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An open-system approach to medical professionalism:
a controversy within the sociology of professions

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This article focuses on a specific debate within theories of professions. Despite different trends, there has been difficulty in theorizing some dimensions of the dominant perspectives because of predominant institutional attention. The aim here was to reinforce the debate with complementary conceptualization of professionalism and, consequently, to foster new understandings of professional relationships. The argument lies in shifting the analytical level from the professions to professionals, as a basic step in conceptualizing individual action within professional contexts. This concern becomes increasingly important as the professional discretion structurally held by individuals becomes greater, since the ability to choose leads more explicitly to internal differentiation of professions. Systemic influence is felt given that social structures are intrinsically involved in actions, which represent exteriorizations of individually internalized processes. Consequently, it becomes necessary to consider the reasons for behaviors and the meanings individually conferred on professional dimensions.

Keywords: Medical discretion. Social structures. Agency. Sociological theory. Sociology of professions.

Este artigo debruça-se, num debate específico, nas teorias das profissões. O objetivo é reforçar o debate numa conceptualização complementar do profissionalismo, abrindo novos entendimentos sobre as relações profissionais. O argumento reside na mudança do nível analítico das profissões para os profissionais, como passo elementar para conceptualizar a acção individual em contexto profissional. Esta preocupação é tanto mais importante como maior for a discricionariedade profissional estruturalmente detida pelos indivíduos, dado que a capacidade para escolher conduz, de uma forma mais explícita, à diferenciação interna das profissões. A influência sistêmica faz-se sentir considerando que as estruturas sociais estão intrinsecamente envolvidas nas ações, as quais representam exteriorizações de processos individualmente internalizados. Consequentemente, torna-se necessário considerar as razões para os comportamentos e os sentidos individualmente conferidos às dimensões profissionais.

Palavras-chave: Discricionariedade médica. Estruturas sociais. Agência. Teorias sociológicas. Sociologia das profissões.

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Introduction[2]

This article is the result of sociological research carried out in public hospitals, the goal of which was to understand the implications of the New Public Management (NPM) on the professional relations between managers and doctors[3]. The initial questions that motivated the research were: how has the increasing power attributed by governments to managers affected medical autonomy? Is medicine under a more rigorous administrative 'panoptic' control?

Here, the goal is not to develop any argument in relation to that empirical process, but to delimitate the discussion around a theoretical controversy inside sociology of professions. In fact, and despite health professions can be analysed either in a sociological or a public health perspective, its main theoretical developments in the European debate come from a sociological background.

The point is that my qualitative-intensive nature research revealed some dynamics that lacked the proper conceptual understanding provided by the sociology of professions. For instance, which theoretical elements are offered by the sociology of professions to explain how professionals in the same situations and contexts, and in the same hierarchical position, i.e. holding identical technical and organizational roles and functions, can exhibit ways of acting that can be so different or even contradictory? Despite the different theoretical traditions, this difficulty illustrates the prominence of a conceptual institutional program in theories of professions, which has therefore been responsible for a process in which this sociological field has been closing in its empirical object. In other words, the conceptual development of professions from the 1960s has somehow been immune to social theory.

The main objective of this work is therefore to reinforce the professional debate to sociological theory and, consequently, to operate what some authors presents as a necessary overview in which social phenomena are analyzed simultaneously from the agential and the structural angle (Guibentif, 2007). This is a very sensitive concern since the relation between action and structure, as the elementary basis of sociology, has been viewed over time as contradictory much more than cumulative[4].

One of the most important implications of such an understanding is to overcome a reifying interpretation of professional groups that is favored when individual action is interpreted merely as the result of professional structures, which subverts the individual's active role concerning the expected intraprofessional similarities and interprofessional dissimilarities[5]. At first sight, this might seem a minor question but considering the professional discretion (Evetts, 2001) structurally possessed by professions as medicine, the implications of this possibility to decide and act individually in performing the day-to-day professional activity cannot be disregarded. What constitutes the individual medical decision becomes a problem, since it seems impossible to understand why organizational rules are respected differently in each medical service.

This reflection is based largely on the francophone literature bringing some contributions not commonly seen in the current debate within sociology of professions. This is the specific case of the open action system presented by Crozier and Friedberg in the late 1970s.

Note that the purpose of this article is not to close this controversy. On the contrary, it is expected to further the discussion on these dimensions, revealing some concerns that have in some way been omitted in the dominant Anglo-Saxon literature. The paper is divided in two parts. First, the problems with the existing conceptual frameworks for an understanding of reflexivity in professional relations

[2] This article is a part of a broad concern that has been presented in different contexts (Correia, 2010, 2009a, 2009b). During that trajectory I had the opportunity to discuss some drafts with persons to whom I would like to express my gratitude for their useful and critical comments: Professor Graça Carapinheiro and Professor Alan Stoleroff (supervisors of my Ph.D. research), Professor Julia Evetts, Professor Carlos Miguel Ferreira, Professor Pierre Guibentif, Professor Noémia Lopes, Professor Lilia Schraiber and my colleague Pedro Jacobetty. I would like also to thank to the anonymous referees for the comments that allowed to improve the final version of this text.

[3] Reference that is made to my doctoral research financed by Foundation for Science and Technology (Portugal), ref: SFRH/BD/35841/2007.

[4] Despite of the delimitation inside sociology this theoretical exercise may also be useful for the conceptualization of health professions from the public health perspective.

[5] The term 'reification' is used in the sense employed by Giddens (1984), according to whom social phenomena tend to overvalue structural properties as if they were laws of nature – which, ultimately, ignores the role of human agency in the course of change.

is explained, and second, a better conceptual framework is presented that enables a new direction to be taken when researching professionalism.

Is there anything left to say about the theory of professions?

No current work on professions can ignore power, autonomy and authority as their elementary conceptual dimensions. This draws on the main trends in the sociology of professions after the Second World War, namely functionalist, interactionist and systemic or comparative trends[6].

After the initial thoughts of classical authors such as Durkheim, Spencer or Weber who considered the role of professions in social development (Dubar, 1991), the trajectory of the sociology of professions in the last 60 years has been mostly characterized as a set of successive reactions to the understandings provided by functionalists (Merton, 1982; Parsons, 1966). Anglo-American interactionists like Hughes (1965), Freidson (2001, 1975, 1970), Johnson (1972), Larson (1977), or Collins (1990) are just a few examples of different conceptualizations whose common denominator is a process-oriented conception of professions. The thought of Michel Foucault (1975) is usually associated to this; his contributions conceptualized how medical knowledge constitutes itself as power, thus structuring different aspects of social life.

More recently, the sociology of professions has witnessed the emergence of a third main systemic perspective that somehow tries a combination of both functionalist and interactionist contributions (Champy, 2009; Abbott, 1988). However, despite these synthesis approaches, is possible to argue that the current debate continues to discuss the difference between functionalist and interactionist premises. An explicit example is found in the conceptualization of professionalism (Evetts, 2006, 2003; Sciulli, 2005; Burrage et al., 1990; Siegrist, 1990).

The main idea on the evolution of the theories of professions is that regardless of such significant theoretical divergence, these authors and perspectives all have a similar aspect: the professions are conceptualized largely on the institutional level. This means that the interest in professions is focused on the influence of other structures (knowledge, state, clients or other professions) much more than on the conceptualization of professionals' behavior. We only need to think, for example, about the main questions that have engaged the protagonists in professions since Second World War: 'what is a profession?', 'how does an occupation becomes a profession?', 'in which circumstances can that process happen?', 'what are the profession's social functions?', 'which are the evolutionary possibilities for professions?' (Rodrigues, 2002, p.3).

Such institutional attention tends to disregard the individual construction of professionalism, how it is interpreted and, more importantly, activated in professional practices. Value is thus attached to what is constituted by practices and representations resulting from a similar education and later from professional socialization (i.e. a body of formal knowledge acquired from school, which extends to work experiences). Consequently, it is largely professional structures that consider, define and differentiate action:

> in these ways, the normative value system of professionalism in work, and how to behave, respond and advise, is reproduced at the micro-level in individual practitioners and in the workplaces in which they work. Some of the differences in occupational socialization between occupations have been identified but the general process of shared

[6] Such a time reference does not ignore earlier contributions like the Chicago School or authors from the 1930s such as Carr-Saunders. On the evolution of the conceptual body within the sociology of professions, see for instance Saks (1983), Torstendahl (1990) or Sciulli (2005).

> occupational identity development via work cultures, training and experience was regarded as similar across occupations and between societies. (Evetts, 2006, p.135)

However, one must question whether professional socialization can be understood as socialization that is independent of other previous and parallel socialization sources. Scrutiny of this kind easily falls into an analytical position that is quite insensitive to what individuals had been before becoming workers and what individuals are simultaneously with being workers. In other words, it can favor a compartmentalized analysis of the subjects, as if their professional practices and, naturally, their representations of the exercise of the profession were enough proof against other social influences. Therefore, the role of individual trajectories in the daily professional activity must be considered, regardless of the restrictive weight of professional fields. At stake is the "presumption of the automatic impregnation of the whole social existence through the professional events" (Pinto, 1991, p.221), bearing in mind that "the significant categories of [social] trajectories are not necessarily the same that structures the fields of social practice" (Dubar, 1991, p.78).

This theoretical concern emerged during my doctoral research[7]. The problem was that the complex empirical reality experienced in hospitals revealed some interactions that were not easily problematized by any of the abovementioned trends: (I) why do some doctors agree that the hospital's chairman of the board must be a manager while others advocate that only a doctor can thoroughly understand the hospital's organizational dynamics? (II) Why do some doctors argue that it is necessary to reinforce administrative control due to public expenditure, whereas others consider it to be unacceptable, offensive and perverse to subject doctors to such control? (This refers to doctors with similar structural positions in the medical career and similar professional experience).

Note that the concern about the processes inside professions cannot be said to be new in this sociological field. Strauss et al. (1963) already designated the 'negotiated order' as a significant process within hospital organizations, in which complex negotiations are conducted by different professionals to fulfil individuals' interests. This paradigm is close to Freidson (1975), for whom professions are more than a uniform body of interests and actions, as well as to other important perspectives of this period which underline how day-to-day processes diversify professional structures (e.g. 'official goals' and 'operative goals' by Perrow, 1963; or 'elastic autonomy' by Stelling, Bucher, 1972).

The question is that despite the explanation of how day-to-day processes are experienced in these organizations, the analytical focus has been centred mainly on the institutional side of professions. This is why we say that even the interactionist perspective does not allow a proper understanding of how those processes are individually interpreted and, more importantly, individually activated. In other words, the different meanings that justify the reproduction of, or change in, the professional structure. My point here is that while, on one hand, it should be understood that professional structures are as much structuring as they are structured as interactionists have shown, on the other, understanding the interaction processes cannot overlook the role of individual action in the enactment of those processes.

This argument leads to an important aspect regarding the construction of the theories of professions in which the discussion carried out gradually ignored the key concepts in sociological theory: structure and action. Note that this must be understood only as a discursive omission, since adopting a functionalist or

[7] As said previously, that research seeks to address the implications of the NPM on the professional relations between managers and doctors in the Portuguese hospital public sector. The field research was conducted in one public hospital from October 2008 to July 2010. It involved a qualitative intensive methodological strategy composed of direct observations of two medical services (surgery, including liver transplantation, and internal medicine) and 26 semi-structured interviews to those service doctors and to the managers of the hospital's board of directors. The case study was chosen according to the legal model of the hospital, since at that time it was the last public hospital in Lisbon not to be turned into a public business entity. This process has meanwhile been completed and has become dominant in the public sector.

interactionist perspective always involves making a decision on the understanding given to structures and actions. How can the way Parsons conceptualizes his professional essentialist perspective (1966) be detached from the social system theory (1951)?

An example of this discursive omission is clearly seen in the analysis made by Strauss et al. (1982). They observe that hospital in-patients have distinctive reactions when hospital professionals expect their behavior to consist of submission and passivity in accepting medical treatment (thus criticizing Parsons' concept of the 'sick role'). Although the theoretical objective proposed by the authors is not to analyze action and structure, this is actually their theoretical basis: the degree to which professional medical knowledge is unable to standardize what constitutes behavioral diversity.

What this proves is a closing process that sociology of professions has been made in their analytical object, thus ignoring the fundamental sociological basis: social order (Pires, 2007). However, it must be stated clearly that like any other sociological field, the sociology of professions is not impervious to the interpretations given to such concepts, since they are elements of unequal meaning within different epistemic frameworks, which define the multi-paradigm nature of the discipline (Silva, 2006).

Some recent contributions on professions have already made reference to the need for an analytical investment in individuals, as we theorize here. Individual professional activity is mainly conceptualized as a result of what professionals conceive as being their professional roles, possibilities, relations, expectations, interests, and experiences (Currie et al., 2009; Timmermans, 2008; Kirkpatrick et al., 2007; Doolin, 2002; Causer, Exworthy, 1999; Harrison, 1999). Although the motives for, and the structure of, individual action are not theoretically conceptualized, these studies offer a trace to a sociological approach that does not ignore individual forms of appropriating (in the sense of internalizing) institutionalization processes as regards professions and their fields of intervention.

Sociological theory's contributions to conceptualizing professionalism from an open-system perspective

As we have seen, the motivation for this discussion is related with problems that the existing conceptual frameworks have to conceptualize freedom of action in professions with a high level of professional discretion. In fact, although at first glance agents seem to be empowered to make changes in the social structures, this ability cannot be seen as common to all: it depends on the places occupied in different social strata and the related power resources possessed (Mouzelis, 1991; Bourdieu, 1989; Crozier, Friedberg, 1977)[8].

However, the possession of the necessary resources to act upon the structures does not mean that this is automatically implemented. That is why contexts of social reproduction do not mean the absence or eradication of individuality, and it is necessary to conceptualize the meanings given individually to the action: 'I do not want to change because…'. From this point of view, situations of change not only involve the capacity to act but also the intention to do so.

This idea is concerned with any kind of behavioral reification: doctors do not necessarily disagree with managers just because they are doctors. Nor are managers against medical professionals' autonomy simply because hypothetically this might be the main obstacle to managerial control. At stake is a more complex and individualized process than institutional professional relations realize. So the objective

[8] Consider an *agent* instead an *actor* means that the performance of a role in a certain social context is understood as the result of past influences and, simultaneously, singular ways of understanding themselves, their social roles and the other agents with whom they are related (for further explanations, see Pires, 2007).

is to overcome an analytical position that, on one hand, inclines towards a structuralism of individual action and, on the other, does not recognize the existence of objective social frameworks that set limits on the social subjects' horizons. After all, as Lahire (2005) mentions, given the complexity of the real, sociology cannot seek pure ways of acting and seeing individuals, supposedly guaranteed by the sharing of similar objective and relational conditions.

On the analytical level, reproduction and change should be left open, and it is necessary to construct a model that takes into account the reasons guiding individual behavior. As Alexander (1988) states, social order does not contradict the contingency of individual action, which has both an interpretive and strategic side. One fundamental clarification is that we are not denying any kind of pattern of action or social pressures external and previous to individuals, which could be interpreted as an individualistic approach of human action. Therefore, the principle of the dualism of structure (Archer, 1995) is adopted, considering that actions are delimitated by previous constraints[9].

Although it has been argued previously that one of the fundamental theoretical arguments of this discussion is the non closure of scientific fields in their empirical objects, a more specific ensemble of pertinent structural dimensions must be considered for the analysis of professional action. Consequently, that principle of non closure process is ensured here on one hand, by the nature of the structural dimensions considered, which involves not only a more specific process to professional sphere but also others from a wider political nature; and on the other hand, by the inclusion of personal (besides professional) socializations in the influence of reflexivity construction, which brings open processes to professional behaviors.

Therefore, the concrete system of action under discussion is defined by three different structural levels: a macro systemic level of supranational influences generating ideologies of the meaning of public activity and, consequently, the function given to the NPM; an organizational level where that ideology materializes in rules and orientations closely linked with the specific contingencies of each organization and medical services and the national political, economic and financial systems; and a professional jurisdiction level, which is the space of action and responsibility of every profession.

Two kinds of professional jurisdiction are at stake here. An internal jurisdiction that refers to the power resources individually possessed within the medical field. Different places are occupied due to dimensions like the professional trajectory, the monopoly of information, the area of expertise or the personal relations.

The second kind of professional jurisdiction is external and represents the space of action, competencies and responsibilities that each profession possesses (e.g. Abbott, 1988). Authors like Freidson (2001, 1994) or Champy (2009) argue that these spaces are created through two different but cumulative processes: as a result of social attributions externally given to professions (e.g. by state) due to their social functions, and as a result of corporative processes of closure and conquest.

Specifically about the medical space of action, Schraiber (2008), considers that its understanding must involve the **dimension of knowledge**, as well as the **dimension of work**. This means that today it is impossible to ignore the labor structure in relation to any profession – even in the paradigmatic case of medicine – in which the knowledge is considered as its structural and differentiated condition. More specific contexts must therefore be considered for professions as well others from a wider nature, which defines the place that each profession occupies in a given space and function[10].

[9] The principle of the dualism of structure relies on the causal relation between structure and action, different from the recursive relation defended by Giddens (2000, 1984). Archer develops her perspective according to the realistic assumption from Bhaskar (1979), to whom the specific ontological statute of the social reality differentiates it from the natural world: first, because social structures only exist through the action that they structure; second, because social structures exist through the way in which individuals construct them; third, because social structures are not immutable in time and space.

[10] A similar position can be identified in Carapinheiro's work (1993) about the medical work in organizational contexts. The author centers on the dimension of medical power derived from the expertise socially possessed, considering hospital organizations as the spaces where such power is constructed and reproduced in interaction with other professional expertise and lay experiences.

It is relatively linear to understand that the performance of any profession as dependent work (dependent on the professional entity responsible for the contractual relation, including payment, work conditions and all other aspects that are associated with this nature) requires submission to different kinds of rules. This submission is the most rigorous mechanism that guarantees the necessary predictable nature of any complex capitalist bureaucratic organization in modernity (Weber, 1983). From the professional point of view, the acceptance of these constraints is related with the financial, social and emotional necessity represented by the performance of a professional activity in the western modern societies.

The rules are not restricted to one source or nature: the formal can be defined by the employment entity (organizational rules), by one particular direction (rules from a service/department), or by the profession (deontological code), and also include all informal rules derived from the regular life in all social spaces.

Another straightforward argument is that the submission to rules tends to be intensify progressively as the professions become less liberal (private). Although the medical profession involves both dependent and private activity, it must be conceptualized through the submission to a social order composed, as has been seen, of a whole ensemble of rules that are general to society and other professions, as well as more specific rules associated to the particular nature of that profession (its social function and the social power acquired). In fact, the system of rules that organizes and coordinates all interactions within each profession is more or less intense, tacit, informal as well as sanctioning (Burns, Flam, 2000; Giddens, 1984), and it is impossible to search for simple and predictable ways of acting in these constraints.

Applying this same open-system basis to both structural rules and intraprofessional relations, the possibility of divergence and contradiction inside relatively stable and similar fields must be considered. For Crozier and Friedberg (1977), the sharing of an individually recognized ethical dimension is the agglutinating element capable of sustainting a system like this – stable even without the necessary formal internal mechanisms of control and domination. Durkheim (1977) has already designated this as the social solidarity present in the division of work, or lately the social function of symbolic power argued by Bourdieu (1989). In medicine, the orientation toward the patient, whose social function is granted by medical knowledge (*expertise*), is the ethical dimension responsible for professional stability that is simultaneously individually perceived. Like doctors, hospital managers have an internal professional structure which is not highly differentiated; this reveals the need to consider other mechanisms responsible for the time/space reproduction of professional structures. In this case, the ethics responsible for the profession is located in the management of public property in order to guarantee patients' general well-being.

As has been argued before, the main theoretical aim of this article is to perceive the dual nature of social phenomena: both from its structural and agential angle (Guibentif, 2007). According to Schraiber (2008), although daily work is a part of a more general configuration of the labor sphere, it also has an individualized existence. At stake is a process that results from the link between the individuals and the different places and roles that they assume in society, taking into account the way in which they locate themselves in those spaces as well as the persons in interaction. It is from this perspective that the systemic articulation emerges between system and agent based on individual action (Crozier, Friedberg, 1977). For these authors the argument is simply that it is not possible to conceptualize the institutional level without knowing how the 'game' is played individually.

A fundamental point must be clearly stated in order to develop this theorization: how can the problem be solved of individual deviations in relation to the external existence of social structures and rules. Durkheim (1887a apud Alexander, 1986) and then Bourdieu (2002, 2001) considered social order as simultaneously external and prior to action and internal to each member of every social fields. It is therefore impossible to search for unequivocal ways of respecting social order in any social group, knowing that the first condition for this variability derives from the resources of power socially possessed by the group and by each of its members individually.

Accordingly, the structure level is not only located prior to agency, delimitating its behaviors, but is also at a subsequent phase, incorporating the agency's reflexivity. In this way, social reality becomes

individually objectified (Boudon, 2003), considering behaviors as individual exteriorizations of previous internalization processes. This internalization relates the reflexive capacities which are constructed in an articulation between social and professional socializations and interests and expectations.

Note that a full discussion on the theoretical construction of how reflexivity is conceived is beyond the scope of this article. In brief, reflexivity is understood to be the regular cognitive exercise usually made by individuals on how they conceive the surrounding contexts as well their places and roles in those different spaces (Archer, 2007; Hamel, 2007). However this does not mean that actions are usually taken consciously in relation to the goals pursued with those actions. The reader must therefore know that it is understood that human action possesses different levels of intentionality: from unconsciousness to consciousness. In other words, from automatic reproductions, in which individuals do not know 'why' and 'for what' they act – basically the *habitus* (Bourdieu, 2002, 2001, 1986) – to reflexive and instrumental intentionality, when the individual is aware of the intent and the purpose of that behaviour. Nevertheless, we are discussing the different ways of 'being' intrinsic to social agents, which allows professionalism to be interpreted by its structures and by the way in which it is structured by the individual action.

Against this double existence of structures – external and simultaneously internal to individuals –, current political contexts, their implementation in each organization and professional jurisdictions can be understood as the product of a symbiosis between constraints and possibilities, exteriority and interiority.

First, considering that NPM is chiefly an ideology about how public activity must be provided according to current fiscal and economic pressure (Pollitt, 1990), its materialization cannot be dissociated from its policy makers. Once more what is at stake is the professional discretion derived from these structural positions. Take, for example, the measures that constitute the welfare state(s). Although it can be claimed that this theoretical proposition has divergent materializations due to the specific reality of each country/or groups of countries (Esping-Andersen, 1990), in our understanding it can be associated to how those politicians responsible for the institutionalization of each model conceive it. Their political convictions, interests and pacts, as well as how they conceive such an intervention model must be known when articulating the dimensions presented in the construction of reflexivity.

Politicians are involved in political structures that socialize them, but their action is the result of how they individually objectify the party's ideology. One leader is not the same as another leader, and the party's action is intimately related to this individuality. From this point of view, they can be assumed as individual and collective subjects, due to their responsibility for how a given model exists and is configured currently and therefore in the future.

Second, if NPM is an ideology which is materialized differently by each political leader, its organizational implementation must also be understood as the product of specific interventions; this considers hospital managers again as individual and collective subjects. Since every organization is a human system that cannot be generalized in its formal and informal conditions and processes (Crozier, Friedberg, 1977), any change introduced at this level has to combine these organizational specificities – the so-called organizational culture – with the managers and environmental contexts. What is negotiated within the organizational 'games' is intimately dependent on its constituted parts, which are influenced by systems outside the organization and by individual ways of performing professional roles, according to past learning, interests and expectations.

Thirdly, as the interactionist perspectives have shown, even when 'professional jurisdictions' are defined, which is the result of an institutional process, it cannot be ignored that once they are individually appropriated they will invariably have the effect of an individual action, hence reflexivity. For example, given the current configuration of professional jurisdictions in Portugal, a doctor who is a service director has full authority to decide on issues as important as the features of the service he/she runs, the kind of intervention professionals may make, or the fulfillment of the rules imposed by the Board of Directors. It therefore comes as no surprise that no two services, even of the same medical speciality, are exactly the same.

It is obvious that the ability to introduce changes into professional jurisdictions is always related to what one considers to be its borders. We are not talking about changes in the elementary skills that

structure and define each profession, but rather the spaces that are more peripheral to that nucleus which distinguish professions from each other. A further example illustrating this is linked to the medicine/nursing relationship. Although main research on this topic mentions unmistakable elements for structuring the content of nursing work as defined by medicine, indicative of Taylorism in this division of labor (Freidson, 1975; Chauvenet, 1972), I consider it extremely pertinent that head nurses could actually constrain the spheres of medical influence on the nursing work. Serum administration and taking blood samples are just a couple of tasks included in the category 'medical work delegated' to nursing professionals, since these are mainly performing tasks. Nevertheless, the head nurses in some services demand that these tasks are performed by doctors (especially younger doctors delegated by older doctors) as they do not consider this part of a nurse's responsibilities.

As this is not common to all head nurses, it illustrates that it is not necessarily the place occupied in the professional structure that is at stake, but mostly the way in which those professionals perform their professional roles reflexively when interacting with others. As a result, these tasks are actually done by nurses in other services without any opposition from the respective head nurse.

This demonstrates that it is vital for current sociological studies, notably where the medical field is the empirical object, to provide a conceptual framework of analysis that encompasses both external social structures and also the way in which these structures represent an intrinsic connection between exteriority and individuality. After all, is action an univocal and linear reproduction of structures? If so, it must be shown how structures are reproduced over time and space independently from the social agents. Transposing this to the understanding of professionalism, we believe it has an ideology constructed by cohesive groups that share specialized and scientific rationalities. These rationalities are communicated through institutions accredited for that purpose, with quite stable rules and structures reproduced in time and space, though potentially variable according to the contingencies of the context in which they are exercised. This stable but contingent external existence of professionalism is associated with a parallel internalized existence as regards the professionals. The reproduction of the rules and structures of these groups, is both dependent on factors associated with the social order, and also filtered by an agency constituted by individual perceptions and interests that diversify the exercise of those structures, hence different ways of conceiving professionalism.

Final remarks

The debate presented addresses problems within the existing conceptual frameworks when an understanding of professional relations among professions with a high degree of professional discretion is at stake, namely in relation to, the structural capacity to act individually as professions. While individual motivation remains obscured in the theory of professions, the main perspectives fail to understand the reason why individual differences can be found in terms of how professional power, authority and autonomy are activated. Furthermore, they justify differences in inter-professional relations, which are not restricted to a manager-doctor relation. In this way, the present discussion is extremely important for reviewing the way nurses or other occupational groups develop their activities under a dominant and structural profession.

Conceptually we saw how reflexivity, as the ability to think and evaluate consciously, may in fact articulate contemporary perspectives from sociological theories not commonly associated with each other. The attention given to reflexivity and to the structure of human action has intentionally been left as an open-ended discussion; however, different traditions (Anglo-American but mostly francophone) have been used to propose what is seen as a more explicit concern of sociology of professions field with the sociological theory. This can be said to represent a first step in theorizing professional action and conceptualizing professionalism in a way that truly materializes Freidson's (2006, p.60) intention: "[…] je suis parfois un interactionniste symbolique, mais qu'en d'autres occasions je suis wébérien, marxiste, fonctionnaliste et même tout simplement un narrateur".

References

ABBOTT, A. **The system of professions**: an essay on the division of expert labour. Chicago: University of Chicago Press, 1988.

ALEXANDER, J. **Action and its environments**: toward a new synthesis. New York: Columbia University Press, 1988.

_____. Rethinking Durkheim's intellectual development 1: on 'marxism' and the anxiety of being misunderstood. **Int. Sociol.**, v.1, n.1, p.91-107, 1986.

ARCHER, M. **Making our way through the world**: human reflexivity and social mobility. Cambridge: Cambridge University Press, 2007.

_____. Realist social theory: the morphogenetic approach. Cambridge: Cambridge University Press, 1995.

BHASKAR, R. **The possibility of naturalism.** Brighton: Harvester, 1979.

BOUDON, R. **Raison, bonnes raisons**. Paris: PUF, 2003.

BOURDIEU, P. **Esboço de uma teoria da prática:** precedido de três estudos de etnologia Cabila. Oeiras: Celta Editora, 2002.

_____. **Razões práticas**: sobre a teoria da acção. Oeiras: Celta Editora, 2001.

_____. **O poder simbólico**. Lisboa: DIFEL, 1989.

_____. Habitus, code et codification. **Actes Recherche Sci. Soc.**, v.64, p.40-4, 1986.

BURNS, T.; FLAM, H. **Sistemas de regras sociais**. Oeiras: Celta Editora, 2000.

BURRAGE, M. et al. An actor based framework for the study of the professions. In: BURRAGE, M.; TORSTENDAHL, R. (Eds.). **Professions in theory and history**: rethinking the study of the professions. London: Sage, 1990. p.203-25.

CARAPINHEIRO, G. **Saberes e poderes no hospital**: uma sociologia dos serviços hospitalares. Porto: Afrontamento, 1993.

CAUSER, G.; EXWORTHY, M. Professionals as managers across the public sector. In: EXWORTHY, M.; HALFORD, S. (Eds.). **Professionals and the new managerialism in the public sector**. Buckingham: Open University Press, 1999. p.83-101.

CHAMPY, F. **La sociologie des professions**. Paris: Presses Universitaires de France, 2009.

CHAUVENET, A. Professions hospitalières et division du travail. **Sociol. Travail**, v.14, n.2, p.145-63, 1972.

COLLINS, R. Changing conceptions in the sociology of the professions. In: TORSTENDAHL, R.; BURRAGE, M. (Eds.). **The formation of the professions**: knowledge, state and strategy. London: Sage, 1990, p.11-23.

CORREIA, T. Rethinking professions: a conceptual framework of analysis by reflexive agency. In: INTERIM MEETING ESA RN19 SOCIOLOGY OF PROFESSIONS: PROFESSIONS AND PROFESSIONALISM IN TIMES OF GLOBAL ECONOMIC CRISIS: CHANGES AND CONTINUITIES, 6., 2010, Paris. **Distributed papers...** Paris, 2010.

_____. Modos distintivos de se ser: uma discussão teórica sobre a profissão analisada através da agência reflexiva. In: CONGRESSO DA ASSOCIAÇÃO PORTUGUESA DE ANTROPOLOGIA, 4., 2009, Lisboa. **Distributed papers...** Lisboa, 2009a.

_____. Reflexões e aplicações da estrutura/acção na sociologia das profissões: considerações teóricas. In: WORKSHOP DE INVESTIGAÇÃO DO CIES/ISCTE-IUL, 2009, Lisboa. **Resumos...** Lisboa, 2009b.

CROZIER, M.; FRIEDBERG, E. **L´acteur et le système**: les contraintes de l´action collective. Paris: Éditions du Seuil, 1977.

CURRIE, G. et al. Professional competition and modernizing the clinical workforce in the NHS. **Work, Employ. Soc.**, v.23, n.2, p.267-84, 2009.

DOOLIN, B. Enterprise Discourse, Professional Identity and the Organizational Control of Hospital Clinicians. **Org. Stud.**, v.23, n.3, p.369-90, 2002.

DUBAR, C. **La socialisation**: construction des identités sociales et professionnelles. Paris: Armand Colin Éditeur, 1991.

DURKHEIM, É. **A divisão do trabalho social.** Lisboa: Editorial Presença, 1977.

ESPING-ANDERSEN, C. **The three worlds of welfare capitalism**. Cambridge: Policy Press, 1990.

EVETTS, J. Short note: the sociology of professional groups: new directions. **Curr. Sociol.**, v.54, n.1, p.133-43, 2006.

_____. The sociological analysis of professionalism: occupational change in the modern world. **Int. Sociol.**, v.18, n.2, p.395-415, 2003.

_____. New directions in state and international professional occupations: discretionary decision-making and acquired regulation. In: SAGE ANNUAL MEETING ON SOCIO-ECONOMICS KNOWLEDGE: THE WEALTH OF NATIONS, 13., 2001, Amsterdam. **Distributed papers...** Amsterdam, 2001.

FOUCAULT, M. **Surveiller et punir**. Paris: Gallimard, 1975.

FREIDSON, E. Pourquoi je suis aussi un interactionniste symbolique. **Savoir, Travail Soc.**, v.4, n.2, p.55-61, 2006.

_____. **Professionalism**: the third logic. Chicago: University of Chicago Press, 2001.

_____. **Professionalism reborn**: theory, prophecy, and policy. Cambridge: Polity Press, 1994.

_____. **Doctoring together**: a study of professional control. New York: Elsevier, 1975.

_____. **Professional dominance**: the social structure of medical care. New York: Atherton Press, 1970.

GIDDENS, A. **The constitution of society**: outline of the theory of structuration. Cambridge: Polity Press, 1984.

_____. Viver numa sociedade pós-tradicional. In: BECK, U.; GIDDENS, A.; LASH, S. (Eds.). **Modernização reflexiva**: política, tradição e estética na ordem social moderna. Oeiras: Celta Editora, 2000. p.53-104.

GUIBENTIF, P. Teorias sociológicas comparadas e aplicadas: Bourdieu, Foucault, Habermas e Luhmann face ao direito. **Cid., Comerc. Territ.**, v.14, p.89-114, 2007.

HAMEL, J. Réflexions sur la réflexivité en sociologie. **Soc. Sci. Inform.**, v.46, p.471-85, 2007.

HARRISON, S. Clinical autonomy and health policy: past and futures. In: EXWORTHY, M.; HALFORD, S. (Eds.). **Professionals and the new managerialism in the public sector**. Buckingham: Open University Press, 1999. p.50-64.

HUGHES, E. Professions. In: LYNN, K. (Ed.). **The professions in America**. Boston: Houghton Mifflin Company, 1965. p.1-14.

JOHNSON, T. **Professions and power**. London: Macmillan, 1972.

KIRKPATRICK, I. et al. Professional strategies and the new public management in healthcare: comparing Denmark and the UK. In: CRITICAL MANAGEMENT STUDIES CONFERENCE, 2007, Manchester. **Distributed papers...** Manchester, 2007.

LAHIRE, B. Patrimónios individuais de disposições: para uma sociologia à escala individual. **Sociol. Probl. Prat.**, v.49, p.11-42, 2005.

LARSON, M. **The rise of professionalism**: a sociological analysis. Berkeley: University of California Press, 1977.

MERTON, R. **Social research and the practicing professions**. Cambridge: Abt Books, 1982.

MOUZELIS, N. **Back to sociological theory**: the construction of social orders. London: Macmillan, 1991.

PARSONS, T. Professional groups and social structure. In: VOLLMER, H.; MILLS, D. (Eds.). **Professionalization**. New Jersey: Prentice-Hall, 1966. p.55-7.

_____. **The social system**. New York: Free Press, 1951.

PERROW, C. Goals and power structures. In: FREIDSON, E. (Ed.). **The hospital In modern society**. New York: The Free Press, 1963. p.217-31.

PINTO, J.M. Considerações sobre a produção social de identidade. **Rev. Crit. Cienc. Soc.**, v. 32, p.217-31, 1991.

PIRES, R.P. Árvores conceptuais: uma reconstrução multidimensional dos conceitos de acção e estrutura. **Sociol. Probl. Prat.**, v.53, p.11-50, 2007.

POLLITT, C. **Managerialism and the public services**. Oxford: Blackwell, 1990.

RODRIGUES, M.L. **Sociologia das profissões**. Oeiras: Celta Editora, 2002.

SAKS, M. Removing the blinkers? A critique of recent contributions to the sociology of professions. **Sociol. Rev.**, v.31, n.1, p.1-21, 1983.

SCHRAIBER, L.B. **O médico e suas interações**: a crise dos vínculos de confiança. São Paulo: Hucitec, 2008.

SCIULLI, D. Continental sociology of professions today: conceptual contributions. **Curr. Sociol.**, v.53, p.915-42, 2005.

SIEGRIST, H. Professionalization as a process: patterns, progression and discontinuity. In: BURRAGE, M.; TORSTENDAHL, R. (Eds.). **Professions in theory and history**: rethinking the study of the professions. London: Sage, 1990. p.177-202.

SILVA, A.S. **A sociologia e o debate público**: estudos sobre a relação entre conhecer e agir. Porto: Afrontamento, 2006.

STELLING, J.; BUCHER, R. Autonomy and monitoring on hospital wards. **Sociol. Q.**, v.13, p.431-46, 1972.

STRAUSS, A. et al. The hospital and its negotiated order. In: FREIDSON, E. (Ed.). **The hospital in modern society**. New York: The Free Press, 1963. p.147-69.

_____. The work of hospitalized patients. **Soc. Sci. Med.**, v.16, p.977-86, 1982.

TIMMERMANS, S. Professions and their work: do market shelters protect professional interests? **Work Occup.**, v.35, n.2, p.164-88, 2008.

TORSTENDAHL, R. Essential properties, strategic aims and historical development: three approaches to theories of professionalism. In: BURRAGE, M.; TORSTENDAHL, R. (Eds.). **Professions in theory and history**: rethinking the study of the professions. London: Sage, 1990. p.44-61.

WEBER, M. **Fundamentos da sociologia**. Porto: Rés-Editora, 1983.

CORREIA, T. Profesionalismo médico visto como un sistema abierto: una controversia en la sociología de las profesiones. **Interface - Comunic., Saude, Educ.**, v.15, n.38, p.779-91, jul./set. 2011.

Este artículo se centra en un debate sobre las teorías de las profesiones. Se intenta fortalecer el debate en una conceptuación del profesionalismo y de las relaciones profesionales. El argumento radica en cambiar el nivel de análisis de las profesiones para los profisionales, como paso elemental para conceptuar la acción individual en contexto profesional. Esta preocupación es tanto más importante cuanto mayor es la discreción profesional estructuralmente consentida, ya que la capacidad de elegir conduce explícitamente a la diferenciación interna de las profesiones. La influencia sistémica se hace notar teniendo en cuenta que las estructuras sociales están intrínsecamente comprendidas en las acciones, y estas son exteorizaciones de procesos individualmente interiorizados. Se hace necesario considerar las razones de los comportamientos y los significados individualmente dados a las dimensiones profesionales.

Palabras clave: Discrecionalidad médica. Estructuras sociales. Agencia. Teorías sociológicas. Sociología de las profesiones.

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