The dark side of professions – the role of professional autonomy in creating 'great professional disasters'

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Draft version. Comments welcome!

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The Dark Side of Professional Autonomy

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The Problem: When and how can professional autonomy lead to a “professional disaster?”

This paper aims to discuss the role of professional autonomy in a different light than is usually done by focusing on the “the dark side of the professions”. Autonomy is usually seen as a necessary and defining characteristic of professional work, beneficial for the professions and their clients and customers as well as for society. Deprofessionalization is for example often operationalized as a loss of autonomy. A high degree of autonomy for a given profession can, under certain conditions, lead to problematic and even tragic outcomes for individuals who are recipients (and in some cases victims) of actions undertaken by members of a well established profession. I will define and describe such instances as “professional disasters”. These can occur when professionals are doing their best, applying the standard scientific knowledge of the profession. Under what social and organizational conditions is the class of actions likely to occur?

What is of primary interest here are not cases of sloppy work or fateful mistakes, produced by a transgression of professional ethics, by misuse of professional power etc. Some of these actions do belong to “the dark side of the professions” but are dealt with by employers, courts and the internal regulative mechanisms of professional associations.

Professions – scientific knowledge and its relation to autonomy

The “bright side” of the professions – the standard assumption

Most of the scholarly work on professions focuses on their place in the social division of labour (Durkheim), their interrelations in a system of professions (Abbott 1988), their role in society and their role in applying scientific knowledge such as delivering socially useful services for the population and for society as a whole (Parsons 1939/1954). The presumption is that professions in this way perform socially useful tasks, within a complicated and intricate division of labour, by putting scientific knowledge to practical use: Professions deliver treatments and develop artefacts such as medicine, technology, organizational formulas etc by making effective use of scientific knowledge. This view of the professions can be summed up by the phrase “the bright side of the professions”.

Some scholars have focussed on the strategy of social closure, i.e. when professions monopolise certain tasks and positions as a means for to enhance their power, influence and monetary rewards (Sarfatti Larson 1977, Collins 1979, Brante 1988 among others). Although this “cynical” view of the professions has mobilised powerful arguments, the basic perspective on professions, developed by authors from Durkheim, Parsons and onwards still embrace a basically positive perception of professions and professional work.

Science and autonomy

The defining characteristic of a profession is that an occupational category or group who perform specific forms of knowledge work (for the relation between occupations and professions, cf. Hughes 1951, 1960, Abbott 1991). They use and apply not only knowledge in the broad sense of the word but specifically scientific knowledge. To qualify as a member of a
profession you have to undergo an intensive scientific training. They are bound by scientific modes of reasoning, and also by ethical prescriptions. The classical and archetypical professions – lawyers, physicians, psychiatrists etc - apply scientific knowledge in providing useful services for the population (or society) at large, or for important segments and groups in society as a whole.

Other occupations, often labelled semi-proessions, strive for recognition of their group as a full “profession”, e.g. teachers (from preschool to high-school level), nurses, social workers, Human resource personnel, etc. They do this by e.g. developing links to the production of knowledge in the expanding university and university college sector. These occupational groups are often linked to new scientific disciplines: social workers to social work, nurses to nursing science etc. Occupational groups en route to professionalization do this for several purposes. They want to increase or at least to defend their salaries, prestige, defend their traditional work tasks, and they will fight for new and more highly valued tasks.

These ambitions, existing as a fact among the well-established professions and as goal for those occupational groups hoping to attain professional status, can be summed up in a demand for more “autonomy”, thereby increasing

- the control that an occupational group has over their work tasks and procedures,
- the manoeuvring space and the autonomy of the individual member of the group in relation to bureaucratic and political decision-makers in complex work settings
- the autonomy (and hence the uncontested power) of a professional in relation to the demands of clients and customers.

The argument for a profession to achieve and claim autonomy is first and foremost the argument that as an delimited occupational group it has access to specific forms of competence based on specific forms of (esoteric and scientific) knowledge. The scientific basis of the profession makes its monopoly in handling certain tasks legitimate. It is also a key argument for demanding autonomy for the professional in his or her execution of tasks.²

In most societies the autonomy of professions are under attack. In some cases computerized techniques become so well developed that many judgements and decisions in practice are built into the procedures and programmes. This has become the case for accountants but increasingly also for medical personnel. Professional autonomy is also affected by new and intricate forms of control and payment-per-procedure techniques, e.g. for physicians in US as well as Sweden.³

From mistakes to disasters

Handling mistakes – protecting autonomy

Professions are not infallible, nor are their members white angels. Certain kinds of mistakes, misuses and transgressions are the same as those performed by members of other occupations, e.g. common forms of criminal offences and misdemeanour.

² The role of scientific training, the role of exams, as well as the licensing of tasks to specific occupational/professional categories, are well known aspects of professions.

³ See papers by Evetts, Divall, Dupuis, Forsberg et.al, Hoffman, Meiksins and Watson, Ovretveit, Ten Have and Terhart.
Members of an occupation have different levels of capability and precision in their work. Plumbers and carpenters can perform good and qualified as well as incompetent and shoddy work. The same is true for members of professions. Dentists can fail to detect and appropriately treat a patient’s sore teeth, surgeons can do fatal mistakes when operating on a patient, nurses can mix up the tubes of different gases that should reach a patient etc.

Occupational training intends to minimise these things from occurring. Licensing and guarantees are modes of ensuring quality work and protecting the customer from the consequences of occupational incompetence and mistakes. However, lawyers and accountants may be fraudulent in relation to their customers and clients. Members of all sorts of occupations, incl. the professions, can cheat the customer by jacking up the bills and charging too much for services or products they have rendered, in relation to social standards and promises given.

Certain forms of misuse do not fall within the category of shoddy work, mistakes and fraudulent behaviour etc. Instead they are related to the power differential between a person pursuing his/her work and the subordinated person who is the object of their work. The space for these forms of misuse of power is due to the asymmetric power relations inherent in specific job situations. Proper rules of conduct are transgressed when teachers are mean to children in schools or when prison guards and wardens in mental hospitals are violent toward the inmates in their care or under their supervision. Psychotherapists have been found out seducing their patients. Teachers, whether in high school or universities have not always been immune to the temptations of their pupils’ or students’ flesh.

These different kinds of misuse, fraudulent behaviour and mistakes can occur in many occupations, including the professions. They are not the exclusive privilege for members of professions and therefore not specific for professions. Fraud, shoddy and incompetent work, misuse of knowledge, procedures or authority - are all forms of actions that professional groups and their associations want to minimise, either through their own jurisdiction and/or by the help and support of the state.

One reason why professions want to stop and punish such actions is that they may lead to harmful consequences for their clients, customers, patients etc. Furthermore these kinds of actions undertaken by members of professions undermine the prestige of a profession as well as its claim for autonomy and non-interference in its affairs by external bodies. Professional groups as well as the State have developed procedures and mechanisms for regulating and licensing specific kinds of tasks and forms of work to specifically defined and qualified groups. They have developed mechanisms for controlling the quality of work of the professions as well as procedures to disbar members of a professions from their work and hence their incomes when they do not follow the rules, or perform their tasks badly, etc.

Common forms of fraud, misuse and mistakes have a prominent place in the criticism of professional groups. They are a cause for the demands from the political and administrative sphere trying to get control of the work and the procedures of professional work. Procedures of self-regulation and self-discipline are developed by professional associations in order to buttress the legitimacy of their autonomy. Professional associations are therefore eager to limit embarrassing mistakes committed by members of the profession. Those who commit such actions are to be controlled and even if nothing else helps, excluded from the profession. Even if exclusion rarely occurs, the formal possibility is still important, for the public as well as for the profession. Disciplinary measures are carried out through the regulating instances of the state and through the internal regulative mechanisms that exist within the professional
associations. The demands of the regulating State and the profession itself are fused into a common set of conditions for attaining legitimate status as a professional through exams, diplomas, accreditation etc.

We have a number of cases where members of solid professions have committed harmful actions. Some aspects of this murky side of professional power have been identified with the concepts of misuse of professional power (e.g. when a patient dies due to maltreatment etc) or by simple mistakes (doctors prescribing the wrong medicine, nurses getting the wrong gas into the tubes because the wrong connection was made etc). Bad training and low professional standards produce these varieties of aberrations.

Professional power has been misused under the dictates of political and bureaucratic power – political psychiatry in the Soviet Union belongs to this category. Then members of the same profession in other countries protested. Physicians and medical researchers have surpassed their formal professional powers and ethical rules, e.g. in Nazi Germany. Experiments were performed on prisoners in concentration camps, producing solid and useful results, but under deeply unethical conditions. Sometimes doctors participated in ethically even more problematic events, such as the Euthanasia projects in Germany (see Mann 2005).

Efficient handling of these forms of actions with harmful consequences, either in the form of proactive measures, such as training, licensing, or thorough disciplinary measures meted out after the fact are two key mechanisms for upholding the legitimacy of the professions. Efficient handling of this kind of mistakes in fact stabilizes the legitimacy of a profession.

The specific character of the professional “accident” or “professional disaster”

This analytical focus of this paper is a specific category of actions undertaken by well-established professions, the professional disaster. A first criterion is that these should have harmful consequences for individuals, groups or society. The harmful effects of those actions we discussed above were caused by fraud, misuse of authority, mistakes and incompetent work. But not all actions with harmful effects have those causes.

Actions of professionals which we define as falling in the category of professional accidents/disasters are undertaken in good faith by bona fide members of a professional group are doing their best, following acknowledged professional standards in their work. The basis for these, treatments and procedures follow from applying recognized scientific theories.

There are several examples of this type of phenomena. Many medical experiments and damaging treatments seem to fall in the category of “professional disasters”. This ranges from experiments in which human beings were exposed to radioactivity in the 1950s to experimental drug tests now going on all over the world. Below I will discuss in more detail one case from neuro-psychiatry. But this kind of phenomenon is not limited to the medical field. We have a number of examples in other areas, in different professions with different scientific bases for their claim to autonomy. The introduction and career of the theory of sets as a foundation for teaching children mathematics in Swedish primary schools can be interpreted as a professional disaster. The same can be said about the emergence of a crucial new category in accounting, the concept of “embedded value” which led to the catastrophes of the Enron Company in US and Skandia in UK and Sweden. Due to the advice and power of professionals and scientists in plant biology new species have been introduced in Swedish forests (fur trees from Canada as well as the Carpathian region), rivers and lakes (crayfish), which have
led to problematic outcomes. In the sphere of social work, treatment of drug abuse etc, new forms of treatment have been foisted upon the poor and the needy, following the professional advice, based on the scientific theories of the day.

**A professional disaster - the rise and fall of lobotomy**

Here I will discuss one specific case of a “professional disasters”, the rise and fall of prefrontal lobotomy as a psychosurgical practice between the mid 1930s and the end of the 1950s. I will discuss the existing medico-historical studies of this treatment to test the argument that professional autonomy was an important precondition for the emergence of this ultimate form invasive psycho-chirurgy. This case will be used to develop an analytical space for the concept of “professional disaster”.

The well-documented history of *the rise and fall of lobotomy* in the US and in Scandinavia fulfils many of the conditions for a “professional disaster”. Given a number of medico-historical scholarly as well as more popular publications we can follow how this treatment emerged, in which institutional settings it became anchored and practised, how it was linked to a rising subspecialty in a professional field, how it spread, how it became scientifically sanctioned.

This treatment and operating technique was scientifically consecrated with a Nobel prize in 1949, a mere fourteen years after having been thrust upon the world in a spectacular and dramatic way. (cf. Stolt 1999) In the mid 1950s this treatment became gradually assigned to oblivion, having been made superfluous by new, effective pharmaceutical treatments.

From the 1960s onwards, lobotomy operations gradually became a symbol of unfettered and irresponsible medical power, of how the psychiatric profession handled powerless patients in overcrowded mental hospitals. In 1962 Ken Kesey’s novel *One flew over the cuckoo’s nest* was published. In the mid 1970s Milos Forman made a successful and emotionally gripping movie based on the Kesey novel. Lobotomy was the treatment that took the spark of life from the rebellious hero of the film.

After an intense public debate the Norwegian government organised a fact-finding public commission in the 1990s to investigate the practice and prevalence of prefrontal lobotomies in the Norwegian mental hospitals. Since the hospitals in Norway are public institutions the government was ready to carry the responsibility for the operations that the psychiatrists and brain specialists had performed *en masse*. The government accepted the burden of responsibility for the damages inflicted upon the patients. It also accepted to compensate the patients for the sufferings the operations had led to. (cf. NOU 1993, Tranøy 2001, Tranøy 1991, 1999)

Since the Norwegian government accepted the responsibility for the damages that the operations had caused lobotomy can be regarded as a “professional disaster” in a strict sense – that

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4 Cf. Masiero for the history of lobotomy in Brazil and Zalashik & Davidovitch on its history in Palestine/Israel.

5 “Just a generation ago, other confident investigators were heralding invasive somatic therapies like prefrontal lobotomy to treat psychiatric illness. *That era of psychosurgery ended with widespread condemnation, congressional calls for a ban, and avow that history should never repeat itself.*” (Fins 2003). “This procedure eventually became widespread and applied to thousands of institutionalized, psychotic patients in the United States and other countries. Despite serious side effects associated with psychosurgery, *the apparent importance and validity* of the treatment was recognized in 1949 when Moniz received the Nobel Prize for his innovation. Psychosurgery was largely replaced by anti-psychotic drugs in the mid-1950s, and the procedure and its practitioners *rapidly fell into disrepute.*” (Tierney 2000) (my italics)
is as actions performed as bona fide professional actors, based on solid science, in good faith but having decidedly harmful effects. Members of the Parliament have demanded a public excuse to Swedish patients who had been subjected to lobotomy, but the Swedish government has not followed the Norwegian pattern.6

The period when lobotomies were performed was rather short. From the birth and emergence to the consecration of this operation technique it only took 14 years. From its zenith of fame in 1949 to its disgrace and downfall in the mid to late 1950s the period was even shorter.

My key question in retelling the lobotomy story is the crucial role of professional autonomy for it to be possible at all – from its basis in science and its role in overcoming the resistance of its opponents. It has to be understood in the broader framework of how it was made possible and effective through a specific institutional order, the large and regularly overcrowded mental hospitals, characterized by an asymmetrical power relation between those who performed the operations and those who were operated upon, between the psychiatrists, neurologists and the patients.

The career of lobotomy
The short and dramatic history of lobotomy has been told in a number of books and articles. The titles of three books about the subject focus on the dramatic and dark aspects of the procedure. In 1986 Valenstein published his book Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness. In 1997 Jack Pressman published his book Last Resort: Psychosurgery and the Limits of Medicine with its detailed and complex analysis of how the use and acceptance of lobotomy can be understood and interpreted. In 2002 Roger Whitaker published a critical work with the telling title Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill, with a long chapter on lobotomy.7 The Norwegian, Swedish and Scandinavian situation regarding lobotomy are dealt with in the works of Tranoy (1992, 1993, 1999, 2005), the articles of Lidberg (Lidberg 1996, 1997), the dissertation by Ögren (2005) and the report made by a Norwegian commission on lobotomy (NOU 1993).

What lobotomy is
Lobotomy is a specific, localised and rather simple form of brain surgery, where the connections between different halves in the brain are cut off and some of the brain tissue destroyed. The technique was symbolised by the specific instrument that was developed to cut out of the tissues that linked emotions and behaviour. The operation was seen a means to help patients who were experiencing deep anguish, constantly suffering from their condition, coming to the fore in violent and extrovert behaviour. In some women there were cases of a compulsive and libidinous sexuality. It was basically seen as a technique that could and should only be used in “the last resort”, as Pressman aptly calls it.

The prehistory of lobotomy is filled by cases of accidental discoveries. A well-known incident involves a man who by accident got a hot iron rod penetrating his head and brain, but who nevertheless survived. It was noticed that his personality changed dramatically – he became mild and even dull in his temperament. Other similar effects were discovered in people who survived extensive demolition of their brains during the First World War. Early experiments

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6 A careful study of the archives of one hospital in Sweden has been published – see Ögren 2005. Ögren’s research is used as an argument by Swedish MPs.

7 Edward Shorter gave a much more understanding interpretation of the lobotomy episode in a chapter devoted to it his treatise A History of Psychiatry: From the Era of the Asylum to the Age of Prozac from 1997.
were also carried out on patients and inmates, but the death rate among them was unacceptable.

Then in the mid 1930s a Portuguese physician and professor, Moniz, launched the discovery of the lobotomy techniques by publishing a series of six well-orchestrated articles in European medical journals. He was inspired by the demonstration of a brain surgery that had transformed the behaviour of chimpanzees – they became much calmer and well adapted. This happened at an international conference in the mid 1930s. The priority of discovery was generally acknowledged to belong to Moniz and in 1949 he was accorded a Nobel Prize for his discovery.

Moniz brought the technique and the treatment into the world. However the technique was used, perfected and found scientific acknowledgment in the US, through the active and diligent work of Walter Freeman. (cf. the biography by Elhai 2005) Pressman analyses how this technique and operation was made legitimate and effective in the American medical and university system. Pressman shows that Freeman, far from being the maverick outsider, entered the medical hierarchy from an advantageous position with the strong support of key members of the medical establishment in the US (such as a key professor and dean at Yale university).

The lobotomy technique spread rapidly – but not uniformly – within US, not least due to the efforts of Freeman and his associates. Articles appeared in the scientific journals, the message spread through conferences. It was also propagated and made known as a good solution for the hopelessly mentally ill in the media, esp. through the quality daily and weekly press. It seemed as if the treatment was a success story. Many patients became calmer and many could leave the mental wars (although a large number seem to have died during the operation).

Many observers noted however that there was a specific drift in the way the personality changed. It was summarized by the observation that who had been lobotomised had lost “the spark of life”, reduced to living vegetables as some critics said.

This operation technique (and the diagnosis as well as theory associated with it) was soon adopted in other countries with similar problems of a large population of very sick and patients in the steadily growing population of inmates in the mental hospitals. The Swedish and Norwegian cases show very clearly that the acceptance of the techniques had to start at the top of the medical hierarchy. If the leading doctor, responsible for a mental hospital was positive, then it was introduced. In many case, in US well as in Scandinavia, many hospitals, and even wards within large mental hospitals did not use the technique if the commanding physician had a negative view of lobotomy.

_How lobotomy became successful_

The autonomy of the not so highly regarded psychiatric subprofession was anchored in the scientific prestige of the broader medical profession. The scientifically based claim for autonomy was in this case combined with the rising sub-profession and its specific mandate and its “power to cure”.

Through the large public mental hospitals that had grown enormously during the preceding decades this sub-profession had a double access to organizationally mediated power – through their scientifically based claim for autonomous decision-making in relation to care and treatments and through its institutionally based managerial power. These psychiatrists could act as both psychiatrists and heads of hospitals or hospital departments in relation to a
class in inmates and patients with no voice of their own. This is very clear in e.g. the Norwegian Gaustad hospital in Oslo. Here the lobotomy treatment was applied on large scale for a long time. (cf. NOU, Tranøy). These two factors made the spread of this psycho-chirurgical technique and its solid *alloy of a theory and a specific clinical practice* successful for a period of time.

The lobotomy treatment was efficient in the sense of decreasing chaos in the mental hospitals—those lobotomized became much calmer. The mental hospitals had grown enormously in the post-WW1 period. Problems with personnel and costs were rising. The cost-efficiency argument was an extra bonus for the sub-profession. Treatment was cheap for the hospitals. At the same time this treatment could increase both the prestige and the incomes of the members of the sub-profession.

There were doubts about this kind of knowledge and professional treatment all the way through its career. It was strongly resisted by the psychoanalytically oriented psychiatrists. Against these opponents the rising psycho-surgical subprofession could mobilize the biological-surgical solution as an ally in their discursive conflict with the “mentalists”. “Real science” had the upper hand in this conflict. During the interwar period the curing of the mentally ill was also redefined as their ability to adapt to society and/or its institutions. Adaptation became a key goal for treatment. (cf. Pressman 1997).

Many psychiatrists in US and in Scandinavia did not practice or recommend lobotomy for their patients. This was the case not only for the psychoanalytically oriented psychiatrist. However, once the leading psychiatrist in a hospital were won over this opened the door for the spread and use of lobotomy. This happened in the hierarchical world of Scandinavian psychiatry. Key figures in Oslo, Copenhagen and Stockholm shared a positive evaluation of the lobotomy treatment. The hierarchy of power in the world of mental hospitals made the selective entry of lobotomy possible, as rule through the decision of one man.

The spread and public success of this treatment was effectively propagated in the popular press. This was the case not only in the US – quality dailies and weeklies - but also in countries such as Norway and Sweden. (Cf. Tranøy 1992, Ögren, El-hai, Diefembach et.al.)

How did criticism eventually emerge? Slowly there emerged evaluations of the cure that did not show any substantiated success, rather the reverse. Standards of evaluation rose gradually in the medical and clinical research. Critical, well-publicized cases slowly began to be known. Well-known figures such as the Swedish artist Sigrid Hjertén died on the operation table. The operation on Rosemary Kennedy in the early 1940s was not a success, etc.

Lobotomy was the most radical of the invasive psycho-surgeries developed in the interwar period (insulin treatment, electro-shock etc). Lobotomy was more definitive in its consequences than the electro shock treatment (ECT). Lobotomy had in the desperate situation of chaos and institutional lack of order, lack of money and personnel resources the advantage of making some of the most unruly patients more passive and obedient rather unruly and demanding. Given the size of the inmate population and the size of hospitals this demand for more order from the hospital staff can be understood

In the early 1950s more rigorous and systematic evaluation of lobotomy began to accumulate. Evaluations of the operation showed that the treatment had much more mixed effects than
earlier proponents had argued. Increasingly, the massive and tragic losses of human capacities were observed among the patients.

However, lobotomy was not defeated by its opponents and their criticisms. Even if it was shown to be a treatment with limited positive effects and at the same time had very serious consequences for the lives of those affected it nonetheless worked for some patients. It became possible for some patients to move out of the mental hospitals, even if – as was often said – lobotomy eliminated “the spark of life” from those who underwent the treatment.

In the early and mid 1950s the chemical revolution came to the treatment of psychic disorders. In 1954 the new potent drug of chlorpromazine was accepted by the Food and Drug administration in USA. The new drugs rapidly changed the landscape of treatment for severe psychic disorders. The new drugs came rapidly into use in the years from the mid 1950s. From the later half of the 1950s these new drugs rapidly phased out the lobotomy as a treatment.

Conclusion: Autonomy and the dark side of the profession – elements of a general model

How can we now proceed to develop a more general analysis of “the dark side of the professions” from our discussion of the lobotomy case and sketch a conceptual space for analysing the “dark side of professionalism”? As a first step in building a model of the “the professional disaster” we should combine different dimensions or properties of the professions, constructed as variables, that are conducive for the emergence of the professional disasters

Variations in the degree of autonomy
In the case of lobotomy we can safely say that the large degree of autonomy of the psychiatric profession was a key factor leading to a “professional catastrophe”. The degree and basis of the autonomy for a profession, esp. the trust and prestige accorded the scientific basis of the profession the degree to which the prescriptions, treatments and procedures put in practice by the profession have their basis in these scientific theories and when the profession itself is the judge of the validity of the scientific results

On the other hand we find situations where a low or nonexistent level of autonomy leads to problematic results. The case of political psychiatry in the Soviet Union is a case in point. Here the political and administrative pressures were overpowering. In other cases we find a professions giving in to moral and political pressures also in democratic societies, e.g. relation to efficient drug treatment programs (e.g. methadone treatments, cf. Johnsson 2003, 2005)

Variations in the scientific basis of the profession
Different professions build their bid for power, prestige and rewards on different systems of thought. Some have hard, codified sciences as their basis while for others the theoretical baggage consists of loose amalgams of thought elements. Natural science and social work may be two extremes here. This difference in the scientific basis for the autonomy seems to lead to different forms of catastrophes and disasters – as well as to different forms of successes.

Variations in access to organizationally mediated power and social influence
Some professions have broad access to “intervention power”, while others have either a more diffuse influence or access only to marginal power locations. In order to map these conditions we should first consider the access to organized institutional power of the profession and its
power to implement its knowledge and procedures with little questioning and resistance from other social actors. Sometimes a profession has a direct “cognitive” access to decision-making bodies (e.g., to politicians in the State, managers in firms or banks, reform bureaucracies influencing changes in public administration etc). Secondly, the power differential between professional practitioners and those subjected to the prescriptions and procedures (existence of a captive audience or population) differs a lot. Which strength do the clients, patients or customers have? Thirdly, the degree to which the practice of professions is set in motion in hierarchical organizational contexts and the character of this hierarchy

*Variation in the stratification of professions*
There is usually an asymmetrical distribution of power within a profession. The influence may rest on the scientific status and position (a division between those developing the scientific basis, the standards and procedures within a profession compared to those who apply them). There is also a stratification of power in the professional associations, where some groups influence the way the professions develops over time,

The limits and possibilities of professional expertise and power are not only those exercised by a profession in relation to its clients, customers and patients. These limits are also set by the influence and power of other social forces, such as the administrators of organisations, the political decision-makers and the limits for professional autonomy set by economic limits and the market and efficiency logics. (Cf. Eliot Freidson 1994, 2001, 1999)

*Varying structure of the context of a profession - inside and outside the system of professions*

The degree of visibility for inspection and control from the outside (public authorities, concerned citizens etc) varies among professions. A high degree of autonomy protects the practices of the profession from being made visible or controlled; instead we have a closed space for applying professional skills and judgements. The barriers for control and insight depend on the specific institutional embeddedness of professional practices as well as the kind of persons or processes involved.

Does a profession have organizational power to override questioning and resistance from other social actors within the institutions and organizations where the profession functions? And does it have power and autonomy enough to override or quell criticism and questioning from actors outside the organisations where the professional power is exerted?

The controlling elements in the context of a given profession are either other professions or forces outside the system of professions. Professionals are not only working in relation to administrators, employers and state officials – they are increasingly working in multi-professional settings. The system of professions that exist in a given field, or around a certain area or problem, set forces in motion that tend to limit the sphere of autonomy for a given profession. Some years ago Lone Scocozza showed that the political level had large problems in regulating medical experiments through the system of medico-ethical committees in Denmark. The medical profession came easily to dominate these committees, due to their professional standing, expertise and status. The most effective countervailing power to the medical profession was not politicians or administrators, but representatives of another profession, in the case the law (Scocozza 1994). This finding thus points to the key role of professions balancing and controlling each other.
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