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Beyond Served and Secured: Client Work and Reconceptualisation of Professionalism

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Abstract

Within theories of professions, clients of welfare-state professionals are typically portrayed as passive beneficiaries who are served and secured by professional expertise and ethics. This framing implicitly omits that in a client position, even the clients perform work.

Drawing on a research project on rehabilitation following traumatic injuries, the article shows both the explicitly expected and recognised work that clients undertake while seeking to recover from impairments, and the largely invisible work shaped by implicit presuppositions embedded in professional services. The empirical findings form the basis for a discussion of the mechanisms by which this work is rendered invisible to professionals and within theories of professions, and of the implications for reconceptualising professionalism. Theories of professions must incorporate that clients are not merely subject to professional work, but that clients' work is conducive to the outcomes commonly attributed to professionals' work.

Keywords

Invisible work, patient work, client work, professionalism, rehabilitation

Introduction

Deeply ingrained in theories of professions is an understanding of professions as occupations that perform specialised work grounded in theoretical knowledge, hold exclusive jurisdiction

over a field of labour, based on credentials achieved through formal education and training, and with a commitment to doing good work, rather than pursuing economic gain (Evetts, 2013; Freidson, 2001; Wilensky, 1964). The citizens who are the professionals' clients—especially the clients of welfare-state services—are visible as beneficiaries of professional work, as people being served and secured.

Clients are served in the sense that they can benefit from and rely on professional expertise. Professional work involves applying specialised knowledge to individual cases to classify and reason about a problem and take appropriate action (Abbott, 1988). In this framing, the clients present or represent professionals' work tasks.

Clients are secured by a guarantee that work is performed according to a code of ethics—a set of moral norms and a service ideal of devotion to the best interests of the clients and society more than personal interests or profit: "Professionalism requires professionals to be worthy of trust, which means to put clients first, to maintain confidentiality and not use their knowledge for fraudulent purposes" (Evetts, 2013, p. 780).

This implicit portrayal of clients, conveyed by theories of professions, as being served and secured by professional work, omits the fact that in a professional-client relationship, clients also work. Client work appears invisible, and to the extent that it is visible, it is seldom described as work. By omitting client work, theories of professions ignore how client work is shaped by the service system—what professional services offer, what they presuppose, and where service boundaries are drawn, and, crucially, how this work is essential for clients to benefit from professional work and achieve desired outcomes.

To locate a more active role for clients, one must look beyond theories of professions to health care research and the sociology of health and illness. As early as the 1980s, Strauss and colleagues pioneered the study of patient work (Corbin & Strauss, 1985, 1988; Strauss et al., 1982), but these insights have hardly diffused into theories of professions.

Based on a research project on rehabilitation following traumatic injuries, the article investigates the efforts—here seen as work—that people undertake while recovering from impairments and how this work relates to professional work. Drawing on the typology from Hatton (2017), the article discusses the spatial, legal and cultural mechanisms that help to explain the invisibility of client work, especially within theories of professions, and suggests implications for the reconceptualisation of professionalism.

The client and theories of professions

In the literature on professions, professions are typically understood as a type of occupation with distinctive features. While the distinction between a profession and other occupations is viewed a matter of degree than kind (Evetts, 2003; Hughes, 1958), most scholars point to the following defining features (Adams, 2018; Evetts, 2003, 2013; Freidson, 2001; Saks, 2012):

specialised expertise grounded in formal knowledge and practical apprenticeship; a code of ethics and service orientation; autonomy with self-regulation and collegial control; and authority recognised and trusted by clients and employers. These ideal traits can be read as an ideology that secures professions' sheltered position in the labour market, ultimately benefitting the profession itself (Evetts, 2013; Saks, 2012), but also as a value system meant to serve the interests of clients and society (Evetts, 2013).

Much research has examined the work of professions, adopting a "doing-lens" on occupations (Anteby et al., 2016). Yet, most attention is given to the consequences of task content and practices for the professionals' identity, meaningfulness and dignity (Anteby et al., 2016) and to the jurisdictional struggles among different professions to define, control and perform certain tasks (Abbott, 1988). Claims for jurisdiction are claims to classify a problem, to reason about it, and to take action on it—the three tasks of professional practice (Abbott, 1988). In this description, clients present or represent professionals' tasks. While Abbott notes that features of clients affect professional work and jurisdiction, for example, clients' willingness to comply with professional prescriptions, the efforts (or work) that clients undertake in professional-client relationships receive little attention.

Thus, in theories of professions, clients are largely invisible and present only implicitly as being served by professional work and secured by professional expertise and ethics. This is not to suggest that research grounded in theories of professions has entirely overlooked the clients of welfare-state professionals or the professionals' relationship with them, although it has not been a prominent topic (Harrits & Larsen, 2016). However, clients are typically examined through the eyes of professionals and in relation to professionals' status and work. Examples include research on how client perceptions influence professional reasoning (Jacobsson, 2014; Møller, 2016), which client situations are deemed "non-problematic" (Rexvid & Evertsson, 2016), which attitudes professionals hold towards patient participation and whether patients' rights and access to knowledge are seen as threats to professional authority (Eklund, 2024; Larsen, 2016; Leemeijer & Trappenburg, 2016). Clients' work remains largely invisible.

Even in a healthcare anthology analysing paid and voluntary "support workers" without professional qualifications, the work of patients receives little attention (Saks, 2020). Included in what the authors see as an "invisible workforce" are unpaid informal carers and peer support workers who transform personal experience into experiential knowledge, but not the work of patients. Here, work is understood as tasks performed for others—work that mirrors professionals' work.

However, a growing strand of scholarship argues that economic, social, cultural, technological, and demographic changes require a fundamental reconceptualisation of what professionalism means and what professionals are. New conceptualisations situate professionalism within relationships to clients, the organisations in which professionals work, civil society and

the broader public (Flam, 2019; Münte & Scheid, 2017; Møller, 2019; Noordegraaf, 2015, 2020). In Noordegraaf's ideal-type "connective professionalism," expertise, autonomy and authority are constituted through these relationships (Noordegraaf, 2020). Professionalism is not solely linked to the professional as an individual but is instead embedded in professional work processes.

Such reconceptualisation repositions the client. For example, it is recognised that the outcome of professional work is produced through interaction with clients (Münte & Scheid, 2017), and that clients want to be co-deciders and even co-producers (Noordegraaf, 2020). It is further argued that a reconceptualised professionalism must take into account that relationships to clients are personal and emotion-based rather than detached (Harrits, 2016). An "explicit" professionalism is suggested, which can promise transparency about sources of knowledge, articulation of judgements, and documentation of decisions (Møller, 2019). Yet, even within such reconceptualisation, the client is typically framed within the bounds of professional work—as the bearer of complex problems and higher expectations that pose new demands on professionals.

Given that client relationships have always been integral to professionalism, and that the success of professions depends on their ability to redefine what professionalism entails, as Alvehus et al. (2021) argue, it is crucial for theories of professions to incorporate the work of clients.

Patient work

While the work of clients seems invisible in theories of profession, the sociology of health and illness conceptualised patient work as early as the 1980s through the formative writings of Strauss and co-authors (Corbin & Strauss, 1985, 1988; Strauss et al., 1982). Their perspectives on the types of work performed by patients in hospitals and by chronic patients and their families at home can also apply to analyses of the types of work performed by clients of welfare-state services more generally.

According to Strauss et al. (1982), patients work to manage and shape aspects of their illness trajectories. In the hospital context, this involves work that mirrors staff work, such as following instructions in the performance of procedures or interventions, and work that is supplementary to staff work, such as maintaining composure during procedural tasks.

Patients also perform work that staff cannot, such as providing information about allergies to certain drugs or explaining other chronic illnesses whose symptoms may interfere with staff's work (Strauss et al., 1982). Patient work may substitute for work that staff did not perform but were supposed to perform or that patients believe is the responsibility of staff (Strauss et al., 1982). Patients may perform work that they find necessary, although the staff might disagree (were they aware), such as monitoring for potential errors or incompetence. Patients may rectify staff errors directly or report or complain to the responsible authorities.

Finally, patients engage in work that lies beyond what staff may consider within the scope of their work, such as coping with highly personalised, deep identity problems caused by severe illnesses or injuries. Corbin and Strauss (1988) highlighted that ill or injured people engage in the strenuous cognitive and emotional work of contextualising an illness into their lives, coming to terms with their body and activity limitations and reconstructing their identity and biography.

Except for this identity work, the work of hospital patients is not directly translatable to work performed during long-term trajectories following injuries, impairments and chronic conditions, as the latter also involves other professional services provided by a variety of organisations within a specialised division of labour. Furthermore, in recent years, focus on self-management of chronic conditions and technological innovations to support this self-care has spurred a revived interest in patient work (Valdez et al., 2015; Yin et al., 2020). However, scholars note that much of that work is invisible, unrecognised by health systems, and poorly understood (Rogvi et al., 2021; Smith et al., 2025; Yin et al., 2020). To understand patient—and client—work, it is necessary to discern the mechanisms by which that work is rendered invisible.

Mechanisms rendering work invisible

Understanding invisible work means understanding what counts as work. Work is visible or invisible because of our mental models of what work is (Budd, 2016). Conceptualisations of work are often narrowly conceived and typically unstated, and work that deviates from dominant conceptualisations is devalued and rendered invisible (Budd, 2016). What is regarded as work "does not depend a priori on any set of indicators, but rather on the definition of the situation" (Star & Strauss, 1999, p. 14).

In her discussion, the invisibilisation of women's work outside paid employment, Daniels (1987) notes that work is typically recognised as work when it is paid, requires skills, and is undertaken in the public world. In contrast, activities that are not valued as work tend to occur in private settings, without an audience, and are often perceived as "natural" for the person performing them, rather than as tasks requiring skills. Daniels argues that expanding the concept of would lead to a keener awareness of the work involved in social constructions of daily life, serve to dignify this work, and foster respect for the efforts and skills it demands. Similarly, Glucksmann (2016) argues for an inclusive concept of work that acknowledges the largely unrecognised "consumption work," that is, the labour involved in the use of goods and services and the acquisition of the skills necessary to undertake consumption.

According to Star and Strauss (1999), either the worker or the work can be rendered invisible. The worker may be made a non-person even if the act of working or the product of the work is visible. The opposite dynamic occurs where workers are themselves quite visible, yet the work they perform is invisible or relegated to taken-for-granted expectations. Work may become invisible by virtue of routine (and social status): "If one looked, one *could* literally see

the work being done—but the taken-for-granted status means that it is functionally invisible" (Star & Strauss, 1999, p. 20).

In a literature synthesis, Hatton (2017) distinguished three intersecting sociological mechanisms—cultural, legal and spatial—through which work is rendered invisible and thus devalued. *Sociocultural* mechanisms are in effect when labour is devalued by virtue of hegemonic cultural ideologies relating to gender, race, class, ability, sexuality, or age. *Sociospatial* mechanisms take effect when labour is devalued because it is physically segregated from a culturally defined worksite—outside of a workplace, for example, in the domestic sphere (in private homes), or in non-traditional worksites. *Sociolegal* mechanisms are in operation when work is devalued because it is excluded from legal definitions of employment, for example, when workers are legally characterised as not working for wages but for some other reason.

Based on these perspectives on patient work and mechanisms that render some forms of work invisible, I turn to the empirical exploration of client work in the context of recovering from impairing injuries.

Empirical material and analysis

This article draws on a five-year project studying rehabilitation following traumatic injury. Rehabilitation trajectories were examined from the perspectives of injured individuals and professionals in hospital- and community-based rehabilitation settings and employment services. In Norway, these are all public services delivered by the state or municipality.

The project involved seven researchers and three PhD students, who participated in data collection and analysis. As the broader findings of the research are reported extensively elsewhere, the present analysis zooms in on the efforts undertaken by injured individuals during their recovery trajectories—efforts which they did not describe as work but nonetheless felt were necessary. Understanding these efforts as work allows me to explore the clients' contributions to outcomes that are often attributed to professional work but remain invisible within theories of professions.

Traumatic injuries are often disabling conditions affecting many aspects of everyday life, including social and vocational participation, and they lead to lengthy recovery processes involving many healthcare and social welfare services (Andelic et al., 2018; Borgen et al., 2022). In many respects, the work undertaken by people living with and recovering from traumatic injuries is also illustrative for other chronic conditions.

Using an open narrative approach (Gubrium & Holstein, 2009), the data comprised interviews with 21 affected individuals conducted at two points in their recovery trajectory: upon discharge from hospital-based rehabilitation and two to three years later. Eleven males and ten females of working age from various occupations were interviewed; the youngest were in their 20s at the time of their first interview, the oldest in their 60s.

The data also included interviews with 16 hospital professionals, conducted following observations of eight one-hour interdisciplinary team meetings about patients. In addition, 25 professionals were observed during these meetings. Furthermore, group interviews were conducted with 34 community-based rehabilitation professionals and 27 employment services professionals in eight municipalities. The educational backgrounds of the interviewed professionals included nursing, occupational therapy, physiotherapy, psychology, medicine, social work, pedagogy and law.

In interviews with professionals from local services targeting a broad spectrum of diagnoses and social problems, an illustrative case story (vignette) was used to focus on the professionals' work with traumatic injuries. For further information about data collection and method, see the more elaborate empirical analyses from the projects (Alm Andreassen & Solvang, 2021; Solvang et al., 2023).

The Norwegian data protection authorities approved the study. The interviewed individuals received invitations to participate from professionals at the hospitals. Informed consent was obtained from the interviewees, from the patients discussed in the observed meetings and from the professionals. To avoid being overly intrusive and to protect the patients' privacy, there are no direct links between the interviewed patients and the observed professionals. All interviews and observations were audio-recorded, transcribed verbatim and anonymised.

The analysis was guided by the concept of patient work. Interviews with the injured individuals were first approached by assembling everyone's story of their recovery trajectory, and then carefully examining these accounts for the kinds of effort involved. The identified efforts were sorted into broader types of work. Thereafter, observations and interviews with the professionals were examined to understand how the service context shaped this work. In the analyses, the professionals' talk and actions were understood as institutionally embedded—as representations of their organisational context, professional role, and problem perceptions. This understanding was supported by the professionals' own accounts. In recounting how "we" act in a given case, they spoke as workers with professional identities and as members of service-providing organisations. The final analytical step involved developing a meaningful categorisation of the types of work, examining mechanisms that rendered some work invisible, and inferring implications for theories of professions.

Client work during trajectories of recovery

Work shaped by service system offers

Recovery trajectories involved work shaped by what the service system offered. This included work that Strauss et al. (1982) described as mirroring or supplementing professional procedures and practices. It was visible work that professionals, and the organisations they represented, expected of patients and clients, although it was not always labelled as work. There was significant consensus among professionals and injured individuals regarding the end goal

of rehabilitation—improved functioning and restored health—and the need for individuals to work on their rehabilitation and to care for their health.

Working on their rehabilitation entailed what I term *restoring work*—extensive training to improve bodily and mental functioning, which was occasionally compared to a full working week of regular employment. One man described the effort required to retain restored capacity as "being sentenced to a life of training." Restoring work also involved applying compensatory strategies and assistive technologies in attempts to control deterioration and manage everyday life, and the following self-care, self-monitoring and self-management of treatment, prevention and control, which is described in much literature on patient work (Grue, 2016; Huyard et al., 2019; May et al., 2014; Oudshoorn, 2008; Pickard & Rogers, 2012).

Another form of work was *capacity assessment*, by which individuals assessed how the injuries affected their lives as employees, parents or spouses, and their ability to care for themselves. For many, this entailed the enduring work of continuous adjustment to both improvements and deterioration. For example, one woman described how she consciously tested her work capacity during her slow and gradual return to work, which included recurring healthcare interventions to address the setbacks she encountered. Learning was part of this process. Professionals taught patients about the consequences of their injuries and ways to handle them. Some referred to this support as "school." Such patient education is designed to equip affected individuals (and family members) with the requisite knowledge, tools and assistance for the work of mental and bodily self-management.

Following capacity assessment was the *work prioritising and balancing* when injuries compelled the individuals to consider how to live with their permanently reduced capacity—a challenging balancing act between working on their personal rehabilitation (as expected by the professionals), being a loyal and caring family member and friend, and living by citizenship obligations of self-support, their own wage-worker identity and returning to work. The injured person was not always the only family member with a long-term condition requiring support and care. Injured individuals also had to determine whether to accept help from others for everyday activities (e.g. getting dressed each morning) or to invest major effort in maintaining their independence while managing the consequences of impairment. Assessing their capacity and finding congruity between their capacity, their own wants, and the requirements imposed on them was time-consuming work.

Perhaps most demanding was the effort to come to terms with their situation as injured or sometimes permanently disabled. This *work of biographical reconstruction* involved managing the "biographical disruption" and disconnect with their pre-injury self, caused by the onset of severe illnesses or injuries (Bury, 1982; Levack et al., 2010). The injured individuals had to learn to live with altered bodies and reconstruct disrupted biographies, self-identities and work identities (Levack et al., 2010; Solvang et al., 2023; Trusson et al., 2021).

Corbin and Strauss (1988) described this work as a process of coping with the profoundly personal issues of identity as falling outside of what professionals conceive as the scope of their work. However, in the studied rehabilitation service, the professionals did provide support for biographical reconstruction. Patients were expected to share their struggles in group settings with professionals and fellow patients in a process of learning and reflection.

Work shaped by service system presuppositions

Some types of work were inescapable consequences of the presuppositions on which professional service systems are designed. For example, when professional services are designed with peer-support elements, clients are expected to work not only on their own recovery but also perform supportive work with others. Also, other forms of work were presupposed.

System-managing work was a type of work presupposed by service design. It involved surveying service systems to understand where and how one's needs might be addressed, identifying relevant services, making sense of service mandates and responsibilities, detecting entry points, and making one's needs known to professionals. It also involved learning service-specific organisation, language and terminology and application and contact procedures. It was described as a hard and lonely job comparable to "wandering in the wilderness."

Employment service professionals illustrated how such requirements were ingrained in procedures. Before sickness entitlements expire, clients receive written information about opportunities to apply for temporary incapacity benefits if their ability to return to work is hindered by injury or illness. The letter includes an invitation to contact the employment agency. However, as the professionals explained, in cases of mental illness or reduced initiative due to brain injury, there is a risk that clients may not respond and therefore lose their income security. Although the professionals acknowledged that outreach might be appropriate in these cases, the employment agency is not set up to reach out to passive clients; clients must assume responsibility for their cases. While the welfare-state grants impaired citizens social rights, the organisation that administers these rights is not designed to accommodate impairments. Others have described similar dynamics, for example, the work that hearing-impaired people must do to access healthcare services and to secure equitable care (DeVault et al., 2011; DeVault, 2014).

Surveying the system also included efforts to identify competent professionals with the requisite knowledge to understand individual needs. Information regarding the expertise, skills, trustworthiness, or personal qualities of the professionals involved in their rehabilitation was requested not out of suspicion or distrust but of a desire for professionals, for example, a physiotherapist, whose interpersonal style and approach matched the patient and who could motivate and support the continuous effort that rehabilitation demanded.

System-managing work also involved ensuring that service providers followed up as planned, promised, or expected. There were stories about checking that the system worked as it

should, detecting and correcting failures, mistakes, and errors, and teaching professionals about the implications of their injury that they apparently were unaware of, but which the injured individuals believed required action. For example, one woman described being assured by hospital professionals that follow-up would be provided, but after waiting many months, she concluded she had been forgotten. She decided to call the hospital every day until an appointment was scheduled; she had to take control, she said, or she might not have received the necessary follow-up care. As illustrated by this story, system-managing work involved administering and coordinating contact with various parts of the service system, tasks that, due to brain injuries, were often handled by family members. This monitoring and rectifying staff errors and responding to service gaps resembles substituting for work that staff did not perform or work that patients believed was necessary, although the staff would disagree (Strauss et al., 1982). The interviewed professionals highlighted dynamics that may drive such work. Mundane workplace events, such as sickness absence, job shifts and staff turnover, based on the professionals' rights as citizens and wage earners, may interrupt clients' relationships with professionals and increase the likelihood of mistakes and errors.

System-managing work is required to make oneself available for professional help, to access and benefit from professional care (Rogvi et al., 2021). In a welfare-state, citizens can access a range of healthcare and social services, with a corresponding division of labour and organisational, professional, and geographical boundaries that define who does what and for whom. Within a system of professions, each profession claims ownership of its own field of expertise (Abbott, 1988). To that end, professions define their own proper work and demarcate their boundaries against others, and in so doing, they define the department, service or area of expertise to which a problem or a client belongs (Cramer et al., 2018). This division of labour and expertise defines which target groups can legitimately request services because they fit the eligibility criteria or the bounds of professional expertise. Those seeking help must therefore understand how to navigate the system, and as services vary by location and change over time with new regulations and professional knowledge, such work is an ongoing task (Dalgarno et al., 2023; Grossman & Mullin, 2020).

Because of this division of labour, administration and coordination are also needed. Problems caused by individuals' injuries frequently crossed jurisdictional boundaries between types of professions, services, and administrative levels. Most services are operated on the basis of client initiative. This is widely noted in research on patient work, for example, in a distributed care system, patients must coordinate their treatment and manage interdependencies between different service providers (Dalsted et al., 2012; Unruh & Pratt, 2008; Valentine et al., 2022).

System presupposition requires also *justification work*—demonstrating need by providing information and documentation about one's illness or impairment. This occurred both in face-to-face encounters with professionals and in written applications for services and benefits.

Professionals used this information to assess an individual's need for professional intervention or eligibility for welfare support and whether the case profile matched the service offering of the intervention or the eligibility requirements.

The interviewed individuals told many stories about such justification work. One woman noted that the forms and questionnaires she had completed enabled the professionals to decide whether her profile matched the available intervention. One man described repeated applications for assistive technology that appeared to be based on the assumption that his condition would improve and his impairments would disappear, rendering him ineligible for welfare support. Another man referred to separate application procedures for a prosthetic, a wheelchair and a modified car, even though they all pertained to an amputation.

Justification work is undertaken because the services are crucial to those dependent on them and this work is a consequence of rules governing access to health care or welfare support. Before being granted social security, citizens are required to demonstrate need, eligibility, and deservingness. Similarly, the principle of needs-based health care requires those seeking help to demonstrate their credibility and legitimacy as recipients of professional services (Edwards & Sines, 2008; Grue, 2016; Johannessen, 2018; Korhonen & Komulainen, 2019; Mik-Meyer & Obling, 2012; Werner & Malterud, 2003).

Work shaped by service boundaries

Also shaped by service design is *residual work* arising from the jurisdictional boundaries of professions and services. While some problems align neatly with the welfare-state's system of support and professional expertise, others are left unattended, for example, because no prescribed measure or intervention exists.

In one observed hospital meeting, a doctor remarked that a discharge-ready patient with injury-triggered social skills deficits was a candidate for programmes in "good management training" and "social communication." The remark was tongue-in-cheek, as no such programme was offered by the hospital or the patient's local healthcare services, which the doctor was uncomfortably aware of. As the patient's problems did not fit any of the available tools or treatment programmes, she and her next-of-kin were left to deal with the problems, which all the professionals regarded as resulting from her brain injury and believed would affect her personal relationships. Similarly, community-based elder-oriented rehabilitation services could not adequately address the needs of severely injured working-age patients. One local professional noted that traumatic injury required "real" rehabilitation and then immediately amended this to "classic rehabilitation," a level of service far more extensive than what the municipality offered. In these and other cases, due to such service gaps, the work of managing residual problems was left to the affected persons and their families.

Translation work was needed to convert abilities learned in formal rehabilitation settings to everyday settings without professional assistance. This work was necessary because the "real

world" differed from the shielded service settings where patients could minimise or deny the severity of their problems. "When you get excellent rehab like I have […] you are wrapped in cotton wool," one man said. One woman referred to the rehabilitation setting as a "bubble;" another used "incubator," likening hospital discharge to "being thrown off a cliff." When discharged from rehabilitation services, injured individuals must translate hard-earned abilities for use in entirely different everyday contexts.

Translation work is a consequence of rehabilitation taking place in professional workplace settings that are structured by service purposes and knowledge bases that shape how clients' problems and solutions are envisioned—privileging organisational and professional goals (Levack et al., 2011). Professional testing and training programmes set measurable short-term goals that may neglect the individual's everyday preferences (Christiansen & Slomic, 2021). When an individual's goals seem unduly ambitious or unrealistic, professionals may set more attainable goals that are achievable with tools under their control, such as muscular strength training or techniques for improving attention. While these concrete abilities may help achieve longer-term goals such as returning to work, the accommodated rehabilitation setting in which they are acquired and learned may differ vastly from ordinary homes and workplaces. Consequently, injured individuals are left with the work of translating their acquired abilities into everyday use, and like residual work, it is a form of work out of sight for the professionals.

Client work and mechanisms of invisibilisation

The above analysis has shown that clients are not (and have probably never been) mere recipients of professional expert work but instead perform many types of work, demanding both effort and skills. The work is a consequence of their impairment but shaped by the setup of the service system. Some client work is visible; other work is apparently invisibilised.

Recognised and most often visible is clients' work on their rehabilitation—restoring health, assessing capacity, prioritising within reduced capacity and reconstructing their biographies. This work conforms to sociocultural models of what clients are expected to do—wanting to get well, learning from professional expertise, and complying with professionals' recommendations (Flinkfeldt, 2017; Parsons, 2005/1951). It is (at least partly) located in professional workplaces and mirrors professional work, is based on professional expertise, often performed alongside or with instructions from professionals and with their educative support. It can even be recognised as genuine work because it duplicates or supplements staff work (Strauss et al., 1982).

There is also work performed in response to presuppositions embedded in the service system that could be rendered invisible through several mechanisms.

Sociocultural mechanisms operate as mental models of clients are inscribed in legislation, professional support and service design. These models prescribe how a proper client should

act, and which tasks are taken care of by the system. They expect clients to work on justifying needs and eligibility, but also presuppose the more invisible system-managing work. Finally, the boundaries of the service system leave to the clients (and their families and network) the work of translating professional help into everyday life and the residual work with all problems that do not fit. These forms of work are consequences of service design but are rendered invisible by the taken-for-granted premises on which the system is built, as illustrated by employment services requiring client initiative. Such work often goes unrecognised as it is perceived as contributory actions—an expectation of clients to "do their part" (DeVault et al., 2011, p.8). The workers are themselves quite visible, yet the taken-for- granted status of the work they perform means that it is "functionally invisible" (Star & Strauss, 1999, p. 22).

Sociocultural mechanisms may also produce invisibility when the work challenges the trust that clients are expected to place in welfare services. This may render invisible the system-managing work of assuring that professionals are personally and professionally capable of motivating and supporting individual needs. Invisibilised, too, may be the monitoring not of their own health condition (as highlighted in research on self-management) but of the actions, and especially non-actions, of the services, ensuring that promised support for recovery is in fact undertaken. Clients might consciously hide this work because they expect professionals to dislike it if they knew, anticipating that staff would not see their work as legitimate (Strauss et al., 1982).

Through sociolegal mechanisms, neither client work nor the workers are encompassed by legal rights to safe physical and psychosocial working conditions. In Norway, the legislative act on the working environment explicitly excludes the work of patients in health institutions, rehabilitation institutions and the like. In effect, almost all client work is non-work—outside the legal definition of work. Sociolegal mechanisms similarly devalue the work required to fulfil the conditions attached to accessing the social and legal rights that welfare-states ascribe to citizens.

Sociospatial mechanisms render much client work invisible since it is dislocated from professional work and workplaces and not performed in the public world of what is seen as a workplace (Daniels, 1987; Hatton, 2017). Work is invisible because it is often performed when professionals are not present (Strauss et al., 1982), away from the locations of professional service providers (Unruh & Pratt, 2008), and linked to everyday life (Grue, 2016). As Daniels (1987) notes, activities that are not valued as work occur in private settings, without an audience, and seen as natural instead of skills-demanding tasks.

Implications for the conceptualisation of professionalism

This analysis has identified many types of client work and how they are shaped, but also invisibilised, by professional services. While the analysis does not claim to encompass all forms

of client work or all mechanisms rendering work invisible, it nonetheless suggests a reconceptualisation of professionalism, one that considers clients as more than passively served and secured by professional expert work.

First, a reconceptualised professionalism must account for connections between professionals and clients beyond mere interaction and heightened client expectations, and must explicitly embrace work undertaken by clients themselves, recognising that professionals' expert work is far from sufficient for clients to benefit from professional services. Clients are not merely the subject of professional work; rather, clients' work is conducive to the outcomes of what, in theory, are perceived as professionals' work.

Second, while the view of professionalism as a value, where clients are ideally protected by professionals' code of ethics, remains, a reconceptualised professionalism must acknowledge that professional ethics cannot prevent all gaps, mistakes or failures. Professionals are human, and problems that cause clients to work are not primarily due to professionals pursuing fraudulent purposes, but due to their being specialised employees with bounded expertise and working hours within services with given mandates.

Third, recognising that clients undertake work does not negate that they can also benefit from and rely on professional expertise. Indeed, in-depth expertise is actively desired by clients (Alm Andreassen, 2016). As this analysis demonstrates, professional work involves not only applying specialised knowledge to classify, reason about, and take action in individual cases, as Abbott (1988) suggested, but also transferring expert knowledge to support clients' own work on their problems. Client work can be facilitated by system-offers of educative support based on professional expertise. Therefore, a professionalism acknowledging that client work is driven also by system presuppositions could incorporate such educative support to better enable the skills-demanding system-managing work.

Fourth, ignoring client work raises ethical concerns due to the detrimental consequences of invisibility (Crain et al., 2016): that the work is not valued, that workers fail to demand recognition for this work and that it may not be addressed in theory or practice. Instead, the burden of unacknowledged, yet essential, work is placed on vulnerable individuals, who are already tasked with much work stemming from the problems that led them to seek professional services in the first place.

Finally, a reconceptualised professionalism must move beyond depicting clients as merely presenting or representing the tasks of professionals. This expert-role model does not align with the actual process of problem-solving. Instead, professionalism must include clients' "consumption work" and the skills necessary to undertake such work (Glucksmann, 2016). By addressing the interconnections between professional and client work, as Glucksmann (2016) suggests, it becomes clear that client work occurs not only because clients want to be co-producers, but is inevitably shaped by the expectation and presuppositions of professional

work and the service system—what is offered, what is presupposed, and where boundaries are drawn.

To conclude: Prevailing conceptualisations of professionalism characterise professions as workers. Expertise, ethics, autonomy, and authority are attributes characterising what professions are, not what they do. A reconceptualisation of "connective professionalism" (Noordegraaf, 2020) properly grasps how the professional-client relationship requires these characteristics to be relationally understood. A revised understanding of professionalism should similarly account for the nature of professional work—not merely of the character of this work, but also how outcomes are produced. Professional work is seldom the sole form of work necessary for clients to benefit from expert services. Professional work and its outcome cannot be viewed in isolation but are intrinsically linked to work undertaken by clients. Without recognising this interdependence of professional and client work, theories of professions risk overestimating the value of professional contributions while neglecting the critical and often invisible role played by clients.

Ethics declaration

The empirical research on which this study is based was evaluated and approved by the data protection officer at Oslo University Hospital in 2013 (2013/1814) and by the Norwegian data protection authorities (Data Protection Services) in 2014 (39475). Informed consent was obtained from all parties, including the interviewed patients, those discussed in the observed meetings and the professionals involved.

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