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Fighting the Enemy Within? Challenging Minor Principles of Professionalism in Care and Welfare

Abstract: Wilensky's seminal article on professionals mentions three identifying characteristics besides the familiar specialized knowledge, autonomy and professional ideology. These are the referral principle, which states that professionals should refer clients to a colleague with a different specialty if necessary, the principle of sloughing off, which dictates that professionals allocate less rewarding parts of their job to lesser paid assistants, and the principle of impersonal service delivery, which admonishes professionals to treat clients equally. A changing clientele in health care and social care warrants a reappraisal of these three principles. Population ageing necessitates a reappraisal in health care. The deinstitutionalization of people with psychiatric or mental disabilities necessitates a reappraisal in social care. Referral, sloughing off and impersonal service delivery are professional characteristics that concur with managerial or political objectives. Managers and politicians are partly responsible for their widespread application. Hence, professionals need their help to fight this "enemy within professionalism."

Keywords: Professionalism, principles of professionalism, Wilensky, new public management, health care, social care

In 1964 Harold Wilensky wrote a famous article entitled "The Professionalization of Everyone?", in which he reflects on the way various occupational groups use their technical expertise and moral norms to acquire the status of the profession. Wilensky discusses different types of knowledge that may or may not further professionalization and looks at threats and barriers along the way. In this article, we will use Wilensky, but not to discuss the fate of occupational groups on their way to professional status. We found in Wilensky's article six implicit "principles of professionalism"—three major ones and three minor ones. These principles serve as hooks for our analysis in this article.

The three major principles, specialized knowledge, the service ideal and professional autonomy, are also identified in other classical studies in the sociology of professions (e.g. Freidson, 2001) and have inspired a large body of literature. Part of this literature investigates professionalism from a "rise and fall" perspective, discussing how one or more professions gained or lost professional status. Another part depicts professions from a "war and peace" perspective, analysing how marketization and managerialism threaten professional autonomy or the service ideal of one or another profession.

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The three minor principles are: the *referral* principle ("refer clients to more competent colleagues"), the *sloughing off* principle ("allocate less difficult parts of the job to other, lower-level personnel"), and the principle of *impersonal* service delivery (professionals should display "little personal and emotional involvement"). In contrast to the three major principles, these minor ones are not at odds with market principles, managerial ideals or political objectives. Both managerialism and marketization reinforce these implicit dimensions of professionalism. However, as the clientele in care and welfare changes, these three minor principles have adverse consequences that need to be addressed. Hence, we will advocate the weakening of referral, sloughing off and impersonal care. Care and welfare professionals, as well as managers and policymakers, should focus on these principles to rethink professional practice.

In this article, we first briefly discuss the three major principles and the "rise and fall" and "war and peace" traditions in scholarly thought. We then discuss Wilensky's minor principles and show how they concur with managerial and political goals. After that, we outline the undesirable consequences of the three minor principles in present-day health care and social care. We also portray recent attempts to fight the deleterious consequences of referral, sloughing off and impersonal care. Finally, we will show why these attempts are fragile and difficult to sustain. We argue that the fight against the three minor principles should be a collective endeavour, to be undertaken by professionals, managers and policymakers, thus placing this article in the "peace" corner of the scholarly literature on professionals and managers.

Major principles of professionalism

The three defining major characteristics of professionalism in Wilensky (1964) are well-known to scholars of professionalism. Firstly, professionals have *specialized knowledge*. Secondly, professionals have a *service ideal*, an ethical code. Professionals do not seek to maximize profits; they use their knowledge to the benefit of their clients. Although critics have argued that the service ideal is a mere myth and that professionals are just as money-driven as everyone else (see, for example, Saks', 2016 account of the critical theories of professions), Wilensky posits that professions discourage mercenary students when they first apply for a place in the profession. Their service ideal appears to be genuine.

Thirdly, if professions succeed in establishing a knowledge claim and a service ideal, they may accomplish a large degree of *professional autonomy.*[1] Because of their specialized knowledge doctors, lawyers, or accountants are presumably the only ones who can judge the competence of other doctors, lawyers, or accountants. And because of their service ideal, they can be trusted to do so with the benefit of their clients or patients in mind.

Rise and fall

A large number of studies since 1964 used the three defining characteristics to determine whether occupations had acquired the status of a profession. Medicine, law and accountancy are long acknowledged professions (see, for example, Abel, 2004; Bloomfield, 1988; Lee, 1995; Starr, 1982). Social work, nursing, and teaching never acquired as much status and privilege and are often characterized as semi-professions (Etzioni, 1969; Svensson & Åström, 2013; Toren, 1972; Weiss-Gal & Welbourne, 2008). Researchers also studied the professionalization of the military (Trim, 2003); nursing (Keogh, 1997); child and youth care (Clarijs, 2013; Lochhead, 2001) and the clergy (Schilderman, 2005).

[1] Wilensky refers to "professional control" or "jurisdiction" rather than autonomy.

Other studies analysed processes of de-professionalization (for example Brooks, 2011). Haug (1975) foresaw that patients would gather ever more medical knowledge and insight. Thus, they would no longer have to rely on their physician's judgement: they might diagnose their own medical needs. This development could make many professionals superfluous in the long run. Decades later, Harshman, Gilsinan, Fisher, and Yaeger (2005) studied the impact of the internet on professionalism. They argue that, on the one hand, the internet may empower clients by giving them access to specialized knowledge that used to be a professional monopoly; on the other hand, the internet offers imposters ways to pose as professionals, hollowing out the public's trust in professional expertise.

War and peace

Many studies in the "fall part" of the "rise and fall" literature simultaneously adopt a "war and peace" perspective. They identify a villain—usually the market, or new public management (NPM)—and subsequently describe the decline of professions, as a result of actions performed or developments caused by the villain at issue. Thus, Dwarswaard, Hilhorst, and Trappenburg (2011) argue that medical professional ethics (Wilensky's service ideal) has changed, because of market elements in the Dutch health care. Ackroyd (2013) studied the advent of NPM in the UK in health, housing, education and social work, hypothesizing that resistance would be greater in highly professionalized health care than in lowly professionalized housing. Rogowski (2010) and Ferguson (2008) witnessed a de-professionalization of social work in the UK with regard to professional autonomy and its service ideal, caused by the advent of neoliberalism. The emphasis on targets, organizational values and consumer input decreased social workers' autonomy and their commitment to their profession. Krizova (2008, p. 111) argues that a decline of professional autonomy due to marketization might cause "a decrease in altruistic or service-oriented attitudes toward patients." Diefenbach (2009, p. 897) claims that NPM causes greater cost-awareness among professionals, which leads to a "deletion of activities that are not profit-making." In a seminal book on professionalism, Freidson (2001) argues that the professional logic is inherently different from the logic of the market and the logic of the state (bureaucracy).

In this part of the "war and peace" literature, professionals are portrayed as "victims" of "evil forces." However, the war and peace literature has representatives of a different persuasion as well. These authors point out that the relationship between professionals and managers is not a battle between right and wrong. Rather, both parties are driven by large-scale societal developments, which they cannot ignore or resist. A few examples of societal developments allow us to get the drift of the peace part of the literature:

- People have become highly educated and individualized. They do not accept professional authority as they did in the past.
- Computer technology changes lay people's access to information and thereby their contacts with professionals.
- Women's participation in the labour market is growing; hence professional work needs to become less demanding, as it has to be combined with family obligations.

According to peace authors, professionals have to adapt to large-scale developments, and this requires managerial capacities (Brandsen & Honingh, 2013; Evetts, 2009; 2011; Noordegraaf, 2007; 2013). Moreover, according to these "shades of grey" authors, professionalism has never been perfect in the first place; hence, a certain amount of de-professionalization might prove beneficial.

Whereas the first group of the war and peace authors usually urge politicians and managers to retrace their steps and make room for professional autonomy, the second group tends to advocate a truce. Professionals should give in and cooperate with

managers, so as to adapt to societal developments. Professional services, in the words of Noordegraaf (2013), should be "reconfigured, restratified, relocated, reorganized." Professionals, in the words of Evetts, must develop from "occupational professionals" to "organizational professionals" (Evetts, 2009; 2011). Professionals, in the words of Brandsen and Honingh (2013), need to organize in networks and develop networking skills. Professionals, in the words of Olakivi and Niska (2017), must draw from "a multiplicity of professional and managerial discourses."

These developments—the demise or reconfiguration of professionalism in relation to its major characteristics—have been discussed elsewhere (e.g., Carvalho, 2014; Duyvendak, Knijn, & Kremer, 2006; Noordegraaf & Steijn, 2013; Olakivi & Niska, 2017). In the next sections, we will look at Wilensky's minor principles and outline how they are affected by large-scale developments.

Minor principles of professionalism

The three minor characteristics are mentioned in passing, each in a different section of the 1964 article. The *referral principle*. Wilensky (1964, p. 141) is phrased as a command for professionals, essential for the maintenance of technical competence: "Be aware of the limited competence of your own specialty within the profession, honour the claims of other specialties, and be ready to refer clients to a more competent colleague."

The *sloughing off principle* (Wilensky, 1964) is described as a process that takes place while the profession seeks to define its core tasks:

> [a] pecking order of delegation occurs. The doctor allocates much of his job to less-trained nurses and laboratory and X-ray technicians; the nurses … allocate much of their less attractive work to practical nurses, aides, and nurse assistants; and these, in turn, allocate some of their chores to ward helpers. A similar tendency exists among all professional groups: dentists, teachers, engineers, scientists, and social workers, all of whom are … sloughing off their dirty work, that is, their less-technical or less-rewarding tasks. (Wilensky, 1964, p. 144)

Lastly, the principle of *impersonal service delivery* is described as a norm related to the service ideal:

> Supporting the service norm are several additional ideas which influence relations with clients and colleagues but which distinguish professional occupations in only minor degree. For instance, norms covering client relations dictate that the professional be impersonal and objective (limit the relationship to the technical task at hand, avoid emotional involvement) and impartial (not discriminate, give equal service regardless of personal sentiment). (Wilensky, 1964, p. 140)

Relevance and restrictions of minor principles

Neither of the three minor principles seems problematic for clients or citizens. If something is bothering you, you want to be helped by the right professional. If you happen to first meet someone whose field of expertise does not cover your illness, you will be glad that they will *refer* you to a professional with more expertise in the field. As for the *sloughing off* principle: although it might be attractive to be helped by just one professional, you understand that time is costly and that it is cost-effective to delegate easier tasks to the assistants of your professional. Regarding the norm of *impersonal and objective service delivery*: it seems reassuring that your professional will not refuse treatment because of your gender, your skin colour, or your personal morality. He does not care that you committed adultery, or behaved ill-mannered toward fellow drivers in rush hour traffic. Nor is the professional allowed

to harbour feelings for you, be they disgust or sexual attraction. A proper professional simply considers the case at hand: your chance of winning your lawsuit, the evidence against you, your illness or your needs.

Thus, the minor professional characteristics concur with our preferences as clients and citizens. Below we will elaborate on how they relate to management objectives and political goals.

Referral and the search for excellence. There is some tension between the referral principle and marketization. In the market, service providers defer from referring potential clients to the competition, even if competitors provide better services than they do ("you should try the grocery over there; they have much better vegetables"). However, real marketization seldom occurs in the public sector, despite all rhetoric admonishing politicians to run the government as a business (e.g., Beckett, 2000). The referral principle ties in with the quest for *quality* or *excellence* that steered the NPM movement alongside the search for efficiency (e.g., Clarke & Newman, 1997; Diefenbach, 2009).

The developments in the Dutch health care provide a telling example. In 2006, a new system was introduced. Citizens buy health insurance from private insurers. Private insurers negotiate with doctors and hospitals about the price and quality of healthcare provisions. Hence, doctors and hospitals compete for both patients' and insurers' attention. This might make them into competing "groceries," oblivious of the referral principle. However, the NPM approach in Dutch health care simultaneously emphasized transparency and high quality—or *excellent*—care: hospitals have to provide excellent brain surgery, excellent heart transplants, et cetera. This can only be accomplished if there are sufficient patients for doctors to keep their skills up-to-date and hospital facilities to accommodate this. Thus, care providers are encouraged to concentrate care in specialized hospitals, for heart surgery, paediatric oncology, neurological procedures, and so on. Patients are referred to specialized hospitals where they can get treatment from the best medical specialists.

Sloughing off and the search for efficiency. The sloughing off principle exists outside the world of professions as well. Political economist Braverman (1998[1974]) describes it in a treatise on labour and management. He calls it the Babbage principle (after Charles Babbage, inventor of the calculator). Companies wanting to make a profit, should divide their work in packages and leave easy tasks to lowly paid employees. Only complicated parts of the job should be entrusted to highly paid workers. According to Braverman (1998[1974]), the Babbage principle is also one of the building blocks of Taylor's scientific management. Taylor started his career as a factory worker and then was promoted to supervisor. He knew from experience that his former fellow workers could deliver more than they did, so he set out to maximize production. However, his workers fought him every step of the way. Taylor concluded that a manager should disempower his workers by cutting up their work in numerous tiny pieces, so it could be done by lowly paid workers from outside the factory (Braverman, 1998[1974]).

Gruening (2001) studied the origins of NPM. He thinks the NPM ideology consists of many building blocks including "the separation of provision and production" and "the separation between politics and administration." These building blocks are subsequently traced back to classical public administration in the Weberian style.

Sloughing off is not just a professional prerogative. It has economic foundations and a family resemblance to classical bureaucracies. Hence, it will not often be fought by managers and politicians.

Impersonal service and the search for objectivity. As for the last minor characteristic, objective, impersonal service delivery is a professional characteristic

that seems to have been actively supported from the outside, for example, by strongly encouraging professional groups to draw up guidelines and protocols, ensuring uniformity, and objectivity. Impersonal service delivery ties in with higher values like transparency, neutrality and equality before the law.

The minor characteristics of professionalism do not seem to have enemies, neither within nor outside the professions. However, as will be shown in the next two sections, a changing population in care and welfare warrants a reappraisal of the minor principles in these two sectors. For each sector, we start with an anecdotal impression to get a feel for the changes that are taking place. These anecdotal impressions are inspired by sociological research, which will be discussed subsequently.

The minor principles in healthcare

In this section on health care, we describe the deleterious effects of the minor principles on an ageing population by drawing up two scenarios, backed by studies into changing populations, demographics and client needs (e.g., Bury & Taylor, 2008; Oliver, 2012; Plochg, Klazinga, & Starfield, 2009; Shipway et al., 2015). We used these studies to generate ideal-typical scenarios that show what goes on in client populations and how this affects care processes. The patient in the two scenarios has the same medical condition but belongs to a different age group. This changes the impact of referral, sloughing off and impersonal care. Subsequently, we provide background information on the effects of ageing in health care and give an impression of attempts to fight the minor principles.

Scenario 1: Age 40. Suppose you are in your early forties. You have an interesting job, a loving spouse and two children, 14 and 9 years old. Then, out of the blue, fate strikes a blow. You have colorectal cancer. Curing you will be difficult, says your doctor. First, you will need radiation to shrink a tumour. After that, a surgeon will remove the tumour, and you need chemotherapy to destroy any remaining cancer cells. The best hospital for colorectal cancer is a two-hour drive from your home, and you will be getting treatment for a whole year. At age forty, you go along with the treatment, because you want to be there when your children grow up. Your spouse needs you. You feel needed at work. Hence, you will fight. You are glad that your doctor referred you to his more competent colleagues in another part of the country. His adherence to the referral principle maximizes your chance of survival.

Once your treatment starts, you meet an impressive number of health professionals. You must go to the radiology unit five days per week for three weeks in a row, and you meet with—rough estimate—twelve different nurses. There are two appointments with a radiologist. After that, you are scheduled for a meeting at the anaesthesiology department where a junior doctor determines whether your body is fit for surgery. The surgeon in charge of your operation explains the procedure. Many people are involved in the actual surgery. There is a whole bunch of faces gazing down at you as you count back from twenty to glide into unconsciousness at 13. Afterwards, the surgeon takes an occasional look at you. Nurses come in to check on you. The next phase is chemotherapy. Again, different doctors, different nurses.

You probably meet one hundred different professionals during treatment. Some are warm and caring and inquire after your children. Sometimes you appreciate this approach. At other times, you prefer the business-like attitude of the less caring professionals, because you do not want to be emotional all the time. But none of all that is terribly important. What matters is that you get well in the end.

In your early forties, you appreciate the referral principle, you do not care about the sloughing off principle, and you do not mind or appreciate the principle of impersonal service delivery.

Scenario 2: Age 83. Suppose you are in your early eighties. You are retired. Your wife is recovering from a stroke. You help her talk again by practising words. She still feels insecure and is glad to lean on your arm when walking the dog. Your son lives nearby and visits you often. Your daughter and her family live on the other side of the country. Then after your wife's stroke—fate strikes another blow. You have colorectal cancer. Curing you will be difficult, says your doctor. You need radiation to shrink the tumour. After that, a surgeon will remove the tumour and then you need chemotherapy to get rid of any remaining cancer cells. The best hospital for your type of cancer is a two-hour drive from your home, and you will be getting treatment for a whole year.

At eighty-three, this prospect sounds totally different. A two-hour drive is a logistical nightmare. Can you leave your wife alone for that long over such a long period? Seeing one hundred different physicians, nurses and nursing assistants in the course of a year will not be easy either at eighty-three. One whole year of medical treatment no longer sounds like a dreadful episode from which you will eventually recover. At eighty-three, your medical history will become—as surgeon Atul Gawande (2014) vividly writes—one damn thing after another. In the future, there may be arthritis, diabetes, sight problems, another stroke, or Alzheimer's disease for yourself, your spouse or both of you. From a medical perspective, it may seem wise to consult the best hospital for colorectal cancer, but from a more mundane perspective, the referral principle does not look sensible at all. You prefer to be treated in an average nearby clinic. You might die of colorectal cancer, but at eighty-three dying is no longer a tragedy (Callahan, 1987). You have had a good life. Your children have lives of their own. Your working days are over. You know the pleasure of becoming a grandparent. Surviving colorectal cancer is no longer overwhelmingly important. Being referred to the best medical specialist for your wife's stroke, the best hospital for your colorectal cancer, or any other condition, no longer seems the best way forward. You are better off with a doctor who knows your medical history, who can see how treatment would impact your life. You do not want a referral and sloughing off. Nor do you want impersonal service delivery. At eighty-three, you want a professional who sees the bigger picture and takes your personal situation into consideration.

Prevalence of scenarios. In the near future, the second scenario will be increasingly common. Marengoni et al. (2011) carried out a meta-review on the prevalence of multi-morbidity (the presence of two or more chronic medical conditions in an individual). Among older persons (differently defined) they found percentages varying from 55 to 98 percent. Several studies observe that clinical practice guidelines are usually geared at patients suffering from one medical condition. They do not take into account that treatments for one condition may conflict with medications prescribed for another ailment (e.g., Boyd et al., 2005; Campbell-Scherer, 2010; Hughes, McMurdo, & Guthrie, 2013; Lugtenberg, Burgers, Clancy, Westert, & Schneider, 2011; Mutasingwa, Hong, & Upshur, 2011).

Fried, Tinetti, and Iannone (2011) did a focus group study among primary care clinicians and found that clinicians worry about the detrimental effects of guidelines on patients with multi-morbidity. They conclude that doctors must pay more attention to their patients' priorities and find ways to reconcile these with the clinical guidelines. Likewise, Boyd et al. (2005) suggest that doctors should try to incorporate patients' short and long-term goals in their treatment plans. The Dutch association for medical specialists (Dutch Association for Medical Specialists, 2015) published a mission statement advocating integrated care rather than ongoing specialization, arguing that, "sensible care for a 50-year old is not always the same as sensible care for an 80-year old." Similar pleas for integrated care are discussed by Plochg, Klazinga, and Starfield (2009), Oliver (2012) and Nolte and McKee (2008). These

attempts to accomplish integrated care may be seen as attempts to diminish the relevance of Wilensky's minor principles in health care.

The minor principles in social care

In this section on social care we describe the deleterious effects of the minor principles on the changing population in social care by drawing up two scenarios, again backed by studies on changing client needs (e.g., Millett et al., 2016; Mowbray et al., 2005, Parish & Lutwick, 2005; Robinson, Dauenhauer, Bishop, & Baxter, 2012; Spratt, 2011; Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016). The first portrays a patient with a mental disability in the nineteen fifties. The second describes the life of people with a mental disability in the 21st century. Obviously, between the 1950s and 2017, the second scenario has become increasingly common, as we will show in the background section after the scenarios. After that, we will give a brief impression of the attempts to fight the minor principles in social care.

Scenario 1: 1950s. In 1950 Pearl Buck (1992[1950]), a Nobel prize-winning American novelist, published a moving book about her mentally retarded daughter Carol. After struggling with the grief that her daughter would never grow up, she embarked on a quest to find her daughter a place to live. In the end, she found a high-quality institute and left her nine-year-old daughter in the care of professionals, who taught her what little she could grasp, and made her life as safe and comfortable as possible. Carol would never marry or have children. Her life was perhaps agreeable, but very limited.

Scenario 2: 2010s. Jim is mentally retarded. At age 18, he meets 22-year-old Sharon. They fall in love and move in together. They have an apartment in an ordinary neighbourhood. Sharon gets pregnant very fast. She has mental retardation too; it is difficult for her and Jim to take care of their child. Fortunately, there is a lady from social services who drops by once a week, to see how the toddler is doing. Unfortunately, Sharon is now expecting their second child, which will make matters even more complicated. Jim used to have a (subsidized) job at the supermarket but was fired a year ago. Once a month Jim has to report to the welfare agency, where a social worker helps him—in vain so far—find a new job. Jim uses marihuana on a daily basis. The social worker at the welfare agency has referred him to a special clinic for substance abuse. Jim is supposed to go there twice a week, but regularly misses appointments.

Jim and Sharon also have financial problems. The social worker at the welfare agency has given Jim a card with a phone number. Apparently, there is an agency in town where specialized social workers know all about debts and the legal difficulties they entail. Jim should pick up the phone and make an appointment. Jim has dialled the number once, but then they put him on hold, and he ended the conversation. As the children of Jim and Sharon grow older, many more professionals will enter their lives. The chances are that the problems will prove hereditary and that the children need therapy for behavioural disorders or extra tuition because of learning disabilities.

Prevalence of scenarios. In the 1950s, many people with mental retardation or a severe chronic psychiatric condition spent their lives in large-scale institutions. Social workers who were employed outside those institutions catered for easier clients: many were poor, some had marital difficulties, others struggled with their religious beliefs, yet others were coping with substance abuse. Often some of these problems went together, but the Jim and Sharon scenario was rare.

From the nineteen-eighties onward, social work underwent a process of specialization. Social workers either specialized in specific clients (women, people with an immigrant background, youngsters), or in specific problems (relationships, debts, substance abuse) (Blom, 2004). This—in terms of Wilensky's minor characteristics—ample use of the referral principle was intensified by NPM inspired government policies that aimed at specialized agencies, producing tangible results (Ferguson, 2008; Rogowski, 2010).

Simultaneously, people with mental retardations and people with a chronic psychiatric condition were deinstitutionalized. Large institutions were discredited for making people overly dependent and seriously curtailing their chance to lead a full life. Hence, all over the globe deinstitutionalization was the way forward (Becker & Kilian, 2006; Fakhoury & Priebe, 2007; Novella, 2010) Although this process was usually acclaimed by patients, policymakers and professional carers, it raised new problems as well. People with mental retardations and people with a chronic psychiatric condition need help in many areas of life. Some struggle with health problems or substance abuse, because they do not take proper care of themselves (Salokangas, 2007; Slayter, 2010; Schmetzer, 2007). Many feel isolated and lonely (Amado, Stancliffe, McCarron, & McCallion, 2013; Asselt-Goverts, van Embregts, Hendriks, Wegman, & Teunisse, 2015; Forrester-Jones et al., 2006; Hall & Hewson, 2006). A relatively large number are sentenced to prison (Gostin, 2008; Wallace, Mullen, & Burgess, 2004).

Thus, social work has to cater for a changing clientele consisting of multi-problem individuals and multi-problem families. This changing clientele does not benefit from the referral principle since that would entail the help of numerous different professionals, each with an adjacent, yet slightly different specialty. It creates havoc for these clients if professionals slough off the less interesting bits of their job to lesser trained and lesser paid aides. Vulnerable people like Jim and Sharon would probably be better off with one all-round social worker, who could take charge of all of their problems simultaneously.

The same goes for the principle of impersonal service delivery. People like Jim and Sharon do not need to be treated like any other citizen who applies for an unemployment allowance, help with substance abuse or remedial teaching for her child. They need professionals who look at the bigger picture, taking into account the mental retardation, the debts, the addiction and the well-being of the children, whether or not this is stated in guidelines or protocols.

Like health care professionals, social workers and the policymakers who enable their work, attempt to fight Wilensky's minor characteristics. In Sweden, Norway, and the Netherlands, specialized social workers have been partially replaced by neighbourhood teams that embody a "one-stop shop" approach (Arum & Schoorl 2015; Blom, 2004; Kok & Briels 2014; Røysum, 2013). These neighbourhood teams are supposed to deal with the many problems that plague their clients in coherence.

Minor principles in the context

The minor characteristics of professionalism have negative consequences in health care and in social work. It is important to keep in mind that their impact is reinforced by managerial and organizational policies. Accountability and registration systems often foster performance and efficiency over integrated care. Hence, the initiatives to roll back the minor characteristics are fragile. Professionals, managers, policymakers and politicians need to realize this. In this last section, we will discuss four reasons why it will be difficult to sustain the attempts to reduce the effects of referral, sloughing off and objective, impersonal care.

A "fight" against a worthy enemy is an uphill battle. If we look at the initiatives to fight the minor principles from the rise and fall perspective, described in Section

2, they may be interpreted as a form of de-professionalization. Professionals derive their status from specialized knowledge. Heart transplants, chemotherapies and radiation undoubtedly qualify as such. Integrated care for elderly patients suffering from multi-morbidity, often consists of talking to the patient, after which patient and doctor together decide to opt for a policy of "medical abstinence." This seems much more like common sense than surgery or radiation. General practitioners used to be "talkers" in the fifties and sixties, but it made them feel inferior to their specialist hospital-based colleagues; they wanted to be "proper doctors" (Dwarswaard, 2011). Thus, they embraced guidelines and protocols and committed themselves to evidence-based medicine. This development concurred with NPM principles, since NPM emphasizes measurable results, and evidence-based medicine delivers just that. A development in the opposite direction, away from evidence-based guidelines and protocols; back to talking and individualized care, might happen at the expense of professional status but is also at odds with policymakers' belief in NPM principles.

A similar dilemma can be detected in social care. Social workers used to be talkers and doers in the fifties and sixties; they lacked evidence-based methods and shied away from doing research. This lack of scientific rigour was heavily criticized in the nineteen seventies both from within and from outside the profession. Thus, social workers tried to develop science-based methods, preferably systematically tested and evidence-based (Otto, Polutta, & Ziegler, 2009). The move toward evidence-based practice in social work was strongly encouraged by NPM ideas. Hence, criticizing and fighting the minor characteristics of professionalism is difficult, because it defers from the earlier chosen route toward professionalism, strongly backed up by politicians and policymakers.

A "fight" that saves money might lose professional support. There is a second reason why the fight against the minor characteristics is vulnerable. It does not deliver impressive results. Ailing octogenarians will remain fragile and die. Families like Jim and Sharon and their children will hardly ever become financially independent. The chances are that they can never do without help (with or without a referral, sloughing off and impersonal care). Thus, politicians and policymakers might be inclined to emphasize other effects of the fight against referral and sloughing off, notably a reduction of costs. Although the fight against the minor characteristics might indeed save money, touting this too much might give citizens the impression that "we no longer spend money on hopeless cases as they are hopeless anyway." This might make professionals abandon the project altogether and fall back on their usual routines.

Losing a battle means losing the war. The third reason why the development is vulnerable is that some things are bound to go wrong. The generalist medical doctor catering for elderly patients might misdiagnose one of them and opt for watchful waiting when a timely intervention in a specialized hospital might have led to a number of extra years in good health. The one social worker who oversees the Jim and Sharon household might miss something crucial (indications of child abuse, lingering depression, criminal activities). The professional at issue might feel guilty and might fall back on the referral principle: "I should have referred to my colleague who knows about this particular problem." This effect might be even stronger if politicians, as they are tempted to do, give in to a phenomenon known as the "risk regulation reflex", in other words, the tendency to take measures and change policies after an incident has happened (Trappenburg & Schiffelers, 2012).

The "fight" may be perceived as ageist and stigmatizing. The last reason why the fight against Wilensky's minor principles is vulnerable is that this is a move that should only be applied to parts of the population, especially clients whose situations

are too varied to approach them with generic (technical) programs. It is important to acknowledge that integrated care is not optimal-service-delivery-plus-personal-attention. Non-specialized care is suboptimal care for many people in many cases. The forty-something colorectal patient described in Section 4 needs referral and objective, impersonal service delivery. Parents who merely need help because their child has a learning disability may seek a remedial teacher who specializes in dyslexia. It is just the fragile elderly and the multi-problem Jim-and-Sharons for whom the normal logic of professionalism no longer applies. This may be perceived as stigmatizing by outsiders but also by family members or representatives of fragile elderly and people with disabilities.

Conclusion

Diminishing the impact of referral, sloughing off and objective, impersonal care is necessary to address the medical needs of an elderly population and the needs of vulnerable people living in a difficult modern world. Professionals can take the lead in this project, as they can see the adverse consequences of the minor principles for large parts of their clientele. However, they cannot do this alone. This is an endeavour that requires careful steering and help from managers and policymakers. Future research might help in showing ways forward and identifying pitfalls and dilemmas. A concerted effort by all might help us criticize and fight the enemy inside professionalism.

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