism' has been observed, campaigning with the appeal of qualification, value and responsibility. Refusing a strict, anachronistic concept of professionalism and questioning the sketchy discourse of professionalism have made the need for new theoretical approaches obvious but nevertheless complicated. The term "hybridization" does not fill this gap but builds a bridge with an appropriate description of new requirements and structural changes in contemporary professionalism. However, as the two empirical examples show, hybridized professionalism can assume different shapes. Professionalism might maintain authority and power but also become more vulnerable. The case of colon cancer research, therefore, underlines the renewal of the professionalization phenomenon under the conditions of the economization of medicine. Industry funding now replaces the institutional shelters against the market. The existing dependencies are being disguised from the public to maintain the difference between medicine and industry, between professional expertise and economic power.

Nonetheless, criticizing opportunistic strategies to uphold status and privileges might be easier than explaining the rationale of the brain cancer example without falling back on an affirmative or a technocratic, concealed normative approach to professionalism. The brain surgeon left medical practice to engage in industrial research. He hoped to help more patients by making a new drug available. His knowledge about brain cancer, his vicarious experience of pain and death, as well as the limits of existing treatments motivated him to leave "true" professionalism for a managerial position. However, he did not succeed. Hired as a specialist to ensure the licensing process, he became an insistent admonisher within the pharmaceutical corporation. In fact, his case particularly illustrated how difficult it was to translate the true complexity of a problem into a one-dimensional concept of efficiency. Otherwise, this brain surgeon's case would be misinterpreted as the story of a lonely hero although his marginalized position made him look like one. The rationale behind this case corresponds to the actual structure of research and development in cancer medicine. Thus, the brain surgeon's understanding of the medical problem and his motivation to take the role of a medical manager had been developed within a collegial exchange and stabilized by professional relationships, side-lining the border between industry and medicine. Maybe this type of hybridized professionalism, in between the germ cell of a new professional project and the ignored critics of hubris and simplification, represents a phenomenon of 21st-century professionalism, which deserves further sociological investigation.

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From Dyad to Triad—Mediatization and Emerging Risks for Professional Autonomy

Abstract: With the emergence and spread of digital media, more business models foster and empower client participation in medical professions. With services and products ranging from rating platforms to apps targeting self-diagnosis, these businesses transform the client–practitioner relationship yet risk undermining a central pillar of professions—autonomy. Practitioners have to take legal actions against these business models, making visible the frictional interplay among the involved actors. This development calls for an analytical understanding of how this technology-induced cultural change affects professions and discourses on professionalism. We argue that a perspective on how practitioners deal with these challenges in various situations can be beneficial. Hence, we conceptualize professionals as engaged in identifying, assessing and managing risks for themselves and their clients. The emerging risk-management practices lead to an understanding of how this apparent cultural change plays an increasingly meaningful role for research on how professionalism regarding legitimation of authority is negotiated.

Keywords: Mediatization, professionalism, risk and uncertainty, participatory culture and professions, professional autonomy, mediatized business models, risk work

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"Doctor bashing as a business model" (Budras, 2016)—this admittedly lurid headline recently showed on one of Germany's most influential weekly newspapers. The article followed the struggle of a doctor who received 17 poor entries on Jameda, the largest doctor-rating website in Germany. The Jameda rating is based on German school grades; therefore, clients may give rates from 1 to 6, where 1 denotes the best score, and 6 signifies the worst possible mark. The results for the doctor were grave, as her rating dropped from a 1.5 to a 4.7, with the overall Jameda average being 1.82. The doctor's page thus moved far down in the search results, and clients were unable to find her as quickly as before on the platform's built-in search and appointment system. After a court ruling on this case, the disastrous ratings had to be deleted by the website owners since the ratings were based on false or made-up accusations.

This example is only one of many since Jameda went online in 2007. Similar rating platforms can currently be found for teachers and professors, with identical consequences regarding court orders and sentences.[1] The typical outcome is that the

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[1] The website www.spickmich.de can be regarded as the predecessor of the emergence of discussions and court sentences with regard to rating platforms as the highest German court ruled it as legal in 2009.

rating websites themselves cannot be shut down as they are protected by the universal freedom of speech, yet professionals always have to be aware of the consequences of poor ratings. Jameda and other rating platforms constitute only one example of how online platforms shape and challenge professional practices, as well as the discourse on professionalism to date. Other prominent examples are self-diagnosis platforms and apps, which were labelled the "doctor in the mouse" trend by the Australian *Daily Telegraph* and the Australian Medical Association in 2013. Most of these platforms and apps are mainly marketed to lay consumers without major forms of regulations in terms of their content, bearing grave consequences that are often related to false diagnoses (Robertson et al., 2014). In short, the spread of these technologies and with it, the rise of mediatized business models (Pfadenhauer & Grenz, 2012) already show significant effects on their targeted professional fields, thereby calling for a systematic understanding.

To prepare for such an understanding, first, we briefly outline two perspectives on professions and professionalism and add another on risk and uncertainty, which in our view, bridges two major aspects of how to deal with contemporary challenges posed by today's business models. First, this approach offers an understanding of contemporary socio-technical processes that undermine some of the ideal–typical components of professionalism, such as the separation from an ordinary labour market or the development and assessment of new and already established knowledge (Freidson, 2001). Second, it introduces a notion of reflexivity based on the concepts of reflexive modernization (Beck, Giddens, & Lash, 1996), which is useful in understanding the socio-technological developments that (at least in the field of medicine) reshape and reorganize both professional-laypeople relations and the discourse on professionalism. Building on these perspectives, we introduce the concept of reflexive mediatization as a standpoint on how to tackle these challenges for further research on professions and professionalism.

Professions, professionalism, and risk management

Regarding the work of Hughes (1958), who elaborated on the role of holding a mandate and a licence as the peculiar feature of professionalism, someone can argue that having a mandate means being equipped with the societal authority or duty to rule, based on the idea of central values and common needs, whereas holding a licence rests on the permission to act in specific contexts. To hold a licence and thereby be attested with professional competence, a practitioner has to obtain certain certificates that are typically bound to specific educational training (Hughes, 1958). This classic distinction appears in a new light with the rise of business models, such as Jameda. Especially due to their built-in rating systems, these business models can be perceived as commercially driven platforms of re-evaluation. With more recent approaches defining the field of professionalism as "a set of interconnected institutions providing the economic support and social organization that sustains the occupational control of work", the question to answer is where these models fit into the picture (Freidson, 2001, p. 2). To understand the impact of mediatization within this set of interconnected institutions, we have to examine in depth the five pillars on which this brief definition is built, as follows: a) the specific body of knowledge and skills, b) the occupationally directed division of labour, c) the occupationally controlled labour market, d) the occupationally controlled education and e) the profession's ideology (Freidson, 2001, p. 180). Rooted in the Weberian tradition, this approach lays a heavy weight on professionalism as an institution, leaning towards ideas resembling neo-institutionalist approaches. Regarding recent societal and political changes, some of the above-mentioned pillars have become the subject of new considerations. Some examples are how the knowledge base of professions has become fluid due to shifting institutional arrangements and expert professionalism (Brint, 1994), the influence of new political policies, such as European Union (EU)

regulations, as well as the effects of globalization in terms of blurring the markets in which professions were typically looking for occupationally controlled closure (Bianic & Svensson, 2010; Evetts, 2012). Nevertheless, professionalism has always been the subject of change, especially involving either technology or its pincered position between ruling bodies (e.g., governments and consumers or rather laypeople) or both (Macdonald, 1995; Saks, 2010). Briefly stated, recent developments ask for concepts that are able to grasp the blurred boundaries that formerly constituted professionalism (Evetts, 2012).

We argue that the discussion on professionalism has reached the point where it has to account for new challenges posed by mediatization. Mediatization can be conceptualized as a dynamic interplay that becomes visible through technology and its induced socio-cultural change. We identify business models that build on emerging technologies, such as online platforms and apps, as the main driving forces for this change, especially since these foster new forms of participation that bear unforeseeable consequences for the involved actors (Pfadenhauer & Grenz, 2014). We contend that only recently, some of these consequences have reached the field of professions by undermining formerly occupationally controlled areas of these professions and ultimately targeting a core pillar of professionalism, their autonomy. Following Evetts' (2011) argument, we assert that some principles of professionalism have been outstandingly successful, only to turn against its core. The aftermath of this development ranges from evaluation programmes to supervision constraints and the undermining of business models such as Jameda, which lead to professional practice and the discourse on professionalism being increasingly confronted with external control and competition. These challenges are each addressed differently by the more prominent approaches in the research on professions and professionalism, namely, the institutionalist neo-Weberianism (Saks, 2010) and the more discourse-oriented approach to the difference between occupational and organizational professionalism (Evetts, 2006, 2012). Focusing on the field of medicine, we elaborate on how these approaches could benefit by adding the perspective of risk and uncertainty, considering professional practice and the discourse on professionalism in order to tackle questions arising from societal and technological developments, such as mediatization.

One of the major aspects of the neo-Weberian approach to professionalism is based on the occupationally controlled market closure. This concept is able to define the boundaries of professions at three major levels, whilst accounting for differentiations within a profession by the same means (Saks, 2010). The first level focuses on self-governance, which refers to closure in the sense of restricting access to the profession. The second relies on the ability to define the needs of laypeople who seek or depend on the profession's knowledge. The third leans towards closure in the profession itself, setting standards and thereby organizing work (Freidson, 1994). With this in mind, this model could easily scale from a perspective on practices (i.e., in the professional–laypeople relation) to rather macro-oriented developments, such as the emergence of specific markets. Although it seems that this approach can be perceived as intrinsically dynamic, it remains unclear how this model accounts for more recent disruptions posed by the likes of Jameda or apps used for self-diagnosis. With the neo-Weberian approach being based on processes of control and closure, the blurring effects seem to pose a challenge, especially since authority, autonomy, public trust and a credential ideology can be regarded as key concepts in this approach (Saks, 2010, 2012; Svensson, 2010).

Examining public trust and autonomy in the medical field, we can identify a shift from an overall high level of trust in professional self-regulation (Allsop, 2006) to the emergence of new forms of legitimacy as observed on rating platforms and the like. The possibility to rate doctors, not by means of their medical skills, education or occupationally controlled body of knowledge but by their clinic hours, staff or social skills, presents a new economically driven challenge, which should be consid-

ered. In this regard, it seems that doctors currently face a greater degree of surveillance, not only by governmental actors but also by their clients. The same situation can be observed in the ongoing trend of digital self-diagnosis. Health and medical apps can be regarded as having a major impact on how the human body is understood, visualized, as well as treated by both medical practitioners and laypeople (Krieger, 2013; Lupton, 2014, 2015; Lupton & Jutel, 2015). In this sense, mediatization can be viewed as a driving process in which the doctor–patient relationship, as well as the practice of medicine, enters the liberalization phase (Lupton, 2015). Although the consequences of this development have yet to be fully outlined, this situation already shows that mediatization and the corresponding emergence of business models, such as Jameda, and the trend of self-diagnosis via apps limit public trust and with it, the autonomy of doctors in practice. On the other hand, these new economically driven actors act as competitors and thereby limit the profession's ability to provide market closure as is typically the case with mediatized business models (Grenz, 2017). From this point of view, the neo-Weberian approach has to address these challenges in order to stay eligible.

Regarding organizational budget cuts, with new forms of jurisdiction by the EU and clients, in general, becoming more demanding, another approach to researching professions tries to account for these developments. Building on some of the claims already established by Freidson (2001), such as the unique forms of occupational control, this discourse-oriented perspective points out the "dual character of professions" (Evetts, 2006, p. 137), which on one hand lies in the occupationally regulated provision of service and its governance. On the other hand, it is characterized by the use of occupationally regulated knowledge, which is applied to accumulate economic power. With the adoption of new public management and other forms of exterior control, the argument outlines how professionalism can be perceived as a discourse of control, directed increasingly by means of economic gains within organizations. At this point, professionalism as a means to organize, regulate and standardize specific practices or fields is bound to managerialist control and can, therefore, be summarized as organizational professionalism (Evetts, 2012). In contrast, this form of discourse has to be separated from what Evetts calls "occupational professionalism" (Evetts 2012, p. 6), which is closely bound to typical key concepts of professions, such as autonomy, a specific body of knowledge and years of higher education, which result in occupational identities and work cultures. It seems clear that these concepts aim towards understanding that diverging interests and an increasing number of external factors shape both the interior and the exterior organization of professions. Therefore, the argument aims to uncover professionalism's "third logic" (Freidson, 2001) as to some extent already assimilated by other groups, leading to the dissemination of former, strictly occupationally regulated forms of governance.

Concerning our introductory example, we point to newer forms of control that seem to influence the discourse on professionalism. With platforms and apps, we identify new developments in the discourse on organizational professionalism since these products are solely grounded on providing as many economic gains as possible. For example, with Jameda, doctors are left out of the equation as their service becomes a "product" that is negotiated through the platform providers and the laypeople using it. The only way for doctors to be heard and therefore shape the discourse is by either going to court or adapting to the standards and the regulations built into the platform. Jameda therefore provides an example of how mediatization or more precisely, mediatized business models, affect the discourse on professionalism at both organizational and occupational levels. Regarding organizational professionalism, the built-in managerial logic of these business models is shown by their way of visualizing and accounting for doctors through ratings and standardized forms of presentation. As for occupational professionalism, it transforms the trust relationship between practitioners and clients since it provides a tool for constant observation, which in some cases, even undermines the autonomy of practitioners.

Following Znaniecki's early work on social roles and exclusive knowledge, researchers may classify present-day professionals as licensed "arbiters" (1975, p. 36) who are consulted in doubtful situations, with the belief that they provide technical advice. Their knowledge and skills are thereby inseparably combined in practice, with their tasks at hand typically divided into making a diagnosis, designing a plan and executing it accordingly. In this sense, professionals can be defined as "risk workers" (Horlick-Jones, 2004, 2005) dealing with the uncertainties and the potential risks of their clients. From this perspective, professions can be regarded as occupational and institutional arrangements that are equipped with specific roles for the challenges of dealing with the uncertainties of modern lives in at-risk societies. Professionals are extensively engaged in "doing risks" through their institutional entanglement and use of expert knowledge (Evetts, 2012; Montelius & Nygren, 2014; Nygren, Öhman, & Olofsson, 2015).

Generally, risk can be understood as a phenomenon of modern societies that is closely connected to the differentiation and democratization of knowledge. The ubiquitous status of risk can be described as an unintended consequence of professionalization since it replaced former societal forms of legitimizing knowledge, in which a specific system of beliefs was able to explain and answer almost any given circumstance in life (Alaszewski & Brown, 2007; Berger & Luckmann, 1966). "The less we rely on traditional securities, the more risks we have to negotiate. The more risks, the more decisions and choices we have to make" (Beck, 1998, p. 10). Concerning the field of medicine, this development led to a major change in the doctor–patient relationship (Hitzler & Pfadenhauer, 1999). As opposed to the doctors' status in the 19th century, when they were able to decide and therefore issue prescriptions from the standpoint of personal authority (Alaszewski & Brown, 2007), today's practitioners are bound to informed consent, supported and regulated by law or in more recent cases, even shaped by predictive technologies and algorithmic decision making (Chorev, 2016). Regarding these developments, doctors are currently closer to becoming informed advisors in terms of how patients can or should deal with their risks. This development has been accompanied by standardization, making vulnerable the body of knowledge circulating within the professions. Ultimately, this corresponds to an erosion of trust in sources of expertise, not only in medical professions, with grave consequences for practitioners and clients alike as this ultimately leads to a structural undermining of expert authority (Horlick-Jones, 2004; Pfadenhauer, 2006). Therefore, we plead for further involving the perspective of risk and uncertainty in the discussion on professions and professionalism.

A major advantage of including this perspective could lie in overcoming the ideal–typical implications of rationality for professional practice, consisting of identifying, assessing and managing risks. In doing so, it becomes possible to broaden the perspective towards specific risk-management solutions and challenges that have impacts on both relations and practices involving clients, as well as other professional practitioners. This seems especially fruitful since the already addressed variable power and authority of professionals over their clients and the control of their work are heavily bound to these specific risk-management solutions (Freidson, 1986). As Evetts points out, risk-management practices and their implications entail unintended consequences on the prioritization and ordering of work activities, as well as focus on target achievements, to the detriment or neglect of other less measurable tasks and responsibilities, which ultimately challenge the occupational value on which professionalism is grounded (Evetts, 2012; see also Pavlin, Svetlik, & Evetts, 2010). Therefore, we agree with the argument that it no longer seems useful to draw a clearly defined line between professions and other expert occupations (Svensson & Evetts, 2003). Instead, we propose to further include the perspective on risk management and the driving forces for risks in the discussion on professions and professionalism.

Mediatization of professions and professionalism

From this perspective, the apparent risks and risk-management practices can be identified as involving an increasingly frictional interplay among technology, clients and practitioners (Andreassen & Trondsen, 2010; Krieger, 2013; Lupton, 2014). To understand this interplay, researchers need concepts that help contextualize to what extent these risks are related to socio-technological developments. Hence, technologies responsible for this development have to be understood as socio-cultural artefacts. This already implies that apps, platforms and the like are first and foremost socially embedded products of people, with specific histories (Lupton, 2014; Thomas & Lupton, 2016). In this sense, technology-induced cultural change becomes observable as a microprocess affecting human actors and their social relations (Krotz, 2003). To approach the effects of this technology-induced cultural change in the field of professions, the concept of mediatization seems fruitful (Couldry & Hepp, 2013). Although it may initially seem contradictory, this concept's advantage lies in its ability to bridge the often-diverging perspectives on how the complex relation between technology and cultural change should be approached (Knoblauch, 2013). Mediatization is therefore not bound to a clear either/or distinction (Beck, 2003), allowing us to capture the processes that currently blur the boundaries between professions and professionalism. As Livingstone and Lunt (2014) propose, mediatization is most useful as a second-order investigation, which assumes the function of gathering and focusing different perspectives on the relationship between technology and specific socio-cultural contexts, such as politics, education, sports and of course, professionalism. Accordingly, research on the mediatization of professionalism may include perspectives on how technology shapes government policies, practitioner practice, as well as the relationship with clients.

Regarding our example, we introduce some aspects of how we think the mediatization concept helps us understand the pitfalls and challenges accompanied by and responsible for the emergence of mobile health phenomena or the iHealth movement (DeJong, 2013) and its implications for practitioners. Besides Jameda as the example targeting the German market, the apparent presence and availability of online platforms and other technologies, such as apps that distribute medical knowledge, are on the rise. Moreover, the catalogue of digital health technologies influencing practitioners today does not stop there. Ranging from web counselling on platforms (e.g., patientslikeme.com) to 3D-printed prosthetics and apps specifically targeting medical students, these technologies, now more than ever, shape professional practices involving both education and occupational work (Lupton, 2016).

Most prominently, these technologies' impacts on practitioners' risk management can be observed as new participatory possibilities for clients. This especially holds true for chronically ill patients using the Internet and specific platforms for decision-making and care practices, as well as for pregnant women consulting apps for self-diagnosis (Kraschnewski et al., 2014; Thomas & Lupton, 2016). Additionally, the use of online reminders, appointment apps or care-planning solutions shapes today's medicalization, with the promise to improve care and patient compliance (Lupton, 2013). Nevertheless, the discussion on this democratization of healthcare via technology is in danger of being heavily biased with all too optimistic expectations for technological progress (DeJong, 2013). What seems to be left out from this discussion concerns the disruptive forces that are inherent in the spread of these technologies. Not only do practitioners and patients need access to specific resources to be able to get in touch with such technologies, but they also require a certain set of skills to use these correctly. Additionally, the sheer number of apps and platforms available today leaves both practitioners and clients with the challenge to choose one, depending on what they are seeking. Furthermore, the Jameda example points to the major lack of regulation until now. This includes both a jurisdictional framework of how these technologies ought to operate and what their contents should comprise.

Especially, the last point has major implications for the client–professional relationship as it leaves practitioners with the need to adapt to the specifications of a business model. Thus, the impact of digitalization does not stop with the implementation of apps in the everyday practice of medical practitioners or the already established "googling for a diagnosis" (Tang & Ng, 2006). As Lupton points out, the devices and the content produced that go hand-in-hand with digitisation have significant implications for how the human body as an object is negotiated and treated by professionals and laypeople alike (Lupton, 2014, 2015; see also Lupton & Jutel 2015). Furthermore, digitisation challenges a particularly important aspect of professionalism as it undermines professional autonomy.

Autonomy is perceived as one of the core characteristics of professions, yet professions are not rooted in autonomy itself, but it is the socio-historically grounded justification of their expertise and with it, their ability to determine what is wrong with their clients or more generally, with society (Mastekaasa, 2011). Besides the connection between this concept of autonomy and Hughes' (1958) early suggestions on the difference between a licence and a mandate, the socio-historical foundation behind this sort of autonomy is the one affected by the socio-technological change. As soon as practitioners start to suggest that women should use specific apps to influence maternity and future planning for care (O'Higgins et al., 2014; Robinson & Jones, 2014; Rodger et al., 2013; Tripp et al., 2014), and clients start to rate their doctors in terms of waiting time and appointment availability (as they can on Jameda and other platforms), these factors influence the justification of professional autonomy (Thomas & Lupton, 2016).

Conclusion

Focusing on the mediatization of professionalism provides researchers with a perspective from which the socio-technological contexts responsible for the rise and success of digital technologies can be understood as entailing a frictional interplay. Regarding medical practitioners, this frictional interplay involves the commercially driven entanglement and blurring of boundaries between service providers and consumers, which ultimately challenge the professionals' relationship with and authority over their clients. This entanglement is increasingly characterized by "feedback loops" (Lash, 2003, p. 54) between the involved service providers (e.g., app developers and platform operators) and clients, leaving practitioners to react according to the actions of both groups. Such reactions range from providing profiles on rating platforms to dealing with self-diagnosed patients. From this perspective, the resulting risk-management practices play an increasingly meaningful role for research on how professionalism in terms of the legitimation of authority is negotiated in practice. This especially holds true since these services perform a significant function with regard to available information on risks for laypeople (Lupton, 2014; Rich & Miah, 2014). Nevertheless, focusing on either these new services or the way that clients are using them would narrow the perspective on the emerging forms of engagement. Instead, this relationship has to be viewed as built on and constituted by constant processes of negotiation, which to some extent are made visible by the provided technology in doctor ratings, forum posts and personalized or privatized health data. Consequently, the ongoing commercially driven entanglement between business models (e.g., app development and user data-based platforms) and their clients bypasses the traditional dyadic healthcare service encounter in a twofold manner. Either the professionals are consulted only after their clients' self-diagnosis or group diagnosis, or doctors have to abide by the specifications of a business model that targets their clients, leaving them out of the equation. Either way, both these phenomena provide possibilities to negotiate the role and the autonomy of practitioners, with them only playing a minor role (Keeling, Khan, & Newholm, 2013; Robertson et al., 2014). In response, practitioners have to develop specific risk-management

strategies according to these challenges. To reveal the effects and the unintended consequences of the mediatization of professions and professionalism, we argue that a perspective on risk drivers and risk management may reveal vital insights to uncover the apparent and emerging socio-technological interplay among rising business models, professional practitioners and their clients.

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Professional Expectation Management: The Doctor as a Social Figure

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

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

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

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

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

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

Analytical strategy and theory

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Empirical findings

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

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

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

Self-evidence of doctoral professionalism in a rationalizing society

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A turning point: From society to interaction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results and outlook

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

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

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

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

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

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

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

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