Normality, Crisis and Recovery of narrating medical Professionalism

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Abstract

This paper presents an analysis of how the narratives of medical professionalism have changed historically based on doctor's autobiographies. Three different phases of narrating professionalism have roughly been distinguished. The first is marked by the struggle to professionalise medicine itself. The second is the Phase of Normality where the legitimization of medical professionalism is self-evident in the face of societal crises such as epidemics. In the Phase of Crises the authoritative doctor is no longer the legitimate source of medical decision-making. In this situation, the will and wellbeing of the individual patient is found to be a key element in how doctors themselves legitimise their actions. Key-result is that we do not interpret the described change in narrating medical professionalism as de-professionalization, but in contrast that precisely the accentuation of the patient's perspective is the modality to recover the crisis of medical professionalism and secure it in a new form.

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Introduction and research question: beyond the normative debate of de-professionalisation

The self-understanding of medical professional service seems to have undergone a fundamental change. The perception of the role of the doctor has fundamentally altered in the face of permanent re-organisation of professional work in the face of an alleged increasing market-orientation. One common diagnosis is that the doctor has lost its dominant position in the practice of providing medical services. In this article we want to challenge this diagnosis by presenting a historical analysis of how on one hand the self-understanding has always altered in the phase of modernity and one the other hand that these alteration can not be perceived as a weakening of the professional role doctors play in providing medical services, but as a permanent adjustment of the perception of medical professionalism to social changes.

Since the 1980s and 1990s, research activities have been aimed at the exploration of how the conditions of professional services have changed (Ackroyd, 1996; Ackroyd, Kirkpatrick & Walker, 2007; Freidson, 2006; Klatetzki & Tacke, 2005), especially in the realm of public health, law, education and economics. The contributions focus on the meaning of political

interventions (Allsop & Jones, 2006), reforms (e.g. Currie, Finn & Graham, 2009; Kirkpatrick, Ackroyd & Walker, 2005), and the consequences of the increasing market orientation of professional work (e.g. Brock, Powell & Hinings, 2001). All these research activities begin with an observation that professions are more and more forced to adapt to market logics. Thus, professional organisations (Klatetzki & Tacke, 2005) are less structured by the orientation of professional values and more by management orientated mechanisms.

The developments are debated under the umbrella term 'de-professionalisation'. Noordegraaf (2011), for example, describes the mainstream positions, that occupations are usually considered to be weakened by organisations. Further positions argue normatively that the decreasing influence of classic professionals (doctors, priests, layers) leads to an enhancement of the quality of the professional service in the context of the organised structures, which then provides better benefits for the clients (Brock, Powell & Hinings, 2001).

In this paper, we do not want to add to this discussion with a further normative statement. Instead, we are more interested in deepening insights into how the self-understanding of medical professionalism simultaneously adjusts with transformations in social discourses (e.g. rationalization, scientification, market-orientation or since the 1980s neo-liberalisation) and the reform projects connected to those modifications. We will thereby perceive professionalism not only as a form of expert knowledge, but rather a specific form of the management of expectations that (Atzeni, 2016) creates a basis for medical practice that is socially accepted and legitimised (Evetts, 2003; Fournier, 1999).

In this study, we therefore seek an approach that differs from the one that explore concrete medical service practices and restrict their empirical and theoretical conclusion to the latest historical phase of new-public management reforms (Nielsen, Knudsen & Finke, 2003; Keshavjee, 2004; Vogd, 2006; Fins, 2007; Churchill, 2007). We assume that research that focuses on the impact of economization of medical professional services too easily comes to the conclusion that professional values are weakened by market orientation. By taking a broader time-frame we will show that the self-understanding of medical professionalism has always (and not only in the so called phase of neo-liberalism) been adapting to changes in societal discourses and we will show that doctors' professionalism should be interpreted as a modality to react, and moreover affect, societal changes.

Instead of observing medical procedures, we will therefore observe how the narrations of professionalism of doctors have changed in the course of modernity. To reflect these changes we will use autobiographies of doctors (memoirs, written mostly after the active career) from Germany and the Anglo-Saxon countries from the mid nineteenth century to the present day and reconstruct on behalf of this material the modification in narrating the professional self-understanding historically (for a in depth analysis of the sociological meaning of doctors narratives in autobiographies and the sociology of professions see Atzeni, 2016). Furthermore, we are interested in exploring how in these narrations a specific professional self-understanding correlates with specific modes of organising health services and broader societal discourses. Autobiographies are relevant material to us as we don't read them as subject attempts to influence a concrete practical setting, but as historical data that reflect time-specific social accepted forms of narrating. Thereby, the material informs us about socially legitimate expectations, both in regard of the status of medical professionalism, but also in regard of how medical services should be organized. Thus, we want to raise and answer the following questions: How has the professional self-understanding of doctors changed in the period of modernity? Consequently, how are these changes interrelated with modifications in societal ideologies and adjustments in organisational structures? As we argue that the use of language, concepts and semantics shape social expectations that make specific forms of social practice more legitimate than others (see the following chapter), this approach allows us to show the corresponding changes in the relation between society and medicine in a bigger framework. Compared to empirical studies on concrete changes in medical practice, this perspective is necessarily rougher and less detailed but nevertheless provides a clearer look at the interdependences between medicine, the profession of doctors, society and organisation.

In the first step towards a deeper understanding of the narrations of professionalism, we sketch our theoretical and methodological perspective. In the second step, we present the observations of our empirical analysis. We reconstruct three different phases of narrating doctors' professionalism in modernity. Our key-argument will be that the reference to the condition of the individual patient is a rather late phenomenon in the narration which emerges in times of heavy critique of the status of medical professionalism. We will argue that this is not a sign for increasing de-professionalisation but that it is the key element in how doctors themselves legitimise their actions. We end the paper with our conclusions.

Theoretical perspective

As the aim of this article is to provide a deeper understanding of the development and change of the self-image of medical professionalism and its correlation with social change in general and changes in the organisation of medical service in particular, the account about our theoretical and methodological approach becomes rather important. The 'problem' of the research question, and therefore its vulnerability for critique, is that it tries to combine a diagnosis about huge historic developments (the development of medical professionalism and its correlation with organisational and wider social shifts) with an analysis of a rather specific form of empirical material: autobiographies of doctors. In this part we therefore want to introduce a perspective of theoretical thinking that explains why we link specific texts that contain concrete contextual conditions, with the diagnosis of rather big societal changes and breaks. We begin by introducing a theoretical perspective that in our reading emphasise that the use of language, concepts and semantics shape social expectations that make specific forms of social practice more plausible than others. As a second step we will show how professionalism can be perceived in this context. We will argue that professionalism is not so much the application of expert knowledge, but rather a specific form of how expectations are managed which create the basis for medical practice that is socially accepted. As a third step we will discuss how we turn these considerations into a methodological approach.

Foucault and Koselleck: the interrelation between the use of language and social practice

This article generally argues from a constructivist perspective. We see the common ground of constructivist thinking in the shared goal to explain social change not by pointing to new concepts, new meanings or a new institutional framework, but by showing how these new concepts, meanings and institutional frameworks emerge (Åkerstrøm Andersen, 2003, p. XI). In the context of our research question this means that our aim is to reconstruct the emergence of time-specific narrations of the self-image of medical professionalism and the changes that these self-images have gone through during the period of modernity. This very basic and fundamental approach can only be achieved if the analysis of how a concept, term or semantic expression, like medical professionalism, emerged and changed over time, is not seen as somehow isolated from social action and practice. This perspective can be found in theoretical approaches that are associated with the 'linguistic turn'. They establish a constructivist perspective, seeing sociality as a result of communicative construction and insist that the use of language not just "naively mirrors or innocently re-presents the world but actively creates and powerfully shapes it" (Kornberger, Clegg & Carter 2006, p. 13). The use of language (or discourse, semantics, concepts, communication – whatever term one uses in a specific theoretical approach) shapes the world by presenting specific forms of meanings and social expectations that make certain forms of practice and action more probable and legitimate than others. This epistemological insight connects the arguments supporting this paper with the theoretical approaches of disparate thinkers like Foucault and Koselleck (Åkerstrøm Andersen, 2011).

With Foucault one can retrace how plausible forms of meaning are established in discourses that lead to certain forms of practice. For him discourse analysis is the way to undermine a distinction between text and a subtext and thus his aim was the questioning of discursive assumptions "by showing how every utterance is an utterance within a specific discourse to which certain rules of acceptability apply" (Åkerstrøm Andersen, 2003, p. 3). The notion of rules of acceptability that are established in a discourse is very important for the study of professionalism as a concept, because our aim is to reconstruct which form of narrating medical professionalism seems socially accepted or legitimate at a specific point in time. We therefore follow a perception of professionalism which uses Foucault's concept of legitimacy (Foucault, 1979) and which emphasises that professionalism is a specific form of government (Evetts, 2003; Fournier, 1999) that establishes expectations about which forms of medical practice are legitimate.

Another author who emphasises a connection between language, its semantics, and social structures is of course Reinhart Koselleck. In his approach of a history of concepts he investigates how concepts like 'politics', 'nature', 'crisis' emerge and are transformed historically and how they affect social and political practices (Brunner, Conze & Koselleck, 1972). He uses the analysis of the emergence and transformation of political and social semantic concepts to indicate the characteristics of modernity. For Koselleck, concepts are the (pre)conditions and agents of actions (1982, p. 410). For example, only the emergence of a concept like individualism made it possible and expectable that a person narrates her or his life as a sequence of their own decisions. The establishment of a concept as a reservoir of ambiguous, but condensed meaning does not lead causally to certain forms of practice, but opens up a space where specific forms of practice are more expectable and plausible than others (Koselleck, 1982). In this line of thinking, professionalism can be perceived as a semantic concept, which opens up a space for possibilities of how a doctor can present and narrate himself in an expectable and meaningful way. Therefore it is not important that the concrete semantic form of professionalism is used

explicitly in the narration and what's more, the existence of a concept like professionalism limits the possibilities of how to present his or her own practice. For example, the concept of individuality does not inevitably lead to everybody using the term of individuality when he or she talks about his- or herself, but that the form of narration is oriented by an individualistic rationality.

Both theoretical concepts point to the constructivist insight that social practice and the change of it is prepared, accompanied, and shaped by language, or more precisely expressed: by its semantics and concepts, that are used at a specific point in time. The use of language, semantics and concepts build a reservoir of meaning that establishes social expectations of which forms of practice are considered acceptable and legitimate. With this theoretical perspective we choose an approach which does not only explain how social structures emerge out of interactional negotiations of social norms (for example Strauss, 1978) but which even more point to the fact that social practice can only be perceived as a process that inevitably takes societal concepts and semantics into account which thereby confirms but also possibly changes legitimate expectations incrementally. This perspective therefore rejects a clear distinction between a 'practice of action' and a 'practice of talk' (Nassehi, 2006). Moreover, we emphasise with this perspective that the emergence of a specific phenomenon can only be explained if you connect it to broader cultural and social change processes, which of course encompass changes in the way of working and organising. By connecting ourselves to these theoretical insights, our study follows an analytical strategy that focuses on the exploration of historical shifts of semantics in order to understand present phenomena and challenges (Rennison, 2007; Åkerstrøm Andersen, 2009; Henkel, 2013).

This is mirrored in our choice of empirical material, where we don't use autobiographical material which is created in interactional settings like interviews, but where we analyse books that are published as autobiographical narrations about one's professional life. This makes the analysis about time-specific characteristics of socially legitimate forms of self-representation possible instead of analysing how autobiographical narrations are negotiated in interactional settings.

Professionalism

In this paper we use a concept of professionalism/profession that is in line with systems theory thinking (see Kieserling, 1998; Luhmann, 1983; Nassehi, 2010; Stichweh, 1996, 1997). This concept of professionalism differs from prominent Anglo-American approaches in the way questions about professionalism are asked. We do not ask what specific traits characterise professional occupation and in which way these can be distinguished from others (Carr-Saunders and Wilson, [1933] 1963; Cogan, 1955; Goode, 1972; Greenwood, 1957) nor do we ask how professions manage to claim their (illegitimate) social status and power (Freidson, 1970; Dezalay, 1995; Larson, 1977), nor about the normative prerequisites that are an important basis for social order (Carr-Saunders & Wilson, [1933] 1963; Freidson, 2001; Parsons, 1951; Swick, 2000). Although we analyse professional self-descriptions, we are not primarily interested in the shaping of professional identities through biographical work (Vachhani, 2013). Instead, the fundamental question we ask is about the function of professionalism for society in a broader historical framework.

The concept is applied rather strictly to what is called the classic professions: doctors, lawyers, priests (and sometimes teachers) as they are the ones whose work aims at changing persons. Luhmann adopts the idea of 'people processing' from the interactionistic approach of Everett C. Hughes (1963) (For the convergences and differences of a system-theoretical approach to professionalism and the approach in tradition of Chicago School see Stichweh, [1997, p. 97]). Classic professions here are seen as occupations which deal with the most existential conflicts of men: The relation of a person to their body (doctor), fellow men (lawyer) and to their maker (priest). Rudolf Stichweh argues that because of this special characteristic of these occupations, professions were the first ones to gain social status by merit instead of birth (Stichweh, 1996, 1997). So on the one hand the level of interaction has an important meaning for the systems theoretical understanding of professionalism, as the people processing does not only deal with existential problems but has furthermore rather precarious status. On the other hand this approach to professionalism is not limited to the level of interaction, but centres on the societal function of the professions. Professions made legitimate the idea to orientate decisions on specific (rational) reasons instead of the conventional societal decision-routines based on hierarchies by social status, traditional or religious patterns of conduct. Stichweh sees the historical meaning of professions in its contribution to manage the transition from a pre-modern, socially differentiated into a modern, functionally differentiated society (For a similar but much broader concept of professionalism see Perkin, 1989, p. XIII). For the actual and future status of professionalism Stichweh is rather sceptical and tends to assume that professionalism, in the sense of occupational groups with a societal function beyond their actual work context, is outdated (Stichweh 1997, p. 95, p. 100).

Instead of explaining the transition form per-modern to modern society, by turning to actual practices of narrating professionalism and analysing the change of semantics and concepts within, we are able to use his argument more abstractly and therefore draw a different conclusion concerning the future of professionalism. In a more abstract sense, we argue that classic professions managed to change societal expectations in a fundamental way. Professionalism in our understanding does not only mean to be able to claim social status due to specialised expert knowledge but more fundamentally to implement new semantic forms that, as we explained previously, open up the space for new legitimate forms of social practices. This is what we mean by the shaping of social expectations.

Methodological approach

The theoretical insight that the particular use of language, semantics and concepts is interrelated with social practice together with the notion of professionalism as a concept that refers to this interrelation in order to establish and secure a socially accepted form of occupational practices, leads to a methodological approach which uses narrations to explore the change of medical professionalism. We assume that the reconstruction of different forms of narrating the self-understanding of work processes and the role of oneself in these processes reveal how the medical profession is able to both adapt to changing social conditions and to shape and create its own conditions of work, to coin social expectations. We use autobiographical books of doctors as empirical material because they can be read both as forms of self-presentations and as texts that inevitably mirror the time-specific expectations of legitimate medical practice. In the analysis, what becomes of great importance is how the texts themselves refer to and use specific semantics and concepts. We therefore refer to our methodological approach as a semantic analysis (Åkerstrøm Andersen, 2011). When we use autobiographies of doctors as empirical material, the question is not so much how doctors present themselves as coherent selves or how the stories about certain procedures and practices shape reality or not, since this is already considered mainly in studies on identity constructions (Alvesson, 2000; Alvesson & Willmott, 2002; Brown, 2001; Muhr, 2012; Paquette, 2013; Vachhani, 2006), storytelling (Boje, 2008; Gabriel, 2000) and (auto)biographical research (Riemann, 2003). The question is rather, how in the autobiographies a time-specific concept of professionalism is revealed and how it is interwoven with other concepts and semantics that inform us about organisational practices and wider social structures. Accordingly, we perceive the autobiographies as a form of text which not only informs us about the time-specific discourse about the self-understanding of medical professionalism, but also about social norms, values, discourses and rationalities that are implicitly transported in (and shaped by) the material. This approach enables us to both reconstruct the adjustment in the professional self-understanding and the change of social institutions and organisations (Alvesson & Kärreman, 2000; Czarniawska, 1997; Foucault, [1976] 1994).

The data for this study consists of 24 autobiographies written in either German or English that were published between the mid nineteenth and the first decade of the twenty-first century. For the analysis it was important that the whole time period was considered and that there were approximately the same number of books for every generation, which we estimate to be 30 years. To begin with we researched all available autobiographies, disregarding the national background of the authors. For reasons of comparability we then limited the books to authors from Germany and the Anglo-Saxon countries as we thought that we could thereby sketch how medical professionalism is shaped in the westernised world. We know that this calls for critique as we consequently ignore cultural differences between these western countries. But since we perceive modernity also as a westernised invention we consider it legitimate to combine books from different nations in the analysis.

There are four steps to our analysis. First, the autobiographies were scanned for episodes that inform us about how these doctors understand their professional work. These text passages were analysed with regard to the question of how this specific form of narration legitimates itself in the context of the entire structure of the autobiography. In the second step, we compared the different passages and try to determine patterns in how medical professionalism was narrated. In the third step, we re-interpreted the patterns we identified, due to references to how the medical work was organised and which broader societal movements were cited in the material. In the last step, we tried to match our findings with other empirical and theoretical work that helped us understand why certain narrations were legitimate at a specific time.

Empirical observation: the modification in narrating medical professionalism

In the following pages, we present three modes of narrating professionalism. These modes can be organised into three successive, historical phases. Of course, the phases are not clearly distinct by strict year dates but we can roughly point them out by looking specifically at the periods, where one can detect significant switches in semantics and issues.

Phase 1: struggle for the acceptance and professionalisation of medicine

The Struggle Phase can be described in accordance with Michel Foucault's (1994) work on the birth of the clinic. On the societal level, in the nineteenth century, the experiences of the French and American Revolution and the impact of the phase of Enlightenment created a meta-discourse, or social ideology, of scientification and rationalisation. This replaced the idea of a social order held together by the will of God. In doctoral autobiographies from the late nineteenth and early twentieth century, we can trace roots of these societal changes. Here the idea of the role of professions in the transformation of society, which we sketched above following Stichweh, can be seen.

The emergence of the concept of rationality

So, for example, doctors promote functional differentiation as they differentiate medical justifications from other types of social justifications. In their autobiographies, they recount how they had to claim validity for their arguments only on the basis of rational, medical reasons against arguments on the basis of social status, of common morality or religious reasons. The autobiographers describe themselves as a new generation of doctors who had to push aside the old medical 'knowledge' of some of their teachers which for the younger seems more like medical superstition. The 'new' professionals are fighting tough battles against religious and political forces (outside and inside medicine), in an attempt to govern medicine. Adolf Kussmaul, a clinician born in 1822, recalls these battles in his autobiography:

> Back then, medicine only began to actively break with natural philosophy, superstition and blind belief. Many academic physicians still believed medicine could be deduced systematically from a general principle. In Bavaria, science and the art of healing even had to subordinate under theosophy[i]; the omnipotent medical officer of health Ringseis[ii], who explained illness by the fall of mankind and cured them by the church's means of grace, often had the decisive influence concerning appointments. One easily believes that the pre-March eras[iii] medical youth, which was driven by an advanced, combative spirit, happily welcomed the swish of the whip, the funny anatomist was cracking over the heads of the men of darkness. (Kussmaul 1903, p. 238)

Kussmaul and his contemporaries, doctors who started their careers around the middle of the nineteenth century, describe how, in this context, a professional self-understanding of doctors emerges that emphasises the scientific aspect of medicine. Doctors save bodies, not souls. This self-understanding is connected with the belief that the human body is the sum of a person (biological reductionism). Through methodical examination, which Foucault describes as the 'medical gaze' on the body (Foucault, [1976] 1994), the doctor deduces symptoms, illnesses, and causes by applying scientific methods. The orientation towards a medicine which relies on scientific and rational experiments is also combined with a new professional self-understanding, which expresses superiority over previous medical knowledge.

> The majority of the doctors, all acclaimed clinical professors, still strongly believed that scabies was not caused by itch mite[iv] but by the acidity of corporal juices. Hahnemann and Authenried were babbling about a hidden, not visible flora […]. We, the student apprentices, laughed about the mythical flora and caught this "flora" in the form of an itch mite […]. We inserted the itch mite under the skin where it ate its alleys, sat still in the cold and woke to bothersome action in the warmth. (Kussmaul 1903, p. 218)

Widening the gaze in terms of social theory, these citations are a hint not only at changes in medicine, but also to a fundamental adjustment in societal ideology. The semantic concept of rationality, represented by the classical professionals, is struggling against the concept of a native, inherited social status. Diagnoses should now be medical scientific findings, instead of a religious symbolic perception about body and soul. By this, the authority of science in medicine became more legitimate against the authority of age, social status and moral integrity. As professionals are first to gain a certain kind of societal influence, not legitimised by their position in society but through knowledge, they spread the idea of rationality into society. By looking at doctoral self-descriptions, presented here in examples from autobiographies, we can see how new legitimate forms of narrating doctoral professionalism emerge and establish.

Hospitals as institutions for medical experiments

The modification in professional self-understanding from a healer whose duty is to preserve the patient as a creature of God in a more or less artistic way to a scientist whose duty is to understand illness in a rational way, also changed the attitude towards patients which, in the age of science, seems almost indifferent, at least from today's standpoint. This change in doctors' self-understanding and the meta-discourse of rationalisation in society are also closely interrelated with the way in which the treatment of patients is organised. Whereas before patients were treated in their homes, hospitals emerge as institutions, not only as an effective means to treat ill people, but also to have access to a sufficient number of patients for medical experiments and to educate young promising medical researchers. The following citation shows how a doctor establishes a hospital, not only as an institution to cure ill people, but particularly as an institution for research:

> First, the aim was to set up a laryngeal course. But how should I do this? Without patients, without instruments! The ambulance was not sufficient with its few patients in the morning […]. To gain sufficient medical material [patients, G.A, V.G.], I turned to the "hostel of the homeland" and to some elementary teachers and promised 20 pennies to everybody who was willing to have a laryngoscopy performed by untrained hands. […] It was surprising that there were a lot of laryngeal diseases amongst the vagrants of the hostel. The song-loving pupils provided us with nodules. (von Müller, 1951, pp. 81-82)

The matter-of-fact description Friedrich von Müller provides us with about the trial-and-error development of medical methods is paradigmatic of the perception which sees patients more as a means to gain medical skills and knowledge than as human beings. We do not criticise this as cruel, inhuman practice, but focus on the functional aspects. We have to bear in mind that autobiographies do not give us a one-to-one picture of medical practices, but – which for us is most important – an insight into the accepted image of medicine during a specific time period.

Surely, caring for sick individuals was the biggest part of everyday practice, perhaps even so self-evident that it does not seem necessary to mention it in the written retrospective of one's professional life. Instead, the new, really exciting aspect of medical work that was worth mentioning was the insight into physiological functions, statistical correlations, and new therapeutic methods. All these aspects led to an advance in medical knowledge and a direct effect of the hospitalisation of sick people within the organisation of medical care. The hardly translatable German semantics 'Krankengut' or 'Krankenmaterial', often used in autobiographies of that time, point to the value of a hospitalised, comparable, large number of sick people as a means for medical education and research.

As Jens Lachmund and Gunnar Stollberg (1995) illustrate in their brilliant analysis of patients' autobiographies from the late eighteenth to the early twentieth century, the wide implementation of hospitals causes a turnaround in the power relationship between doctors and patients. No longer was the doctor under surveillance of the patient's relative, forced to adapt his[v] diagnoses and therapies to a lay audience, as in former times (Lachmund & Stollberg, 1995, 2012). With the advent of hospitals at large, the definition of illness, the choice of possible cures, and the observation of the patient become, for the first time in history, exclusively under medical control. This process of medical professionalisation, which primarily took place in the second half of the nineteenth century, marks the beginning of a new era of medical self-understanding. We will call it the Phase of Normality, as it defines, until today, the ideal type of the medical profession.

Phase 2: normality

Whereas the fight to establish rational, scientific arguments marked the phase of struggle for the professionalisation of medicine, at the beginning of the twentieth century there is a strong belief in scientific, and thereby, societal progress. The control of nature and the world through the identification and application of (natural-) scientific laws in a Weberian sense dominated societal discourses. In societal circumstances like these, the medical profession no longer had to legitimate its focus on scientific knowledge. Instead, it represented a societal knowledge elite. The idea that all illnesses can potentially be cured if the human organism is completely understood, perfectly matched the zeitgeist.

Scientification and the heroic doctor

Ferdinand Sauerbruch, born in 1875, was probably one of the most famous physicians of his time and is still the prototype of the heroic surgeon. His autobiography helps us shape the ideal type of this period's image of a doctor, which is strongly influenced by an awareness of their unique position in modern society, shaped not at least by doctoral self-descriptions like this one:

> There were more such possibilities but there was always danger for the lung and the like for
> the human. One had to find a means to operate on the thorax without the described dangers.
> This was a problem concerning all of mankind. (Sauerbruch, [1951] 1979, p. 48)

We do not observe a simple doctor whose aim is to cure influenza or gastritis. We observe a man whose aim is to solve one of mankind's biggest medical problems. Until then, surgeons could not operate inside the patient's chest cavity. Under normal conditions, when opening the thorax the lung collapses due to the pressure-change, and the patient dies. Sauerbruch's idea was to construct a hypobaric chamber in which the thorax could be opened without risking a lung-collapse.

As the following quote shows, a doctor who experiments with such sophisticated and risky methods is no longer the family's doctor. Such a doctor refers to himself more as a soldier going to war against a mighty and anonymous aggressor who does not only threaten the patient in question, but also mankind in its entirety.

> As I went through the corridors of the clinic in order to get to the operation, everyone was
> tense and excited. People waved to me like to a soldier on his way to battle, a battle that
> concerns everybody. They followed me and as I came to the operating theatre I found this
> picture: my chamber stood lonely in the middle; all doctors who were not involved in the
> operation stood around it in a wide circle and waited for the things to come. Before I went into
> the glasshouse I felt the expectant tension of the auditorium. (Sauerbruch, [1951] 1979, p. 73)

So far, our descriptions point to a change in medical self-perception in which the organisational structure of medical care plays a crucial role. Without the adjustments in the health care system and the renovation of medical science mentioned previously, the self-image of Sauerbruch and his colleagues cannot be explained.

Hospitalisation creates a public setting for professional representation

In the beginning of the twentieth century the working conditions for doctors changed dramatically. The audience for medical activities was no longer a lay audience; the location of medical care was no longer the patient's home; and the benchmark for medical success was no longer just the healing of curable diseases, but the enlargement of medical possibilities as such. The relevant public was no longer the patient's family, but the public of other doctors.

We argue that only organisational settings that combine medical practice, scientifically oriented research and professional direction, supervision and concurrence provide the frame for a professional self-perception. The importance this organisational environment had in establishing doctors' professionalism can best be seen in cases of failure. In contrast to the many times Sauerbruch used the hypobaric chamber on dogs, the first attempt on a human patient failed. The woman's death was, at least at first glance, a defeat for the ambitious young surgeon. If we look more closely at the text, the defeat was not so much the death of the patient, but the failure of the method. The description of what happened after this operation is an excellent example of medicine's organisational aspects:

> When I came to the privy councillor[vi] late at night, he explained to me what he thought: Any
> struggle for a new surgical field has claimed its victims, this will not be different in the field of
> thoracic surgery. The final aim, life for tens of thousands of patients struck by pulmonary
> tuberculosis, justifies our actions. (Sauerbruch, [1951] 1979, p. 76)

In this phase the clinician is primarily surrounded by his peers. Contact with patients and their relatives is reduced to a minimum, whereas doctors are constantly in contact with colleagues who share the same professional background. The crucial difference is that, only within an environment that shares the same patterns of cultural interpretation, a new medical self-understanding can be established as legitimized form. Surely, not every physician was a Sauerbruch. The majority of physicians did not work in hospitals. However, through professional modes of education, new medical knowledge and techniques, as well as the self-perception and –description, in the form of the professional medical habits, spilt over to private practices. We want to stress the importance of semantic figures of narrating the doctoral self for these transformation processes. A new professional self-perception as heroes or 'demigods in white' characterised by narratives of feasibility and progress not only reflected but also shaped the new societal and organisational situation.

Phase 3: crisis and recovery

From the late 1960s onwards, the image of the heroic, paternalistic doctor disintegrates. Societal change, status and the self-image of the professionals as well as transformations in the organisation of healthcare are closely connected. This can be seen not at least in sociologies perspective on medicine and doctoral professionalism which shifts its focus from functionalistic approaches, which centre on the societal role of professions (see for example Marshall, 1939; Parsons, 1951; Merton, 1957, 1958) to interactionistic approaches (see for examples Glaser & Strauss, 1965; Strauss et al., 1964; Roth, 1963). Societal acceptance of hierarchies and social asymmetries continually declines. The year of 1968 symbolically marks a shift also in the medical field. Democratisation and everyone's right to critique becomes legitimate in the field of politics, in families, between genders, and also in the medical field. Ironically, the triumph of public critique, which focused on all kinds of societal elites, was an effect of the professional project. As mentioned previously, the classic professions played an important role in the implementation of rationality as a dominant societal discourse. In effect, the substitution of social status ascribed by birth through social status with one that depends on merits in a specific field came back like a boomerang to professionals, especially to the doctors. Accepted once as a basic principle for decision-making, rationality cannot be limited to special persons. And so, the door for critique is open and cannot be closed by further argument only (see Atzeni & Mayr, 2014; Nassehi, 2010; Nassehi, Saake & Mayr, 2008). One can say that there is a pluralisation of societal valid rationalities, which in effect lead to a de-validation of the single rationality.

Significant areas of medical sociology and the sociology of the professions are interested in how these societal and organisational ideologies affect the medical profession. Commonly, de-professionalisation is diagnosed albeit with different foci. This crisis of medical professionalism is referred to with concepts like autonomy of the patient, professionalisation of paramedical occupations, ethics and managerialism.

Sociological studies seem to match the diagnosis. Three major topics pointing to processes of de-professionalisation of doctors can be identified: First, attempts to control the doctors externally, especially restrictions by new forms of economic control of healthcare but also regulations on doctors' (continuing) education are interpreted as signs of a loss of doctors' autonomy (Armstrong, 2007; Haug, 1976, 1988; Pfadenhauer, 2005; Vogd, 2002). Second, a change in the doctors' 'audience' is observed and interpreted as loss of authority. More specifically, intentions to professionalise other professional groups, e.g. nurses, midwifes, within the hospital (Bollinger & Hohl, 1981; Larkin, 1983) as well as patients claiming more autonomy and revolting against medical paternalism (Britten, 2001; Gerhards, 2001; Haug & Sussmann, 1969) are identified as important agents in this process. Last but not least, the increasing significance of modern organisations and new concepts of management in the healthcare sector (Ackroyd, 1996; Dent, 2003; Llewellyn, 2001; Starr, 1982; Ritzer & Walczak, 1998; Vogd, 2005, 2006) all seem to align perfectly with the thesis of doctors' de-professionalisation.

Critique and the emergence of the concept of an autonomous patient

Our professional self-descriptions under these changed societal circumstances also show these new aspects, which we tend to interpret as signs of a crisis in doctors' self-perception, but not automatically as signs of de-professionalisation. Autobiographies during this time period begin to reflect extensively on the doctor's place in medicine and society which is no longer self-evident as in the autobiographies of Sauerbruch's time. Other paramedical professions come into sight; not only as subordinate co-workers, but as critics and rivals. Patients now become relevant not only as 'working material' but as autonomous persons. Finally, the autobiographers reflect on different, often conflicting, public and organisational expectations towards themselves. Accordingly, the focus of the descriptions and the semantics slowly shifts. What comes into sight is a critical audience, consisting of patients who cannot be simply reduced to ill bodies, as well as other professional groups, like psychotherapists in this example, who apparently claim responsibility and define power for at least parts of the process in the patient's rehabilitation. What is new here is not the fact that doctors are dependent on others for the running of medical practices in hospitals, but that these others claim to be visible as stakeholders.

The figure around which psychotherapists, nurses and patient representatives as new stakeholders can formulate their claims is the patient. In the autobiographies, it is exactly here where one can not only observe a more explicit reference to other professional groups in the hospital, but also a striking turn to the individual patient's fate:

> The progress in the field of intensive care also leads to new questions in the field of morality
> and ethics. For example: is it legitimate to extract, with approval of the patient's relatives,
> organs like the heart in order to transplant them? At what point in time? – Today, "braindeath"

is the accepted decisive factor in many countries. […] When the diagnosis "braindeath" is drawn correctly and without doubt, the situation of the patient concerned is hopeless, death is inevitable. This authorizes us to stop life prolonging measures. […] But are we authorised to explant the still beating heart for transplantation? In fact, from the viewpoint of morality it is not the same to stop life prolonging artificial respiration (passive) than to actively intervene by explanting organs, even if both actions have the same effect, namely, perhaps – but not for sure – a quickening of the metaphysical process of dying, a pre-drawing of the actual death of the person. The metaphysical meaning of death implies the separation of the immortal soul and the non-eternal body (Plato, Christianity), a process which can not be determined empirically and which can't be fixed in time. I personally have approved organ transplantation on basis of braindeath diagnosis. We hazard the possibility/risk to fail in sense of morality or ethics but: We do not harm anyone considerably (included the donor). For the organ recipient the transplantation is indispensable to life. If we would say no, this would be his death sentence. This would be a much bigger moral risk, a bigger mistake. We are facing a moral dilemma but we must not and cannot avoid it and wash our hands in innocence. Every doctor has to take the responsibility alone. But nonetheless I have checked with common moral theologians. (e.g. with the professors Dr. H. J. Münk and Abbé P. Laroche). (Probst, 1998, pp. 149-150)

What change in organisational and societal expectations to medical practice can be taken into account to explain such a shift in medical self-perception and -description? Apparently, the authoritative doctor is no longer the (only) legitimate source of medical decision-making; there are outside expectations from a critical public who questions the doctor's legitimacy to decide on his own. Patients, relatives, other professional groups inside and outside the medical sector and also the media join in the process of decision making by posing uncomfortable questions and articulating reasons from other perspectives. Doctors' autobiographies from this period mirror the irritation and show beginnings of new semantic forms of dealing with these irritations. The autobiographers struggle with the new critical audience – on the one hand it is no longer possible to neglect the *voluntas aegroti* completely, on the other hand they have to be balanced against medical reasons.

The will of the individual patient as key element in legitimizing doctoral actions

But gradually, the discussion of such issues becomes an integral part of doctors' autobiographies, not least by mentioning specific patients and their stories. Subtle modifications in the narrating mode permit the sketch of a new professional self-image by integrating different perspectives into the doctor's history. This is why we prefer an interpretation, differing from the de-professionalisation topos. We focus not only on the fundamental change in the doctor's status in the system of organised medicine, but also on how doctors handle the modified expectations by adopting new semantic forms of narrating their professional self. The most obvious change is that the typical autobiographical narration focuses on concrete descriptions of individual patients. Our analysis identifies the articulation of the will of the individual patient as the key element in how doctors themselves legitimise their actions. One example is taken from the autobiography of Wilhelm Queißer, born in 1936, who dedicates a big part of his autobiography to the memory of a patient representative who fought for a stronger position of patients in relation to their doctors:

I remember very well when Mrs. Ursula Schmidt called me in spring 1977 and informed me about her plan [to establish a self-help society for breast cancer patients, G. A., V. G.] and to ask me for a personal interview. […] She was a rather small, slim person, who fascinated me nonetheless by her frank and forthright way approach to people. Due to her liveliness she won her conversational partner at once, reaching the essential immediately and explained her concern without extended introduction. She was extraordinarily intelligent, sophisticated and very charismatic. In our first conversation she explained her ideas without further delay, which was to replace the traditional authority of the doctor by a cooperative relation of doctor and patient, wherein also the patient could formulate his wishes freely. She advocated the "informed patient". For me, she was one of the strongest personalities I had the chance to get to know during my professional life. (Queißer, 2001, p. 298)

In Sauerbruch's description, the doctor (and his peers) is the only protagonist. In newer autobiographies more and more patients as individual persons are spotlighted. In the example from Wilhelm Queißer's autobiography, one can see how by introducing the patient as an actual autonomous subject, new forms of semantics find their way into the self-descriptions of doctors. The 'informed patient' or the 'cooperative relation of doctor and patient' are no longer seen as threats to doctors' professionalism but open up new legitimate forms of professional self-description and thereby new forms of legitimate professional practices. This result is surprising, as the self-descriptions of medical professionalism have always pointed to the recovery of the individual patient. The neglect of the patient as an individual is one of the most common approaches used to criticise the medical profession. Our sociological perspective, which interrelates individual, societal, and organisational structures, can show that self-descriptions which point to the patient-doctor relationship, and thus to the semantic of the individual patient and its recovery, have only very recently affected the activities of doctors.

The flexible nature of professionalism

In contrast to the diagnosis of de-professionalisation, which parts of the sociology of the profession see in the changed and still changing treatment of individual patients and in new power constellations between doctors, other medical professionals and patients, our thesis is that these findings are a hint at an extremely powerful resource of the medical profession – as Ellen Kuhlmann puts it – at the "highly flexible nature of professionalism" (2006, p. 609) rather than to its decline or the loss of importance of the doctor's influence in medical decision-making. The semantic of the individual patient is not only the catalyst for the crisis of professionalism, but also for its recovery. We believe that the power of medical professionalism lies exactly in the capability to refer to, and shape, new social or organisational expectations in the mode of these expectations. This flexibility is the core of professionalism. Our empirical findings illustrate that this ability does not question professional autonomy, but helps to adapt it to new societal expectations.

Again, the following quote from Queißers autobiography gives an insight as to why the preoccupation with patients plays such a crucial role for narrating medical professionalism nowadays. This last example illustrates how, by allying with critical, mature patients, the doctor can retain or regain control of the defining power of what is medically right and wrong:

> Very soon the two of us built a sort of team supporting each other. She had various requests,
> not only principal questions, but her concern was also about single patients in her group. She
> looked for my advice in order to get appropriate references for events for the self-help-group
> […] In the beginning, the group was very open to alternative medicine. My effort was to get
> them off that track with the necessary caution. (Queißer, 2001, p. 298)

The doctor here, in adopting the expectations of a new kind of audience, the autonomous patient, and transferring them into the medical rationale is a perfect example for our idea of professionalism. This does not mean that in every single case of a doctor-patient encounter the doctor defines the situation alone or that he is the only one to decide what to do (This would probably not even be true for Sauerbruch's era). We refer here only to the level of narrating professionalism that is to say on legitimation strategies. But as we showed in our theoretical reflections above, those semantic changes do not leave actual practices unaffected. We argue that by adopting the patient's and others' perspective, the crisis of medical professionalism is recovered. Here, recovery does not mean the reinstallation of a former status quo, which we saw in the Phase of Normality. Instead, recovery means a continual process of dealing with different perspectives. Ethics committees, institutional review boards and the like can be seen as organisational locations in which this permanent recovery through the focus on the individual patient's recovery is institutionalised.

Conclusions

In analysing doctors' autobiographies, we identified three forms of narrating professionalism. The first form is the form of struggle, where doctors' professionalism emerges as parallel to the emergence of rationality as a societal ideology. The second form is the Phase of Normality, where the scientifically orientated doctor is unquestioned. We call this the Phase of Normality because the ideal type of medical doctor, as we currently refer to it in sociological analysis, as well as in our everyday image of a doctor, is constituted. It is in the third phase where this ideal image cracks. Accordingly, the third form of narrating professionalism that we identified in the autobiographies is the Phase of Crisis and Recovery. Whereas the autobiographical descriptions of the crisis perfectly match the sociological analyses suggesting de-professionalisation, the autobiographies reveal a different picture concerning the status of professionalism. Though the

new and often conflicting external expectations are experienced as quite crisis-laden, doctors develop a professional mode to recover from this crisis. The well-being and will of the individual patient are the key elements for the recovery of professional narration. Medical and scientific progress, serving an abstract patient or humankind as a whole, is central to professional self-descriptions. However, the patient-doctor relationship also becomes a crucial point for narrating the professional self-understanding of doctors. The doctor, as an individual, cares for an individual patient. The emphasis on the patient's individuality and his explicit will (re)legitimates the professional work vis-à-vis his critics. This is surprising in so far as one could believe that this relationship would have always been the most important point for medical practice. But only in a period of critique does this relationship have to be established as an element of professional self-understanding.

During the time period when societal ideology has changed from rationality as a central value, to autonomy and authenticity as central values, doctors' professionalism recovered by switching to these values. In this sense, we do not interpret the loss of an absolute autonomy with reference to medical-scientific knowledge as a loss of professionalism. Instead, we see doctors' professionalism in the way doctors react to, and moreover affect, societal changes.

In the context of modern Western culture, where individualism, autonomy and authenticity are central values, a semantic shift to the will of the individual patient cannot be interpreted as a sign of de-professionalisation. Quite the contrary: the adaptation of these central values as key-narratives of professionalism is a sign of the flexible nature of professionalism (Kuhlmann, 2006) which is one of the reasons for the unquestioned importance of modern medicine in the Western world. The shift in how professionalism is narrated shows that apart from specific criteria, such as scientific knowledge or an absolute autonomy, a peculiar way of dealing with societal expectations is the key element of professionalism. Thereby, we argue that the adjustment in professionalism is understood only by linking this change to changing social expectations, which are always incorporated in narrations in professionalism. The recent Ebola epidemic in Sierra Leone, Guinea and Liberia sadly illustrates our assumptions. The observation, that people infected with Ebola flee from the Western doctors or that relatives hide Ebola patients from them shows what happens, when modern Western medical practice does not fit to social expectations. We do not value these reactions as irrational. In contrast, this example shows that a concept of doctoral professionalism is inevitably interlinked with specific societal forms of treating the problem. Doctoral professionalism in our understanding can not be reduced to knowledge, skills, social status or power but is dependent on a socially legitimate narratives.

Particular attention should be paid to the role of organisations, as the organisational level has been of crucial importance for doctoral professionalism since its beginnings. Doctors' professionalism could only emerge at a time when the practice of doctors is embedded in organisational structures. Therefore, organisational practice is the nucleus of medical professionalism. The same is true for the critique of doctors' professionalism. It is in organisations where doctors are under surveillance from a critical mass of co-workers, where economic affordances directly affect medical practice, where medicine is exposed to permanent observation by a critical public and the media. It is in organisations where (narrative) professional modes of adapting to and shaping, the new situation are born.

References

Ackroyd, S. (1996). Organization contra organizations: Professions and organizational change in the United Kingdom. Organization Studies, 17 (4), 599-621.

Ackroyd, S., Kirkpatrick, I., & Walker, R. M. (2007). Public management reform in the UK and its consequences for professional organization: A comparative analysis. Public Administration, 85 (1), 9-26.

Åkerstrøm Andersen, N. (2003). Discursive Analytical Strategies: Understanding Foucault, Koselleck, Laclau, Luhmannn. Bristol, England: The Policy Press.

Åkerstrøm Andersen, N. (2011). Conceptual history and the diagnostics of the present. Management & Organizational History, 6 (3), 248-267.

Allsop, J., & Jones, K. (2006). The regulation of health care professions: Towards greater partnership between the state, professions and citizens in the UK. Knowledge, Work & Society, 4 (1), 35-57.

Alvesson, M. (2000). Social identity and the problem of loyalty in knowledge-intensive companies. Journal of Management Studies, 37 (8), 1101-1124.

Alvesson, M., & Kärreman, D. (2000). Taking the linguistic turn in organizational research: Challenges, responses, consequences. The Journal of Applied Behavioral Science, 36 (2), 136-58.

Alvesson, M., & Willmott, H (2002). Identity regulation as organizational control: Producing the appropriate individual. Journal of Management Studies, 39 (5), 619-644.

Anwar, P., & v. Düffel (2013). Geschichten vom Sterben [Stories of dying]. München, Germany: Piper Verlag.

Armstrong, D. (2007). Professionalism, indeterminacy and the EBM Project. Bio Societies, 2, 73-84.

Atzeni, G. (2016). Professionelles Erwartungsmanagement. Zur Soziologischen Bedeutung des Arzt-Narrativs [Professional Expectation-Management. The Sociological Meaning of the Doctors Narrarive]. Baden-Baden, Germany: Nomos.

Atzeni, G., & Mayr, K. (2014). Ethische Expertise. Ethikkommissionen und Klinische Ethikkomitees als Räume ethischer Rede. [Ethical expertise. Ethics commissions and healthcare ethics commitees as spaces of ethical talk]. In A. Nassehi, I. Saake, & J. Siri (Eds.), Ethik, Normen, Werte: Studien zu einer Gesellschaft der Gegenwarten [Ethics, norms, values: Studies on a society of presents], forthcoming. Wiesbaden, Germany: VS-Verlag.

Bleif, M. (2013). Krebs: Die unsterbliche Krankheit [Cancer. The immortal illness]. Stuttgart, Germany: Klett-Cotta.

Boje, D. M. (2008). Storytelling organizations. Thousand Oaks, CA: Sage.

Bollinger, H., & Hohl, J. (1981). Auf dem Weg von der Profession zum Beruf. Zur Deprofessionalisierung des Ärztestandes. [On the way from profession to occupation: On the de-professionalisation of doctors] Soziale Welt, 32 (4), 440-464.

Britten, N. (2001). Prescribing and the defence of clinical autonomy. Sociology of Health & Illness, 23 (4), 478-496.

Brock, D. M., Powell, M. J., & Hinings, C. R. (2001). Restructuring the Professional Organization: Accounting, Health Care and Law. London, England: Routledge.

Brown, A. D. (2001). Organization studies and identity: Towards a research agenda. Human Relations, 54 (1), 113-121.

Brunner, O., Conze, W., & Koselleck, R. (1972). Geschichtliche Grundegriffe: Historisches Lexikon zur politisch-sozialen Sprache in Deutschland [Historical basic concepts, Historical lexicon of the political and social language in Germany]. Stuttgart, Germany: Klett-Cotta.

Brunsson, N. (2002). The organization of hypocrisy: Talk, decisions and actions in organizations. Oslo, Norway: Copenhagen Business Press.

Carr-Saunders, A. M., & Wilson, P. A. ([1933] 1964). The professions. Oxford, England: Clarendon Press.

Churchill, L. R. (2007). The hegemony of money: Commercialism and professionalism in American medicine. Cambridge Quarterly of Healthcare Ethics, 16, 407-414. doi:10.1017/S0963180107070508.

Cogan, M. L. (1955). The problem of defining a profession. Annals of the American Academy of Political and Social Sciences, 297, 105-111.

Currie, G., Finn, R., & Graham, M. (2009). Progesional competition and modernizing the clinical workforce in the NHS. Work Employment & Society, 23 (2), 267-284.

Czarniawska, B. (1997). Narrating the organization: Dramas of institutional identity. Chicago, IL, London, England: The University of Chicago Press.

Dezalay, Y. (1995). 'Turf battles' or 'class struggles': The internationalization of the market for the market for expertise in the 'Professional Society'. Accounting, Organizations and Society, 20 (5), 331-344.

Dent, M. (2003). Remodelling hospitals and health professions in Europe: Medicine, nursing and the state. Basingstoke, England: Palgrave Macmillan.

Evetts, J. (2003). The sociological analysis of professionalism. Occupational change in the modern world. International Sociology, 18 (2), 395-415.

Fins, J. J. (2007). Commercialism in the clinic: Finding balance in medical professionalism. Cambridge Quarterly of Healthcare Ethics, 16, 425-432. doi:10.1017/S0963180107070533.

Foucault, M. (1974). The order of things. London, England: Routledge.

Foucault, M. (1976). Mental illness and psychology. Berkeley, LA: University of California Press.

Foucault, M. ([1976] 1994). The birth of the clinic: An archaeology of medical perception. New York, NY: Vintage Books.

Foucault, M. (1998). The will to knowledge. Vol. 2 of The History of Sexuality. Harmondsworth, England: Penguin.

Fournier, V. (1999). The appeal to 'Professionalism' as a disciplinary mechanism. Social Review, 47 (2), 280-307.

Freidson, E. (1970). Professional dominance: The social structure of medical care. New York, NY: Atherton Press.

Freidson, E. (2001). Professionalism: The third logic. Chicago, IL: University of Chicago Press.

Freidson, E. (2006). Professional dominance: The social structure of medical care. New Brunswick/London, England: Transaction Publishers.

Gabriel, Y. (2000). Storrytelling in organizations: Facts, fictions, fantasies. Oxford, England: Oxford University Press.

Gerhards, J. (2001). Der Aufstand des Publikums. Eine systemtheoretische Interpretation des Kulturwandels in Deutschland zwischen 1960 und 1989. [The revolt of the audience: A systems theoretical interpretation of transculturation in Germany between 1960 and 1989] Zeitschrift für Soziologie, 30 (3), 163-184.

Glaser, B. G., & Strauss, A. (1965): Interaktion mit Sterbenden: Beobachtungen für Ärzte, Schwestern, Seelsorger und Angehörige [Awareness of dying: Observations for doctors, nurses, chaplains and relatives]. Göttingen, Germany: H. Huber.

Goode, W. J. (1972). Professionen und die Gesellschaft: Die Struktur ihrer Beziehungen. [Professions and society. The structure of their relation] In T. Luckmann, & W. M. Sprondell (Eds.), Berufssoziologie [Sociology of occupation], (pp. 157-168). Köln, Germany: Kiepenheuer & Witsch.

Greenwood, E. (1957). Attributes of a profession. Social Work, 2 (3): 45-55.

Haug, M. R., & M. B. Sussman (1969). Professional autonomy and the revolt of the client. Social Problems, 17 (2), 153-161.

Haug, M. R. (1976). The erosion of professional authority: A cross-cultural inquiry in the case of the physician. The Milibank Quarterly, 54 (1), 83-106.

Haug, M. R. (1988). A re-examination of the hypothesis of physician deprofesssionalization. The Milibank Quarterly, 66 (2), 48-56.

Henkel, A. (2013). Geneaology of the pharmacon: new conditions for the social management of the extraordinary. Management & Organizational History, 8 (3), 262-276.

Hughes, E. C. (1963). Men and their work. London, England: Free Press.

Keshavjee, S. (2004): Medicine and money: the ethical transformation of medical practice. Medical Education, 38, 3, 271–275.

Kieserling, A. (1998). Zur Lage der Profession zwischen Interaktion, Organisation und Gesellschaft. [On the situation of profession between interaction, organization and society]. In A. Brosziewski, & C. Maeder (Eds.), Organisation und Profession [Organization and Profession], (pp. 63-72). Rorschach, St. Gallen, Switzerland.

Kirkpatrick, I., Ackroyd, S., & Walker, R. (2005). The new managerialism and public service professions. Basingstoke, England: Palgrave Macmillan.

Klatetzki, T., & Tacke, V. (eds.) (2005). Organisation und Profession [Organization and Profession]. Wiesbaden, Germany: VS Verlag.

Kornberger, M., Clegg, S. R., & Carter, C. (2006). Rethinking the polyphonic organization: Managing as discursive practice. Scandinavian Journal of Management, 22, 3–30.

Koslowski, L. (2001). Chirurgie 1945 bis 2000: Ein Weg durch viele Schulen [Surgery 1945 to 2000: On a way through many schools]. Stuttgart, Germany: Schattauer.

Koselleck, R. (1982). Begriffsgeschichte and social history. Economy and Society, 11 (4), 409-427.

Kuhlmann, E. (2006). Traces of doubt and sources of trust: Health professions in an uncertain society. Current Sociology, 54 (4), 607-620.

Kussmaul, A. (1903). Aus meiner Dozentenzeit in Heidelberg [From my time as a lecturer in Heidelberg]. Stuttgart, Germany: A. Bonz.

Lachmund, J., & Stollberg, G. (1995). Patientenwelten. Krankheit und Medizin vom späten 18. bis zum frühen 20. Jahrhundert im Spiegel von Autobiographien [The worlds of patients: Illness and medicine from the late 18th to the early 20th Century in the light of patients autobiographies]. Opladen, Germany: Westdeutscher Verlag.

Lachmund, J., & Stollberg, G. (2012). Der Arzt, sein Publikum und die Deutung der Krankheit: Das Drama der medizinischen Praxis im 18. und frühen 19. Jahrhundert. [The Doctor, his audience and the interpretation of ilness: The drama of medical practice in the 18th and early 19th Century]. In W. Bruchhausen, & C. Kaiser (Eds.), Szenen des Erstkontakts zwischen Arzt und Patienten [Scenes of first contact between doctor and patient], (pp. 23-40). Bonn, Germany: Bonn University Press.

Laclau, E., & Mouffe, C. (1985). Hegemony and Socialist Strategy. London, England: Verso.

Larkin, G. (1983). Occupational monopoly and modern medicine. London, England: Tavistock.

Larson, M. S. (1977). The rise of professionalism: A sociological analysis. Berkeley, LA: University of California Press.

Llewellyn, S. (2001). 'Two-Way Windows': Clinicians as medical managers. Organization Studies, 22 (4), 593-623.

Luhmann, N. (1983). Medizin und Gesellschaftstheorie. [Medicine and theory of society] Medizin, Mensch, Gesellschaft, 8, 168-175.

Luhmann, N. (1996). Social systems. Palo Alto, CA: Stanford University Press.

Luhmann, N. (1997). Die Gesellschaft der Gesellschaft [Society of society]. Frankfurt am Main, Germany: Suhrkamp.

Luhmann, N. ([1980] 2004). Gesellschaftsstruktur und Semantik 1: Studien zur Wissenssoziologie der modernen Gesllschaft [Social structure and semantics 1: Studies on sociology of knowledge]. Frankfurt am Main, Germany: Suhrkamp.

Marshall, T. H. (1939): The recent history of professionalism in relation to social structure and social policy. The Canadian Journal of Economics and Political Science 5(3), 325-340.

Merton, R. K. (1957): Some preliminaries to a sociology of medical education. In Merton, R. K., Reader, G. C., & Kendall, P. (Eds.), The student-physician (pp. 3-79). Cambridge, MA: Harvard University Press.

Merton, R. K. (1958): The functions of the professional association. The American Journal of Nursing 58(1), 50-54.

Muhr, S. L. (2012). Strangers in familiar places – Using generic spaces in cross-cultural identity work. Culture and Organization, 18 (1), 51-68.

Müller, F. v. (1951). Lebenserinnerungen [Memories of life]. München, Germany: J. F. Lehmann.

Nassehi, A. (2006). Der soziologische Diskurs der Moderne [The sociological discurse of modernity]. Frankfurt am Main, Germany: Suhrkamp.

Nassehi, A. (2010). Asymmetrien als Problem und als Lösung. [Asymmetries as problem and as solution] In B. Fateh-Moghadam, S. Sellmaier, & W. Vossenkuhl (Eds.), Grenzen des Paternalismus [Borders of paternalism], (pp. 341-356). Stuttgart, Germany: Kohlhammer.

Nassehi, A., Saake, I., & Mayr, K. (2008). Healthcare ethics comitees without function? Locations and forms of ethical speech in a ‚Society of Presents'. In B. Katz Rothman, E. M. Armstrong, & R. Tiger (Eds.), Bioethical Issues, Sociological Perspectives, (pp. 131-158). Oxford, England, Amsterdam, Netherlands, San Diego, CA: Elsevier.

Nielsen, A. J., Knudsen, M., & Finke, K. (2003). Expansive or limitative strategy? A case study of organisational responses to new public health. Journal of Health Organization and Management, 22 (4), 384-399.

Noordegraaf, M. (2011). Risky business: How professionals and professional fields (must) deal with organizational issues. Organization Studies, 32 (10), 1349-1371.

Parsons, T. (1951). The social system. Toronto, Ontario, Canada: Collier-Macmillan.

Paquette, J. (2013). Storytelling, organizations, and the coherent self: The chronotope of childhood in professional life histories. Culture and Organization 19 (2), 146-161.

Perkin, H. (1989). The rise of professional society. England since 1880. London, England: Routledge.

Pfadenhauer, M. (2005). De-Professionalisierung durch Lernkulturalisierung: Zur Herausforderung des medizinischen Standes durch Life Long Learning. [De-Professionalisation through culturalisation of learning: On the challenges of the medical stand throug life long learning] In H. Bollinger, & A. Gerlach (Eds.), Gesundheitsberufe im Wandel: Soziologische Beobachtungen und Interpretationen [Changing health care occupations: Sociological observations and interpretations], (pp. 207-221). Frankfurt am Main, Germany: Mabuse-Verlag.

Probst, C. (1998). Unterwegs als Neurochirurg: Erinnerungen, Deutungen, Ausblicke, Hoffnung [On my way as a neurosurgeon: Memories, interpretations, prospects, hope]. Stein am Rein, Germany: Christiana Verlag.

Queißer, W. (2001). Biographische Notizen: das Leben eines Arztes und Internistischen Onkologen [Biographical notes: the live of a doctor and internist]. München, Germany: W. Zuckschwerdt.

Rehn, J. (1997). Erlebte Chirurgie [Lived surgery]. Landsberg am Lech, Germany: ecomed.

Rennison, B (2007). Historical discourses of public management in Denmark: Past emergence and present challenge. Management & Organizational History, 2 (1), 2-26.

Riemann, G. (Ed.) (2003). Doing Biographical Research, Thematic Issue. Forum Qualitative Sozialforschung/Social Research (FQS), 4 (3).

Ritzer, G., & Walczak, W. (1988). Rationalization and the Deprofessionalization of Physicians. Social Forces, 67 (1), 1-22.

Roth, J. A. (1963): Timetables: Structuring the passage of time in hospital treatment and other careers. Indianapolis, IN: Bobbs-Merrill.

Sauerbruch, F. ([1979] 1951). Das war mein Leben [This was my life]. München, Germany: Kindler.

Starr, P. (1982). The social transformation of American medicine. New York, NY: Basic Books.

Stichweh, R. (1996). Professionen in einer funktional differenzierten Gesellschaft. [Professions in a functionally differentiated society] In A. Combe, & W. Helsper (Eds.), Pädagogische Professionalität: Untersuchungen zum Typus pädagogischen Handelns [Paedagogic professionality: Studies on the type of padeagogic action], (pp. 49-69). Frankfurt am Main, Germany: Suhrkamp.

Stichweh, R. (1997). Professions in modern society. International Review of Sociology, 7 (1), 95-102.

Stichweh, R. (2000). Professionen im System der modernen Gesellschaft. [Professions in the system of modern society] In R. Merten (Ed.) Systemtheorie sozialer Arbeit: neue Ansätze und veränderte Perspektiven [Systems theory and social work: New approaches and changed perspectives], (pp. 29-38). Opladen, Germany: VS Verlag.

Stichweh, R. (2005). Wissen und die Professionen in einer Organisationsgesellschaft. [Knowledge and the professions in a society of organisations] In T. Klatetzki, and V. Tacke (Eds.), Organisation und Profession [Organisation and profession], (pp. 31-44). Wiesbaden, Germany: VS Verlag.

Stichweh, R. (2008). Professionen in einer funktional differenzierten Gesellschaft. [Professions in a functionally differentiated society] In I. Saake, & W. Vogd (Eds.), Moderne Mythen der Medizin. Studien zu Problemen der organisierten Medizin [Myths of modern medicine. Studies on the problem of organised medicine], (pp. 392-444). Wiesbaden, Germany: VS Verlag.

Strauss, A., et al. (1964): The hospital and its negotiated order. In E. Freidson (Eds.), The hospital in modern society (pp. 147-169). New York, NY: The Free Press.

Strauss, A. (1978). Negotiations. Varieties, contexts, processes and social order. San Francisco, CA, Washington, DC, London, England: Jossey-Bass Publication.

Swick, H. M. (2000). Toward a normative definition of medical professionalism. Academic Medicine, 75 (6), 612-616.

Vachhani, S. J. (2007). The death of a salesman? An exploration into the discursive production of sales identities. Culture and Organization, 12 (3), 249-264.

Vogd, W. (2002). Professionalisierungsschub oder Auflösung ärztlicher Autonomie: Die Bedeutung von Evidence Based Medicine und der neuen funktionalen Eliten in der Medizin aus system- und interaktionstheoretischer Perspektive. [A push to professionlism or breakup of doctors autonomy: The meaning of evidence based medicine and of new functional elites in medicine from a systems- and interaktions theory perspective] Zeitschrift für Soziologie, 31 (4), 294-315.

Vogd, W. (2005). Führt die Evolution moderner Organisationen zu einem Bedeutungsverlust der Professionen? Untersuchungen zum medizinischen Feld. [Does the evolution of modern organisations lead to the professions loss of importance? Studies on the medical field] In H. Bollinger, A. Gerlach, & M. Pfadenhauer (Eds.), Gesundheitsberufe im Wandel: Soziologische Beobachtungen und Interpretationen [Changing healthcare occupations: Sociological observations and interpretations], (pp. 189-205). Frankfurt am Main, Germany: Mabuse-Verlag .Vogd, W. (2006). Verändern sich die Handlungsorientierungen von Krankenhausärzten unter den neuen organisatorischen und ökonomischen Rahmenbedingungen? Ergebnisse einer rekonstruktiven Längsschnittstudie. [Do the orientations for action of hospital doctors change due to new organisational and economic conditions? Findings of a reconstructive longitudinal study] Sozialer Sinn 7 (2), 197-229.

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[i] Esoteric world view, key figure in German tradition was Helena Blavatski, influenced by Indian religion, spirituality and philosophy.
[ii] Johann Nepomuk von Ringseis (*1785 ,† 1880).
[iii] Name for the historical epoch preceding the 1848 March-revolution.
[iv] The itch mite is a very small parasite, not visible for the eye, that makes burrows into the host's skin. This leads to allergic reactions.
[v] We stick here to the masculine form, as doctors in this time were exclusively male.
[vi] Privy councillor (Geheimrat) von Miculicz was Sauerbruchs teacher and boss at the time of his rise to one of the most famous doctors of his time.