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Professionalism: A Review of Its Impact on the Health Services

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INTRODUCTION

In Ancient Egypt the rules were simple. Occupational position was hereditary: if you were born into a "professional" household, you were a professional (Titler, n.d.). Even six hundred years ago, although a different rule applied, the rule was still simple. If you spoke Latin in your work, you were a professional (Joe, 1981). Thus, the three traditionally learned professions, law, clergy, and medicine have a common linguistic base. Such was the status of professions until the rise of the universities in the later middle ages. There was no social trauma in accepting the university professor—he was probably a cleric, at least he was schooled in Latin (Cogan, 1953).

The present state of the professions arose as a result of the Industrial Revolution. In 1833 Samuel Taylor Colderidge wrote, "Every true science bears necessarily within itself the germ of a cognate profession, and the more you can elevate trades into professions the better." As technology has brought increased specialization, the individuals within those specialties, fragmented from the traditional professions, have aspired to be recognized as being of professional status. This "professionalization" has been most noted in the helping professions, particularly in medicine. Martin (1934) described the difficulties of professionalizing surgery, and Reiser (1983) noted 152 allied health specialties constituting one-third of the medical work force.[1]

This paper will review the literature of professionalism, comment on professionalism as it relates to the health services professions, present a model of reaction to professionalization, and draw conclusions about the results of this trend.

REVIEW OF THE LITERATURE

Flexner (1915, p. 576) was the first to attempt to delineate the basic characteristics unique to a profession. They are as follows:

> ". . . professional activity was basically intellectual, carrying with it great personal responsibility; it was learned, being based on great knowledge and not merely routine; it was practical, rather than academic or theoretic; its technique could be taught, this being the basis of professional education; it was strongly organized internally; and it was motivated by altruism, the professionals viewing themselves as working for some aspect of the good of society."

Carr-Saunders and Wilson (1933) agreed basically with Flexner and predicted a gradual extension of professionalism into all occupational fields (Bennett and Hokenstad, 1973, p. 24). Attempts to "nail down" a definition have been as complex as Wilensky's (1964) and Hall's (1968), both of whom listed ten characteristics, or as simple as Hughes (1958), who said that a profession has a lay clientele. Significant attempts have been those by Coogan (1953),

Goode (1957, 1960), Greenwood (1962), Volmer and Mills (1966) and Moore (1970).

Finally, in 1973, Morrow reviewed nine of the major definitions of "profession." Characteristics were divided into "Attitudinal Qualities" and "Structural Qualities." Included were 11 characteristics (Figure 1).

Most proved to be in agreement in structural characteristics, but attitudinal characteristics were emphasized less by Foote (1953) and gradually again approached Carr-Sanders' 1928 original by 1968 (Hall).

Attitudinal Qualities

- Colleagues are major reference group
- Public service value
- Self regulating
- Sense of calling
- Autonomy
- Rewards justification

Structural Qualities

- Full time occupation with specialized knowledge
- Own training schools
- Professional association
- Licensing/certification, community recognition
- Code of ethics

Figure 1

Volmer (1966, p. vii) in his monumental work *Professionalism,* attempted to put the matter in its proper perspective:

> ". . . we avoid the use of the term 'profession,' except as an 'ideal type' of occupational organization which does not exist in reality, but which provides the model of the form of occupational organization that would result if any professional group became completely professionalized. . . . We suggest, therefore, that the concept of 'profession' be applied only to an abstract model of occupational organization, and that the concept of 'professionalization' be used to refer to the dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of a 'profession,' even though some of these may not move very far in this direction . . ."

Flexner had undoubtedly anticipated the problems of specific definition, for he qualified his analysis:

> "What matters most is professional spirit. All activities may be prosecuted in the genuine professional spirit . . . The unselfish devotion to those who have chosen to give themselves to making the world a fitter place to live in can fill social work with the professional spirit and thus to some extent lift it above all the distinction which I have been at such pains to make."

Professionalism has all in all been seen as something good (Durkheim, 1957).[2] Both internal and external forces work on the segments (Strauss, 1975, p. 21) within an occupation and generate the dynamics that move towards professionalization (Gustafson, 1982, p. 508). In the health care area this has been brought about by an increasing de-professionalization (Haug, 1973, p. 197) of the physician and an increasing specialization of function that causes the physician to rely more and more on auxiliary personnel (Barish, 1975, p. 974). The public has certain expectations of ability in health care workers (Battle, 1981), (Barringer, 1983), identifying quality health care with innovation. There is a positive correlation between change, innovation, and professionalism (Palumbo, and Styskal, 1974). From within the developing profession, roles (Gingras, 1984) and abilities (Schoenwald, Scott, and Lance, 1984) are identified. As previously noted, the process is deemed "good" and even Marxist scholarship (Larson, 1979, p. 613) attributes this quality:

> "Professionalism also contains potentially emancipatory elements: the most significant are, in my view, the claim of work autonomy and self control, together with the aspiration to 'serve' human needs and to produce worthy, high quality objects or services."

We have established that "professionalism" is an ongoing societal process

affecting the health professions: it is needed, desired, and beneficial. Let us now comment on health services specifically in terms of professionalism. Precedence for and evaluation of a health service was set by Tworek (1981) in his study of the physician's assistant. Tworek attributes ten characteristics of "professionalism" to Schein (1972), and it is by this standard of ten that I will proceed.

1. **A Full Time Occupation.** Health service professionals are, except in very few instances, employed in their profession as their full time livelihood.

2. **A Strong Motivation or Calling for the Career.** While many health service professionals find themselves in a profession by placement or birth, many find "a dignity to one's work that can be affirmed . . . [and] a sense of fulfillment and meaning that can come from being of service to others and to the common good" (Gustafson, 1982, p. 584).

3. **A Specialized Body of Knowledge and Skills Acquired During a Prolonged Period of Education and Training.** Health service professionals require a minimum of two years college-level training. Most require a minimum of four years, though it may be combined didactic and clinical learning. In many specializations claiming to be professional, the educational requirements are sadly lacking. This is surprising as, "The most common criterion describing professions . . . is their emphasis on education" (Nyre and Reilly, 1979, p. 10).

4. **Decision Making on Behalf of the Client in Terms of Principles, Theories or Propositions.** "To be a professional person is to learn to think . . . and to exercise practical reason in making judgements. . . . Exercising discretion, making judgements and moving from the established and familiar to what is different in particular features distinguishes professions from most other occupations" (Gustafson, 1982, p. 506).

5. **Service Orientation.** "All true professions deal with humans in special existential states of vulnerability in which there is some wounding of the very humanity of the person in need. . . . The tradesman's promise to help is made as a means to make a profit, not primarily for the good of the customer" (Pellegrino, 1983, pp. 172, 174).

6. **Service Based on the Objective Needs of the Client and Mutual Trust.** "The action taken and advice given must be not only technically correct but 'good'; that is, it must be congruent with the best interests of the person in need" (Pellegrino, p. 173). Trust in the professional to act in this way and in maintenance of confidence and the withholding of judgment (Tworek, p. 112) is implicit in any health care professional patient relationship.

7. **Autonomy of Judgment for Performance.** Health service professions are at varying levels of autonomy. Most, even if doing repetitive tasks, must possess a high level of skill and judgment to be able to carry out that function. The question of autonomy is often raised and hotly debated. Wilensky (1964, p. 156) stated, "It seems clear that ancillary medical occupations will arrive at an autonomy befitting professional status only at the expense of the control now in the hands of physicians and board members who will not readily yield." The end result is that "Physicians are likely to be very poorly informed about any institutional and occupational resources that lie outside their own jurisdiction . . ." !(Freidson, 1970, p. 150). In this contest, the health service professional is truly caught in the middle. Skills and services are needed by the patient, but a health service professional's employment may be jeopardized if discretion is not exercised (Barker, 1979). Nickel (1983, p. 14), on the other hand, relates that "My method is to emphasize the skills of each professional required for a competent rehabilitation service and note the improvement in patient care that will result when all members are permitted to work to their full potential."

8. **Formation of Professional Associations and Other Professional Credentials.** ". . . this is accompanied by a campaign to separate the competent from the incompetent. This involves further definition of essential professional tasks, the development of internal conflict among practitioners of varying background, and some competi-

tion with outsiders who do similar work" (Wilensky, 1964, p. 144).

9. **Specific Set of Knowledge.** In the health professions, each has a function in which, while the knowledge application and its results are not necessarily unique, the skills of application and the yielding of results are unique.

10. **Professionals are Not Allowed to Seek Out Clients.** Most professional codes of ethics forbid or at least regulate these practices. Health professionals are all in a state of "professionalization." None have yet achieved an equal standing with the established professions. The achievement of professional status has been accomplished by surgery, dentistry, and veterinary medicine. I would propose a model by which professionalism occurs in the health service professions (Figure 2).

The occupation tends to stay as it is by force of social inertia. Traditions of place externally and traditions of skill internally tend to maintain the status quo. Conflict then comes to a head (Wilensky, p. 144) with the recognition of the ecological niche that needs to be filled and with the fledgling professional's realization that he or she may be the one to do so. Thus, aspiration changes self image.

Power is not absolute, but is often viewed as if it is. Power gained is thought to be gotten from someone. Physicians are not eager to give up authority (Wilensky, 1964). Within the aspiring profession, reactionary forces come into play and a tendency to undermine the professionalism and espouse return to the traditions of skill and place ensues (Potenberg, 1983). As these resistances are overcome, assistance comes into play with legal responsibility being dictated externally, and with control of entry and association coming from within.[3]

What does this mean to the aspiring health professional? I project increased responsibility resulting from primarily legal requirements. Flores and Johnson (1983, p. 544) described the requirements for responsibility:

> "1. Individuals must have some degree of autonomy in the position that they hold. . . . 2. The individual must have contributed by his action or inaction to the production of the . . . product or service; and 3. the individual must have a duty to protect public safety. It is obvious that by these standards the health professional is "responsible."

The legal requirements of this responsibility will require new emphasis on records (Reiser, 1983) as legal documents and evaluation by external agencies such as JCAH (Joint Commission on Accreditation of Hospitals, 1980) and PSRO's (Reynolds, 1976).

Structurally, administrations must recognize and actively promote the socializa-

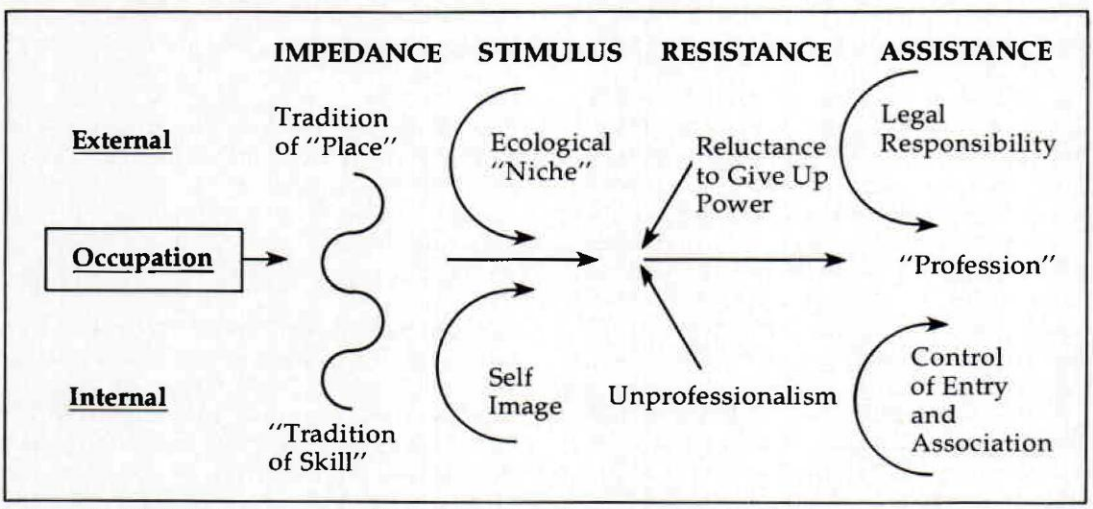

Figure 2. Model of professionalization in health service professions.

tion of emerging professions.[4] The recognition must come if optimum quality of patient care is to be achieved. No "critical person can survive . . . because assessment of one's academic or professional service and related occupational survival requires an ethical stance from others who value that work" (Mason, 1983, p. 133).

Health professionals will be increasingly involved in patient management decisions (Weiler, 1975). The team concept is coming into more widespread use (Engel and Hall, 1971). These trends may be further stimulated by the efficiencies required by DRG's (Bombert, 1984). There is an increased tendency for health care professionals to be in salaried positions (Reiff, 1974) and a tendency for preference of employment in non-profit organizations (Majone, 1984).

What can the health professional do in the throes of all this? First, support education. Moore in 1953 (p. 11) said:

> "We suggest that in the contemporary United States the minimum educational requirement be placed at the equivalent of the college baccalaureate degree. Since nearly all of the older and well-recognized learned professions in fact require training beyond the baccalaureate degree, this minimum may be too low. Second, become involved in PSRO. Your profession must meet the challenge of PSRO and list itself among other concerned and dedicated professions. Now is the time for your own profession to decide: (1) What is and what is not appropriate health care? (2) What is acceptable quality relative to needs of the patient? Can you measure your profession's services in terms of quality and medical necessity?" (Watters and Hall, 1977, p. 264).

Last, demand the best from yourself. "A true professional is, in sum, an ordinary person called to extraordinary duties by the nature of the activities in which he or she has chosen to engage." (Pellegrino, 1983, p. 175).

If you see yourself as a professional, practice your occupation as a professional and conduct yourself as a professional. Who then can doubt that you are one?

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[1]The process and its effects are ongoing as evidenced by the changes in headings in *The Cumulative Index to Nursing and Allied Health Literature*. With Volume 28:6 (1983), ten subjects ranging from "Professional Competence" to "Professional Practice" are noted. Prior to this issue "Professions" said simply—"See occupations."

[2]There have been several who disagreed. See McKinlay (1973), Daniels (1971), Haug (1973), Saks (1983), Dumont (1970), and Begun (1979).

[3]For the sake of this model, I am assuming that schools are already in existence (Wilensky, p. 146).

[4]For a discussion of what may happen if this recognition does not occur, see Haug and Sussman (1971) and Ehrenreich and Ehrenreich (1975).

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