International Journal of Applied Sociology 2019, 9(2): 31-35
DOI: 10.5923/j.ijas.20190902.01

The Sociological Foundations of Caring Relationship: Some Annotations for Healthcare Professionalism

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Abstract The categorical imperative of the service, which includes the commitment to maintain the highest possible level of competence and the fundamental orientation towards the community interest rather than towards the individual interest, the system of recognitions (economic and status) and the high degree of self-control of behavior through internalized ethical codes, distinguishes a profession from a generic occupation. Wanting to transpose the above connotations to the health professions, it must first of all be remembered that the acquisition of social importance of a value such as health goes hand in hand with the birth of a "vehicle" for this value, or of an organized category of professionals who claim jurisdiction. This paper proposes a brief reflection on the contribution of sociology discipline to consolidation of a renewed professional awareness increasingly oriented towards the development of a holistic approach to patient and, with this, to the inter-professional processes of sharing care.

Keywords Health, Health Profession, Care Relationship, Symbolic Interactionism

1. Introduction

The current epidemiological scenario and the development of new cultural paradigms based on the organizational and management flexibility of the health sector represent characteristic and distinctive elements of a process of radical professional renewal. Increasingly, and in various forms, this renovation urges health professionals to test and adjust contingent but adequate intervention plans to changes and recommends the acquisition of knowledge and the development of "transversal" skills, not exclusively reducible to the technical-specialist level.

In effect: the affirmation of the concepts of "autonomy" and "centrality" of the patient to guarantee effective and efficient assistance actions; the abatement of self-referential diagnostic and therapeutic models; the passage from the logic of medicalization to that bi-directional of the "participatory" intervention by the patient, warn health personnel to take health and illness interpretative codes, borrowed from the social sciences, from the perspective of interdisciplinarity.

Limiting health professional competence to the therapeutic area only through learning and offering experimental methodologies and techniques, protocols and validation of evidences involves, in fact, the risk of non-compliance with a "latent" social demand which, by now, asks the professional not only healing but trust, sense and quality of life.

Instead, expanding the conceptual boundaries of biomedical sciences to a multidimensional cognitive and operational horizon means facing and satisfying that structurally complex question, weighting "fuzzy" variables, more or less controllable but dynamically interacting such as subjectivity, cultural, emotional and relational components of well-being, essential for the person treated and, often, for the same efficacy of care.

Indeed, the multidimensional approach responds to the need to deal with complex needs not simply whit "performance"; it satisfies the need for customization of the help process avoiding predefined or standardized paths; it changes professional culture by overcoming the "mechanical" and sectoral organization of care activities; it redefines the role of different professional skills by reducing the conflicts and obstacles typical of the professional hierarchy; it allows an "integrated" and shared supply of the service to health; it goes beyond the representation of a system that, traditionally based on monocratic and "isolated" professional figures, has been transformed into a "horizontal" organization aimed at coordinating functional and managerial profiles towards the same objective (the answer to health needs); it increases the decision-making autonomy and the responsibility of each professional.

On the other hand, the essence of professionalism lies precisely in the dynamic interweaving of specialist

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Published online at http://journal.sapub.org/ijas

knowledge and the ability to devise effective treatment plans by drawing on several disciplines.

It is increasingly evident that the efficient rationality of a clinical intervention that exclusively refers to the "body" and "pathology" is not always effective in terms of educational and social rehabilitation of the patient: openness to "other" reflections, knowledge and epistemologies is an added value of professionalism and therefore arises as a mandatory requirement. Ensuring that treatment plans and assessments are focused on the person rather than on the etiological components of the disease means intervening with respect to certain priorities (patient preferences) urging the health staff to continuously review the activities.

The sick person is the only person capable of attributing "meaning" to the act of care and cannot be reduced to objectifications: in this "strong" affirmation the meaning of a real qualification of the professionalism more appropriate to the peculiarity of the expectations of an "allied" patient and no longer delegating is perhaps enclosed.

The care response that derives from this, therefore, involves a highly complex negotiation and social networking process that involves, at different contractual levels, different disciplinary and "naives" knowledge. Starting from these premises, this document aims to contribute to the reflection on the characteristics of healthcare professionalism, highlighting, at the same time, an intrinsic sociological foundation referable to the symbolic-interactionist rooting of the care relationship.

2. The Healthcare Profession: Elements for a Definition

The recognition of the competence, relevance and sphere of action typical of the health professions, takes place in parallel with the evolution of the social representations of health historically elaborated in a register that from the purely organic (health conceived as absence of illness) goes to the combination of psychological and socio-cultural factors for well-being.

Parallel to the conception of illness as a form of life is the transformation of the care activity connoted by the sociologist Strauss [1] as “work on the trajectory of the disease”. It refers not only to the evolution of the patient's illness on the physiological level but also to the whole organization of the work employed to follow his course, as well as to the return effect that this work and its organization do not fail to have on all those involved in it.

The consideration of Strauss is particularly important also for the purposes of developing systems for continuous improvement of the quality of the service provided. Beyond the purely clinical aspects, in fact, it is not only the patient who evaluates the health treatment, the procedures and the level of effectiveness of the interventions received but also all the different stakeholders of the health organization. In fact, the satisfaction of the end user is a function of the quality level of the various exchange relationships, relevant to the effects of the final result achieved, developed within the organization between each operator and the beneficiaries.

In this perspective, therefore, the health profession can be defined as a work activity of recognized social utility, carried out by individuals who have acquired a specialized competence following a long course of study and aimed primarily at this purpose in sectors closely related to central values for survival and the balance of society as a whole. Implicit in this definition is the attribution of autonomy and responsibility to the professional; he must constantly strive to guarantee the "seriousness" and the continuous qualitative improvement of the performances also in the interest of the users.

The studies produced on the subject oscillate between classification hypotheses and new interpretative categories tending to overcome the merely descriptive analysis of the professions. The former are aimed at capturing the organic combination of characteristic features, such as adherence to a service ideal, the aforementioned establishment of a base of specific knowledge acquired through specific and certifiable training courses, the development of forms of dissemination of information and comparison of theories and practices, the birth and consolidation of associative forms (colleges, orders, associations), the definition of rules of conduct, of ethical codes and, more generally, of a professional ethic. The latter, instead, aim to identify the "essence" of professionalism in the specific and complex ways of "collegial control" of specialized occupations. This takes place in more or less complete forms and above all is not defined once and for all but constitutes a balance always subject to adjustments or tensions.

This statement is particularly important (and we will have a chance to reflect on it soon with the analysis of the evolution of health professions) for the professions that aspire to the growth, transmission and refinement of their specific knowledge and are oriented to the development of identity, shared values and evaluation systems of non-arbitrary, incompetent or incorrect practices, but firmly anchored to the consensus of professional communities. In fact, the regulatory revolution that accompanied the process of professionalisation for health professions is symptomatic of the social recognition of the importance of activities previously considered as secondary and auxiliary to the medical one. The regulatory provisions actually outline a situation of greater flexibility in the interpretation of the roles and functions of each professional figure; it is more coherent with a reading in a historical-evolutionary sense of the health reality with particular regard to the specialization of the knowledge necessary to plan the assistance methodologically and to safeguard individual and collective health. Therefore, it is no longer the doctor who imparts, approves and controls the work of subjects subordinate to him and destined to the training and exercise of mere "tasks": from the "apprentice" of the Hippocratic corpus we pass to the professional who, as such, is autonomous and

can enjoy the special privilege of being free from control.

This privilege, recalls E. Freidson [2], is justified by at least three claims: "First and foremost it is argued that professional work involves such a high degree of skill and knowledge that those who are outside of it are not able to evaluate it or to regulate it … Secondly, professionals would be endowed with such a sense of responsibility and would do their job so conscientiously as to render any control superfluous ... Finally, on those rare occasions when a member of the profession does not prove competent and does not respect professional ethics, the profession itself will intervene and take action". The ownership and self-regulating capacity that the legislative provisions fully recognize in the health professions entails a necessary revision of the organization of care work, encouraging personalized assistance models based on a concrete operational autonomy, not comparable to the medical one but, indeed, with this decidedly integrated and complementary in order to identify the needs of the assisted person and guarantee a global and individualized intervention. The layered, hierarchical and pyramidal system, which delegated the mandate and responsibility to provide the health service to the medical profession alone, thus yields the step to a symmetrical organizational structure in which the physicians "align", on an equal footing, to other autonomous professionals in a consultative and collaborative perspective. So, the norms refer to the need for a more complete definition of the role and responsibility of the emerging health professions which, although differing in culture, training, history and specific field of action, all tend towards a common goal and are, therefore, interdependent.

3. Beyond Interaction: The Transactional Relationship

As well highlights Swick [3]: «The key to understanding medical professionalism is not to be found in a simple dictionary definition. Rather, the concept of medical professionalism must account for the nature of the medical profession and must be grounded in what physicians actually do and how they act, individually and collectively. Bearing this in mind, I assert that medical professionalism consists of those behaviors by which we - as physicians - demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients' and the public's good. Failure to demonstrate that we deserve that trust will result in its loss, and, hence, loss of medicine's status as a profession. Some might argue that humanistic values are not requisite to professional behavior, that a physician can exemplify professionalism without humanism. Yet values such as compassion, altruism, integrity, and trustworthiness are so central to the nature of the physician's work, no matter what form that work takes, that no physician can truly be effective without holding deeply such values». So, the normative definition of the activities that provide a public good such as health and embody values that include, among others, commitment to service, protection, altruism and respect for the patient and the patient collectivity, includes a set of behaviors that, traditionally ascribed only to the medical profession, are, in reality, common to those who work in the health sector. Among these, it should be remembered: the stipulation of a "social contract" with the community also through the knowledge of the non-biological determinants of health need, or of the psychological, economic, social and cultural factors that contribute to the development or incidence of illnesses; the constant expression of the "core value" that characterizes the practice of medicine (altruism, understanding, empathy, respect, trust, ...); the responsible exercise of the activity which is the foundation of professional autonomy; the continuous commitment to excellence through the constant acquisition of knowledge and the development of new skills; the dedication to advance research and increase the ability to decide on more effective care practices in unstable circumstances or in the presence of incomplete information; the ability to critically rethink the actions taken to solve patient problems. The realization of the right to health of every citizen passes, therefore, also through a process of improvement of the organizational and professional quality of the service called to guarantee that right and refers to a structure in which specialized groups interact and "re-negotiate" the limits of the their business.

This form of social relationship constantly engages the participants to define, establish, maintain and renew the tasks performed as well as the reciprocal relationships, in respect of the functions identified by the institutive norms of the relative professional profiles as well as by the specific deontological codes.

The resulting responsibility implies a precise commitment to play a constructive role and the ability to take on tasks independently that allow for a more effective fight against diseases and a more productive promotion of health. In this regard, Edwards *et al.* [4] speak of "shared care" or the inter-professional sharing of care: «Shared care requires the establishment of standards of care that are agreed by all those involved».

Indeed, although it is difficult to identify a single term to characterize the complexity of this collaborative process, the aim of the model is to aid communication and accessibility, and therefore bridge the gap between the service health providers and patients. Despite the term collaboration oversimplifies the multifaceted nature of the procedure, this approach involves multiple stakeholders in a complex process that provides a nexus for differing agendas, priorities, leadership styles, and negotiation strategies.

This model represents an attempt to systematize the role and functions of all the "actors" of a health process and highlights the importance of a multi-skilled team to complete the process of assessment and management of patient using a biopsychosocial approach. Realizing a joint care system means, in fact, coordinating the interventions of all those who work in the interest of the patient's health and the health

system's balance in the logic of sharing all the professional categories concerned.

Moreover, the participatory model and the integrated management of the health care profile most suitable for dealing with a given pathology and the verification of the sequence of interventions that can actually be provided have the great merit of shifting the attention of the professionals involved in the assistance, from the single benefit for which they are responsible, to the pathology as a whole. Attention is paid to the overall management of the patient, regardless of the individual, partial components in which the treatment of the same can be disarticulated. This approach aims at overcoming a fragmented and seamless mode of treatment and care, which would also be sterile with a view to the progressive rationalisation of the overall expenditure induced by diseases.

In a certain way, as Cox [5] says, this model «is tailored to each individual's need and taken at each person's pace. This may mean that information is covered in different speeds and in different environments. Information is used to support the discussion of aspects of patient lifestyle management. This "lifestyle management" does not represent a "cure" neither is it prescriptive or inflexible. The sufferer is the one who is able to cope with the illness».

The changes in level of cultural and social representations of health and disease, the consideration of the effects induced by medicalization as a condition of dependence on a "reparative" medicine, above all source of relational asymmetry and social distance between health professionals and the patient, passive actor and submissive of the infirmity, have led in various ways to the decline of the conception that the disease is a decodable reality only on the biological level and of the corresponding model of diagnosis-treatment inculcated, for decades, by contemporary medicine. The need to "look beyond" a fragmented body into a collection of physical symptoms, is the foundation of the so-called holistic patient approach. In this approach, the therapeutic treatment is not separated from the "take care of someone": the assistance is aimed both at the treatment of the disease, in order to avoid as much as possible the aggravation and complications, as to the help to the person to manage his wider context of life, often compromised by the pathology.

In fact, the recognition of the healthcare profession as a highly qualified activity with a strong social utility refers to the definitive release of the same from a biomedical, analytical, reductionist orientation and a merely "executive" performance. On the other hand, the notion of competence itself refers not to operational "training" but to the acquisition of cognitive, value, relational and educational skills: health personnel are aware of operating on a non-inert "matter" that is an active part of the healthcare organization, working in a "helping relationship" appropriate to achieving an optimal level of well-being. The effectiveness of this relationship is based on the recognition of the degree of autonomy and responsibility of the patient who must be involved in not paternalistic decision-making processes, characterized by the commitment to better mutual possibilities of expression, that favor both his well-being and the elimination of asymmetries and disparities of role.

For some time now, a substantial part of the theoretical paradigms of health assistance has adopted this perspective, interpersonal and interactionist that clearly draws on sociological sources. Said otherwise, the care relationship implies a re-balancing of the respective functions and is characterized, as Strauss states, as a "negotiation process" between active interlocutors in the therapeutic situation in which no one has, a priori, a definitive supremacy. While the majority of trades starts from the mutual "domestication" between man and matter, the care process begins from the interaction between subjects in possession of some elements of the process itself. It is a complex process of "action-explanation-interpretation" in which the different and complementary competencies of the subjects involved aims at enhancing the abilities and resources of each one.

Although implicit, the reference to the arguments borrowed from the sociological theories of symbolic interactionism is clear. So, professionals and patients acts toward care on the basis of the meanings they ascribe to it; the meaning of care is derived from, or arises out of, the social interaction that the professional has with patient and the society; the same meanings are handled in, and modified through, an interpretative process used by the professional and by patients in the clinical encounter [6].

Moreover, the act of care is built "step by step" during its development rather than being a simple "response" to a "stimulus" or the result of a choice between previously established or "a priori" alternatives. If this were not the case, the relationship between professional and patient would remain "trapped" within inevitable dysfunctional actions to the protection of the patient in the totality of his being.

4. Conclusions

As we have tried to show, the "dynamics" of the care relationship refers to a meaningful synthesis operated daily by the professionals between theory and practice. The professional competence cannot be reduced to a simple observable performance but is characterized as "contextualised" and strategic knowledge that continuously draws on the vital contexts of the patient and from these draws inspiraction for the theory, the research and the experimentation of new solutions for care. Subjecting the theoretical acquisitions of the professional to the scrutiny of operational effectiveness (especially with respect to the perceived quality of the service provided) represents an implicit component of a professionalism constantly oriented to problematize the therapeutic encounter: the person-patient "escapes" to a biomedical and reductively deterministic reading of a pathology that can only be managed therapeutically.

Certainly, it is a mere illusion to believe that we have understood the patient classifying him in a "clinical case" and including his discomfort in "neutral" and predisposed protocols. Moreover, an insensitive approach to the

meanings of the disease attributed and expressed by the patient is inevitably destined to increase the danger of affecting the transaction with professionals, fueling neutral and poorly productive exchanges at the level of consent and adherence to care. Hence the meaning of these brief notes: there is no doubt that the peculiarities and characteristics emerging from the "balance sheet" and from the "personal report" of the patient improve the implementation of the role traditionally ascribed to the professionals appointed to the service of health. The frequent references to attention to the quality of life of the patient and to the definition of health as "personal and social responsibility" are an important signal and are increasingly valid for guiding health practice.

The hope is that the correspondence and interpenetration of "finite provinces of meaning" [7], diametrically opposed to the paternalistic professional culture, increasingly characterize the commitment of professionals to the development of "sensitive" and really effective relationships to lead the patient to the highest levels of autonomy allowed by her conditions.

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