Global Journal of Medical Research: K
Interdisciplinary
Volume 20 Issue 12 Version 1.0 Year 2020
Type: Double Blind Peer Reviewed International Research Journal
Publisher: Global Journals
Online ISSN: 2249-4618 & Print ISSN: 0975-5888

Professional Power in Health Care

By Dr. Bachchu Kailash Kaini & Shahil Kaini

Arden University

Abstract- Health care professionals exercise professional power which is set by their training, education, skills, regulation etc. 'Professions' are seen as a source of power (by the use of knowledge, skills and expertise) in professional power perspectives of theory of professions, which is mainly focuses on control over professions, dominance, autonomy and professional relationships. In this perspective, health care professionals gain such professional power from knowledge, training, education and form their interprofessional team and organisations, and professional power has a great influence in determining professional behaviour and dominance. As a result of advancement in therapeutic technologies, emergence of new specialities in health care and managerial control, power dynamics between health care professionals are changing. Relative power between health care professionals is evident and health care professionals complement to each other for flawless health services and learning from each other.

Keywords: health care; interprofessional; professions; professional power; theory of professions.

GJMR-K Classification: NLMC Code: W 84

Strictly as per the compliance and regulations of:

© 2020. Dr. Bachchu Kailash Kaini & Shahil Kaini. This is a research/review paper, distributed under the terms of the Creative Commons Attribution-Noncommercial 3.0 Unported License http://creativecommons.org/licenses/by-nc/3.0/), permitting all non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

Professional Power in Health Care

Dr. Bachchu Kailash Kaini [α] & Shahil Kaini [σ]

Abstract- Health care professionals exercise professional power which is set by their training, education, skills, regulation etc. 'Professions' are seen as a source of power (by the use of knowledge, skills and expertise) in professional power perspectives of theory of professions, which is mainly focuses on control over professions, dominance, autonomy and professional relationships. In this perspective, health care professionals gain such professional power from knowledge, training, education and form their interprofessional team and organisations, and professional power has a great influence in determining professional behaviour and dominance. As a result of advancement in therapeutic technologies, emergence of new specialities in health care and managerial control, power dynamics between health care professionals are changing. Relative power between health care professionals is evident and health care professionals complement to each other for flawless health services and learning from each other.

Keywords: health care; interprofessional; professions; professional power; theory of professions.

I. Introduction

Health services are delivered by wide range of healthcare workers, practitioners or professionals. Healthcare professionals belong to a certain profession based on their education, training and skills. In other words, they are grouped into different professional groups categorised by their skills gained through training and formal education. Sometime a professional group can be defined by a legislation of the country they reside. Alternatively, it can be defined universally by international bodies or an institution such as the World Health Organisation or an international authority.

There are many definitions of profession. One of the frequently cited definitions of profession in the recent days is as follows defined by The Professions Australia[1]:

> *"A profession is a disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others."*

Johnson[2] asserts that there was no consistent approach in defining the term profession in the early literature on this topic. The term 'profession' describes a vocation structured under a certain training or educational activity for a specific purpose. Hammicket al.[3] define the word 'profession' as a group of people who have undertaken a given programme of education and/or training, and as a result of this are permitted to become part of much larger and somewhat exclusive group. Jackson[4] describes a profession as a special type of occupation ... prolonged specialised training in a body of abstract knowledge, and a collectivity or service orientation...a vocational sub-culture which comprises implicit codes of behaviour, generates an esprit de corps among members of the same profession, and ensures them certain occupational advantages. It is observed that profession is viewed from different approaches - functional, process and power or status approaches.

There are many arguments about defining the features of a profession. Flexner[5] states six criteria characterising a profession - *intellectual activities,* based on *science and learning,* used for *practical purposes,* which can be *taught*, and is *organised internally* and is *altruistic* (quoted in Ducanis and Golin[6]). Larson[7] mentions that professional association, cognitive base, institutionalised training, licensing, work autonomy, colleague control and code of ethics are the main characteristic features of profession. Duncanis and Golin[6] argue that professional standards of ethics and training are set through various professional organisations and associations. These organisations also set requirements for certification and licensure and implement them through legitimisation of power and the perpetuation of autonomy.

Different scholars cited different traits of the professions. The most commonly cited traits (Becker[8,9] Millerson[10], Larson[7]) are;

- the acquisition of skill based on abstract knowledge
- provision for training and education, usually associated with a university
- certification based on competency testing
- formal organisation
- adherence to a code of conduct

Goode[11] describes similar traits of professions and highlights two more characteristics of professions - 'offering a service to the community' and 'acknowledgement by others that the occupation is regarded as a profession'. Gargon[12] describes three attributes of a profession – substance, organisation and

Author α: Associate Lecturer, Arden University, London, EC3N 4DX. e-mail: bkkaini@gmail.com
Author σ: Fifth Year Medical Student, University College London, London, WC1E 6BT.

© 2020 Global Journals

regulation. He describes substance as a mixture of skill, knowledge, scope and complexity of a profession. He argues that organisation was a kind of unstructured setting with flexible boundaries at the early stage of evolution in the profession and it is gaining maturity with the provision of training to enhance members' skills and development of workplace infrastructure and regulations for every profession. Gargon[12] argues that regulation for profession is about maintaining the professional boundaries and it is 'who is to control' rather 'whether to control'.

Some research scholars and authors (Goode[13] Becker[8-9]; Millerson[10]; Strauss et al.[14]; Larson[7]) have focused on traits of professions based on the traits or characteristics that differentiate professions from other occupations. The professional trait approach mainly focuses upon at the ideal type features of a profession. However, traits approach of theory of professions does not describe the relationship between traits and does not consider power relationships between professions. Johnson[2] argues that traits approach assumes extreme pre-conditions for an 'ideal profession' such as 'medicine' or 'law'. This approach reflects an established view of the professions[16]. Strauss et al.[14] argue that the trait approach in theory of professions has now moved onto work, tasks and functions. Strauss et al.[14] criticise that traits of any professions are not fixed and they are subject to many factors such as change in their roles and functions.

II. Professional Power

Professional power perspectives of theory of professions ignores social function in health care. Social functions of the professions advocate harmony by promoting social integration through professions and their expertise support to the society[16]. Social function of the professions focuses on the highest level of knowledge, community-oriented service, professional ethics or code of practice for control and rewards system. Giddens[17,18] conceptualised power as a social factor and stated that power is created by human agents for them which limits and influences them in various ways.

The prevailing model of technical rationality with a vision of practitioners' discovering their own knowledge base from reflection in action to reflection to action[19, 20]. The study of epistemology is concerned with the nature of knowledge, questions of what is regarded as acceptable knowledge in a discipline[21] and the justification of truth[22]. Rawson[22] describes that interprofessional working has embraced Schon's theme. It offers liberation from the intellectual hegemony of discipline-based knowledge. According to Best and Kellner[23], interprofessional working has its philosophical roots in structuralism, post-structuralism and post-modernism; and it stresses the importance of social context, history, power and culture in society and in medicine.

Larson[7] developed a new approach on the theory of professions called 'professional project'. Larson[7] suggests that professional project is an effort to transform professional skills and expertise into various benefits to society. Larson[7] further states that exclusive knowledge in the professions is required in the professional project so that professionals can demonstrate exclusivity of knowledge. In this sense, professional project helps to determine professional identity. It is also linked with professional practice through knowledge, skills and expertise. Macdonald[24] asserts that professional project should be considered as a product of individual and collective actions in the social process and should be collectively practised. It does not consider other aspects of the theory of professions such as, autonomy, traits, power and dominance.

Changes in health care are linked to post modernity[25] as professional boundaries between health care professionals become more permeable[26]. Biggs[25] argues that there has to be a balance between expertise and responsibilities. He further highlights that there is a tendency to ignore structure and differences in health sector.

Roles of health care professionals are used to identify people's behavioural strengths and weaknesses in the workplace[27]. This information can be used to build productive working relationships, select and develop high-performing teams, raise self-awareness and personal effectiveness, build mutual trust and understanding and aid recruitment processes. Beblin[27] describes different nine team roles, which he called plant, resource investigators, monitor evaluators, co-ordinators, implementers, specialist, completer finishers, teamworker and shapers.

III. Theory of Professions

The professional power aspect of theory of professions is important to consider when discussing the delivery and management of health care. Different health professions have their own territory, power, authority and recognition in the society and in health care organisations. The gap in territory and authority contributes to a degree of mutual suspicion and defensiveness in interprofessional care context.

Pointon[15] argues that the sociology of the professions offers different views of how and why professions exist. Point on describes four approaches to the theory of professions. Firstly, 'traits model' which reflects an established view of the professions. The second approach describes the professions in terms of 'power' and privileges. The third approach considers the professions as the 'status' and public

© 2020 Global Journals

acknowledgement. The final approach represents the professions as a 'professional project'.

In many cases health care professionals have to complement to each other by linking the main body of the health sciences to provide effective and continuous health services, and to learn from each other[28]. According to Leggatt[29], interprofessional care team members learned complementary skills to provide the best health services to service users. Autonomy gives the power to health care professionals to make assessment, develop care plan and make clinical decisions based on their independent judgement, which has to be supported by evidence-based practice. Is this case autonomy complement to shared work and it does not contradict with interprofessional working in health and social care.

Canning and Dwyer[30] suggest that protecting professionalism and public interest are important features of the theory of professions and this can be done by registering qualified members which control entry into the profession to ensure that members meet the standards set by the regulatory body and councils.

Health care organisations provide power and authority to different health care professionals, interprofessional care teams and sub units. The power of such a sub unit is 'determined by its relationships to other sub units in the organisation, and by its response to its environment'[31]. Clegg[31] further asserts that different sub-units in organisations receive power based on functional inter-relationships. However, this concept is focused on the power of managers in a pure management environment, rather than the power of trained and specialised health care professionals. Health care professionals can exercise professional power individually or collectively based on the condition of service users. They gain such professional power from knowledge, training and education as well as form their interprofessional team and organisations.

Etzioni[32] argues that organisations create, use and sustain power through management and use of professional knowledge. Etzioni[32] asserts that 'the ultimate justification for a professional act is that it is, to the best of the professional's knowledge, the right act. This is relevant in the context of health care organisations and health care professionals. According to Etzioni[32], professionals manage and control the context within the boundary of their knowledge and expertise. It is also important that health care professionals have to use their knowledge, power and authority within the boundary of organisational aims, objectives and strategies.

IV. The Medical Profession

Drinka and Clark[33] mention that humanistic approach to medicine considers social and behavioural approaches to be as relevant as the biological whereas the reductionist and scientific approaches believe in the rational solution of medical problems, dedication to competency in clinical practice and the standards of clinical science and disinterested concerns for the society and patient. Humanistic perspective is a more holistic approach towards the patient and emphasises social, personal and behavioural aspects of medical practice. The reductionist and scientific approaches discount personal, social and behavioural aspects of illness. According to Bloom[34], medical science struggles between two different philosophies – reductionist and scientific; and social and humanistic. Drinka and Clark[33] describe that by its nature scientific methods have had growing centrality in medical care. Ahnet al.[35] argue that the implementation of clinical medicine is systems oriented, therefore science of clinical medicine is fundamentally reductionist. However, Beresford[36] suggests that 'holism' as compared with 'reductionism' is the proper approach to medical science.

Even though medical professionals are put on top of the occupational hierarchy; they have experienced changes due to transformation of roles of nursing and allied health professionals[37]. Gillespie et al.[37] further assert health care organisations are going through changes in organisational culture and these changes have helped medical professionals to strengthen their relationships with other health care professionals. Each group of health care professionals distanced themselves with other professional groups in clinical practices due to the specialisation and demand in health services. This may also be due to the increased cost of health services and pressures from regulatory bodies in health care market.

Freidson[38] asserts that even junior medical professionals use discretionary power in their clinical practice compared to other groups of health care professionals. This concept focuses on control and domination of a certain professional group and managing professionals at micro level. However, Freidson[38] did not examine if there are differences in using discretionary power between various specialties and sub specialties of medicines.

V. The Nursing Profession

Drinka and Clark[33] state that nurses follow the holistic approach to the patient and have less influence of reductionist approach compared to the medical profession. The holistic approach is a comprehensive patient care which is associated to an understanding of the hopes and priorities and physical, emotional, social, economic and spiritual needs of the person. Holistic nursing is the total nursing care practice that expresses this philosophy of care. Historically, nursing has been care related whereas medicine has been cure related by education, tradition and socialisation[39]. Svensson[40] states that nurses role in the health care delivery system

© 2020 Global Journals

is changing and they are now more questioning and can negotiate with doctors in decision making.

In the early days of nursing professionals, they used to come under the direct control and management of medical professionals[41]. After the establishment of separate councils for the registration of nursing and allied health professionals; these professionals gained a status of well recognised professions. They had to struggle decades to gain the full professional status. Moreover; with the specialisation, globalisation, advancement in science and technology, expansion of academic arena and training; other occupations such as pharmacy, nursing, optometry, radiography, physiotherapy and social care gained the status of a profession. The outcomes of these changes are mainly empowerment for these professionals and they gain more professional autonomy.

VI. The Allied Health Professional

As a registered, legal and established profession, each practitioner is required to follow his or her professional conduct and responsible for any professional advice to their service users[42]. Allied health professionals also need to work in a collaborative environment and need to maintain a cohesive relationship with medical and nursing professionals in order to establish their identity in health care and to achieve the desired outcome.

Over the last two decades expansion of roles of nursing and allied health professionals have developed in response to a complex mixture of pressures from a professional, social and political perspective[43]. Expansion and development of health care professional roles and their support staff are therefore considered an important part of service development within the hospitals. As with any change it is essential that such role developments are carefully planned, managed, supported and evaluated[22].

Most of the medical treatments take a reductionist approach to alleviate or cure symptoms or medical conditions and ignore holistic approach to balance the physical, emotional, personal and behavioural needs of service users. Since allied health care professionals represent a big number of health care professionals (excluding nursing, midwifery, medicine and dentistry), it is difficult to analyse the approach that different professions and specialties take. A balance approach between reductionist and holistic approaches is an appropriate solution for allied health care professionals as both approaches can be complementary to each other. Furthermore, Zakim[44] noted that holistic approaches could be as absurd in their complexity as reductionist in their simplicity.

VII. Summary

The relationships and power dynamics between health care professionals have changed in the recent decades due to the emergence of various clinical specialties, technology and specialised knowledge. This may have contributed to changing boundaries between health care professionals. Furthermore, the changing scenario in health care cannot be separated from the wider transformations in the modern society. For example, changes in health care system may occur as a result of state intervention or development of stronger community, which is not discussed widely in the context of health care professionals. Hardy[45] asserts that medical knowledge is becoming increasingly deflated and the power of the medical profession is gradually decreasing as a result of rapid changes in the health care field. In his earlier work, Friedson[46,47] did not mention medical professionals' role as a management or corporate function. Later, Friedson[38] argued that if medical professionals are considered as a part of corporate function in health care organisations, power of medical professionals has not been diminished.

Relative power is observed between health care professionals and in most interpersonal, interprofessional and inter-organisational relationships in health care. In health services, it means power that an individual professional or specialty has in relation to another professional or specialty.

The power and authority of health care professionals is not the same all the time. It depends on the assigned roles and the nature of the task that health care professionals need to perform. Moreover, the task specific roles may be influenced by the knowledge, skills and expertise of health care professionals. It is also determined by the nature of interprofessional working.

Health care organisation's policies have to reflect the emphasis upon role development and new ways of working. The modernisation agenda also focuses on a new division of labour with the introduction of new roles throughout the clinical professionals and new classes of multi skilled health care professionals. Hence, clinical work are now organised to enable health care professionals to exercise the full range of their skills, knowledge and expertise for the advantage of the service users.

Conflict of Interest: No

References Références Referencias

1. Australian Commissions of Professions. Professions Australia (online). [cited 21 June 2020]. Available from: http://www.professions.com.au/define profession.html
2. Johnson T. Professions and Power. London: Macmillan; 1972.

© 2020 Global Journals

3. Hammick M. Freeth D. Copperman J. Goodsman D. Being Interprofessional. Cambridge: Polity; 2009.
4. Jackson JA. Professions and Professionalisation: Sociological Studies. Cambridge: Cambridge University Press; 2010.
5. *Flexner A.* Is Social Work A Profession?. USA: Cornell University; 1915.
6. Duncanis AJ. Golin AK. The Interdisciplinary Health Care Team: A Handbook. Maryland: Aspen Systems Corporation; 1979.
7. Larson MS. The Rise of Professionalism: A Sociological Analysis. California: University of California Press; 1977.
8. Becker B. The Nature of a Profession. Chicago: Chicago University Press; 1962.
9. Becker H. Sociological Work. Chicago: Aldine; 1970.
10. Millerson G. Dilemmas of Professionalism. New Society. 1964; 2: p.15-16.
11. GoodeW. The Theoretical limits of Professionalization: The Semi Professions and Their Organizations, Teachers, Nurses and Social Workers. New York: Free Press; 1969.
12. Gargon JJ.Specifying Elements of Professionalism and the Process of Professionalisation. International Journal of Public Management. 1993; 16(12): p.1861-1884.
13. Goode WJ. Community within a Community: The Professions. American Sociological Review.1957; 22:p.194-200.
14. Strauss AL.Fagerhaugh S. Susczek B. Weiner C. The Social Organisation of Medical Work. Chicago: University of Chicago Press; 1985.
15. Pointon JC. Perceptions of Profession and of being a Professional among Personnel/HRM Practitioners: A Phenomenographic Inquiry. Unpublished thesis for the degree of Doctor of Philosophy, Open University; 2009.
16. Durkheim E.Professional Ethics and Civic Morals. New York: Free Press; 1957.
17. GiddensA. Profiles and Critiques in Social Theory. Berkeley and LA: University of California Press; 1982.
18. Giddens A. The Constitution of Society: Outline of the Theory of Structuration. LA: University of California Press; 1984.
19. Schon DA. Educating the Reflective Practitioner: Towards a New Design for Teaching and Learning in the Professions. London: Jossey-Bass; 1987.
20. Schon DA. The Reflective Practitioner: How Professionals Think in Action. Aldershot: Avebury Academic Publishing; 1991.
21. BrymanA. Bell E. Business Research Methods. Oxford: Oxford University Press; 2011.
22. Rawson D. Models of Interprofessional Work: Likely Theories and Possibilities in LeathardA. (Ed.) Going Interprofessional – working together for health and welfare, East Essex: Brunner-Routledge; 1994.
23. Best S. Kellner D. Post-modern Theory: Critical Interrogation. London: Macmillan; 1991.
24. Macdonald K. The Sociology of the Professions. London: Sage; 1995.
25. Biggs S. Interprofessional Collaboration: Problems and Prospects, In: Ovretveit J. Mathias P. Thompson T, Interprofessional Working for Health and Social Care. Hampshire: Macmillan. 1997; p.186-200.
26. Baxter SK. Teamwork and interprofessional networks in stroke care: towards an understanding of joint working practice. Unpublished thesis for the degree of Doctor of Philosophy. Sheffield: University of Sheffield; 2007.
27. Beblin M. Beblin team roles. [cited 20 June 2020]. Available from: http://www.belbin.com/rte.asp?id=8.
28. Haire B.Interprofessional Care: A Model of Collaborative Practice. Charlottetown: PEI Health Sector Council; 2010. [cited 25 June 2020]. Available from: http://peihsc.ca/wp-content/uploads/ IP_care.pdf.
29. Leggatt SG. Effective Healthcare Teams Require Effective Team Members: Defining Teamwork Competencies, BMC Health Service Research; 2007 7(17). [cited 15 June 2020]. Available from: http://www.biomedcentral.com/1472-6963/7/17.
30. Canning M.O' DwyerB. Professional Accounting Bodies. Disciplinary Procedures: Accountable, Transparent and in the Public Interest? The European Accounting Review. 2001; 10(4): p.725-749.
31. Clegg S. Power, Rule and Domination: A Critical and Empirical Understanding of Power in Sociological Theory and Organizational Life. London: Rouledge & Kegan Paul; 1975.
32. Etzioni A. Modern Organizations. New Jersey: Prentice-Hall; 1964.
33. Drinka TJK. ClarkPG. Health Care Teamwork: Interdisciplinary Practice and Teaching. Connecticut: Auburn House; 2000.
34. Bloom SW. Socialisation for the Physician's Role: A review of some contributions of research to theory. In Shapiro EC. Lowenstein LM. (Eds.), Becoming a Physician: Development if Values and Attitudes in Medicines, Cambridge, MA: Ballinger; 1979.
35. AhnAC.Tewari M.Poon CS.Phillips RS The Limits of Reductionism in Medicine: Could Systems Biology Offer an Alternative?; 2006. [cited 20 August 2020]. Available from: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0030208.
36. Beresford MJ. Medical Reductionism: Lessons from the Great Philosophers. QJM - An International Journal of Medicine. 2010; 103(9):p.721-724.

© 2020 Global Journals

37. Gillespie R. Florin D. Gillam S. Changing Relationships: Findings from the Patient Involvement Project. London: King's Fund; 2002.
38. Freidson E. Professionalism reborn: Theory, prophecy and policy. Cambridge: Polity Press; 1994.
39. Sullivan TJ. Collaboration: A Health Care Imperative. New York: McGraw-Hill; 1998.
40. Svensson R. The interplay between doctors and nurses – a negotiated order perspective. Sociology of Health and Illness. 1996; 18:p.379–398.
41. Fletcher IP. Power and Politics in Academy Land. Unpublished thesis submitted for the Professional Doctorate in Education. Bristol: University of the West of England; 2008.
42. Health Professional Council. Standards of Conduct, Performance and Ethics. London: HPC; 2008.
43. Humphries D. Masterton A. Developing New Clinical Roles. Churchill: Livingstone; 2000.
44. Zakim D. (2011) Reductionism in medical science and practice, QJM - An International Journal of Medicine. 2011; 104 (2): p.173 - 174.
45. Hardy M. Doctor in the House: the Internet as a source of lay health knowledge and the challenge to expertise. Sociology of Health and Illness.1999; 21(6):p.820–835.
46. Freidson E. Professional Dominance: The Social Structure of Medical Care. New York: Dodd, Mead and Co; 1970.
47. Freidson E. The Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead and Co; 1970.

© 2020 Global Journals