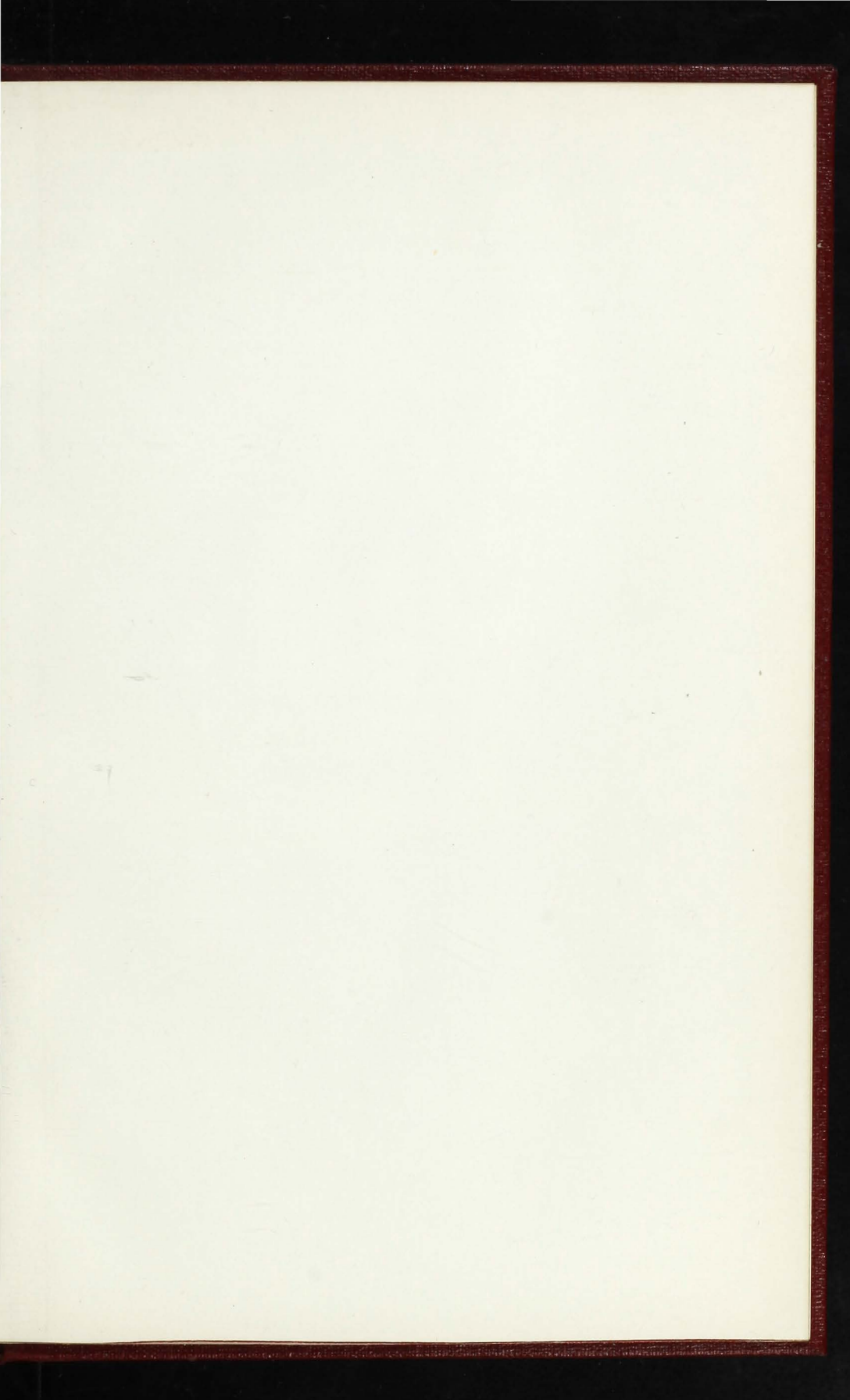
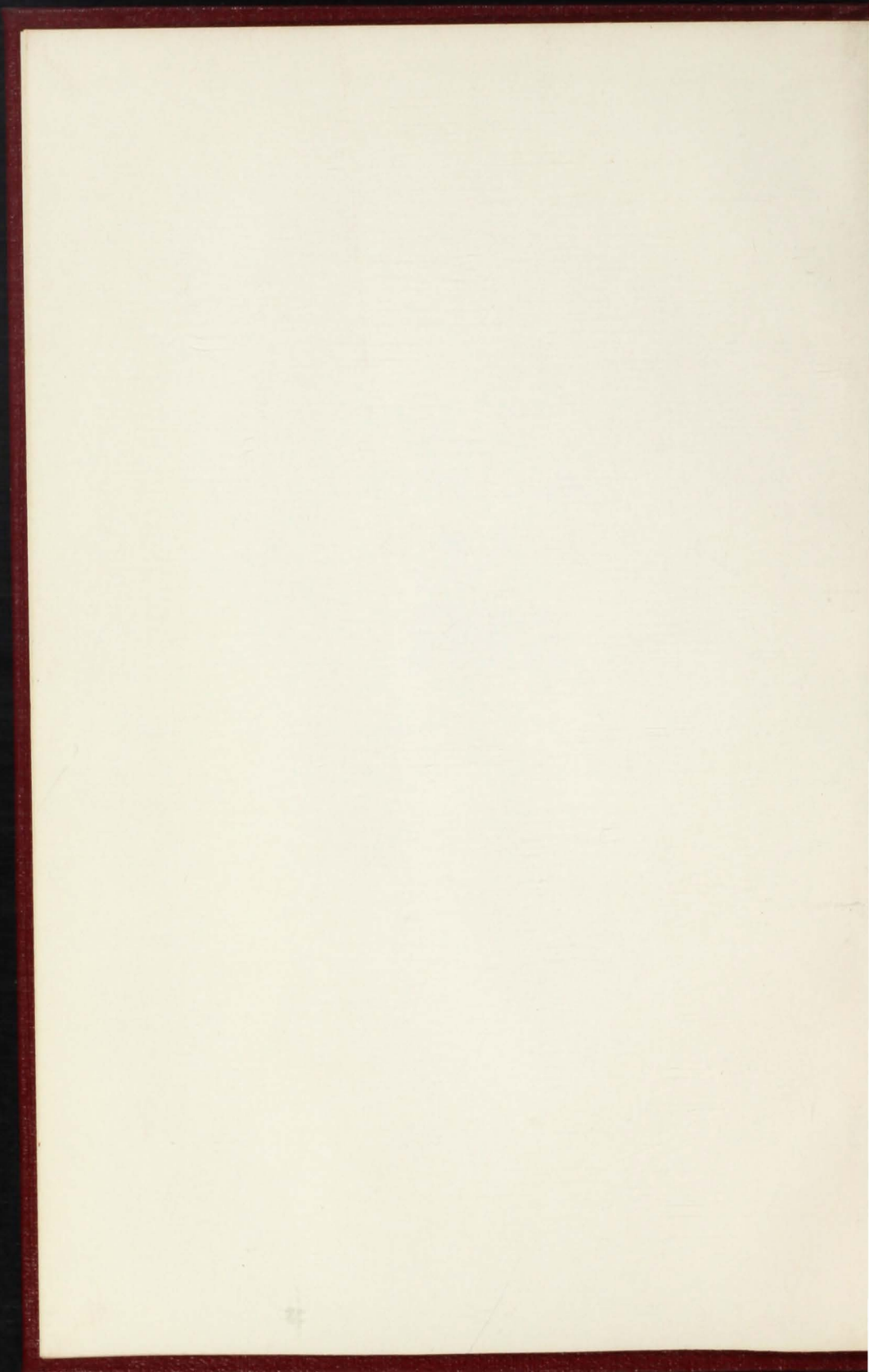


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# socialism and professionalism

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Paul Wilding  
fabian tract 473

75p



the social  
welfare  
professions

# fabian tract 473

## socialism and professionalism

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this pamphlet, like all publications of the Fabian Society, represents not the collective view of the Society but only the views of the individual who prepared it. The responsibility of the Society is limited to approving publications it issues as worthy of consideration within the Labour movement. Fabian Society, 11 Dartmouth Street, London SW1H 9BN. March 1981      ISSN 0307 7535      ISBN 7163 0473 2

# 1. introduction

Socialists have never been able to make up their minds about the professions. Some commentators have seen the rational, scientific approach to dealing with social problems and human needs as a stage on the road to socialism. Other socialists have seen the professions as the allies and servants of an economic and social system hostile to socialism, and so as obstacles to be overcome.

In fact, historic differences in socialist philosophy lead to quite different attitudes to the professions and these differing traditions are reflected in contemporary uncertainties. G D H Cole and the Webbs can serve as representatives of the two strands of thinking. "He still conceives the mass of men", Cole wrote of Sidney Webb in 1918, "as persons who ought to be decently treated, not as persons who ought freely to organise their own conditions of life; in short, his conception of a new social order is still that of an order that is ordained from without, and not realised from within" (A W Wright, *G D H Cole and Socialist Democracy*, Clarendon Press, 1979). Cole's socialism was quite different. It was a socialism realised from within not ordained from without and the crucial factor in its achievement was the more equal distribution of power in society. In Cole's view, says Wright, "the character of human relationships was seen as the product of the nature of power in society, polity and economy. Was the exercise of power democratic or autocratic? Was it remote or accessible? Was democracy narrowly political or genuinely social? Was it unitary or functional? The answer to these questions were consistently regarded by Cole as the key determinants of the character of social relationships. They would determine whether there was solidarity or division, willing service or compulsory labour, vitality or sterility, cooperation or competition, freedom or servility, distrust or fellowship" (*ibid*).

There has been little real attempt to think through the role of the professions in a socialist society or, more immediately, to work out a policy for the professions which should be pursued by a

Labour government under welfare capitalism.

This pamphlet seeks to open for debate and discussion the role of certain of the key professions in our social welfare system where the issues of the public accountability and control of the professions are perhaps most obvious. The problems posed by different professions do vary considerably but this pamphlet will discuss them at a general level; since the issues are sufficiently similar to make general discussion the best way of proceeding. The discussion is in three parts. Chapter 2 looks at the position of the chosen professions in our social welfare system and the power they exercise. Chapter 3 looks at the current critique of the professions which has developed in recent years. Chapter 4 outlines the basis of a socialist policy for the professions and suggests some of the measures which need to be adopted if the professions are to assume a more acceptable role in society.

The discussion concentrates on the professions and would-be professions whose role in the social welfare services is most obvious—doctors, teachers, social workers and town planners. Other groups certainly have a claim to be included—accountants, lawyers, architects and surveyors for example—as they exercise considerable power, but the concentration here is on those professions most obviously and directly involved in the delivery of social services.

Another problem for anyone seeking to explore the position of the professions in modern society is the unbalanced nature of the available literature. Much more has been written about the medical profession than about the other professions and any discussion tends to be medically dominated. This pamphlet tries to avoid this difficulty but without altogether succeeding. The argument for a general discussion even though the medical profession provides an excessive number of examples and illustrations is that medicine provides a model which other professions aspire to emulate. If that is what professionalism is really like





## 2. the professions and social welfare

The central issue raised by an examination of the position of what may usefully be called the welfare professionals—doctors, social workers, teachers, town planners—is the power they wield. As government responsibilities have expanded, its dependence on experts and professionals has increased. Public acceptance of the legitimacy of the power and influence of the professions owes something to a general faith in experts and something to the way in which such power and influence are accepted by government. There is room for debate about the reasons for the rise of the professional estate, less about the fact that the professions have now in many important areas become what Titmuss called “the arbiters of our welfare fate”. For democrats and socialists, the key issues revolve round the legitimacy of such power, the use to which it is put and its impact on our social welfare system.

The power of the professions can usefully be considered under five headings—power in policy making and administration, power to define needs and problems, power in resource allocation, power over people, and power to control their area of work. This chapter will explore the extent of professional power in each particular area and why it is problematic.

### power in policy making and administration

There is a mass of evidence about the enormous influence which the professions exercise in policy making and the administration of social services. The most obvious example of such influence is the role of the medical profession in relation to health policy and the administration of the National Health Service. “The history of the British health service”, says Rudolf Klein, “is the history of political power, ministers, civil servants, Parliament, accommodating itself to professional power” (R Klein, *Complaints Against Doctors*, Charles Knight, 1973). All the major changes in the organisation of health services this century—1911, 1946 and 1972—bear witness to the enormous

power and influence of the medical profession, both to control the terms of debate, to lay down the parameters of the possible and, in the end, to ensure that any changes take full account of the profession's demands and interests.

Speaking of the reorganisation of the National Health Service which was effected in 1974, R G S Brown describes the new structure as “modelled to the desires of the medical profession” (R G S Brown *et al*, *New Bottles Old Wine*, University of Hull, 1975). But apparently enough was not enough for the medical profession and it successfully persuaded the Conservative government of 1979 of the need to simplify the professional advisory machinery in the NHS “so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities” (*Patients First*, HMSO, 1979).

Do other professions have a comparably commanding position in policy making? Teachers lack the standing and status of doctors. They have been less successful in asserting their special role as generalised wise men *vis à vis* anything remotely to do with education, but their role in educational policy making is central. Maurice Kogan describes the teachers' associations as “only a wafer away from the Local Authority Associations in consultative status” (M Kogan, *Educational Policy Making*, Allen and Unwin, 1975). The profession has successfully opposed the use of auxiliary teachers in the classroom. It persuaded Edward Short when he was Secretary of State to end the right of unqualified staff to teach. It has been a force for the abolition of selection for secondary education.

What of the influence of social workers? Two pieces of recent legislation show the importance of social work influences on policy making—the Children and Young Persons Act 1969 and the Local Authority Social Services Act 1970. The 1969 Act shows in substantial measure the triumph of social work definitions of the problem of delinquency and marks a significant transfer of power from magistrates to the professionals. It is a tribute

to the power and influence of social workers that the Seebohm Committee was set up in 1965 to review the structure and responsibilities of the personal social services. The composition of the Committee is a further comment on the success of the social work world in persuading the authorities that the issues were such that social work representatives should predominate on the Committee. When the Committee reported, the Cabinet's initial reaction was that it was, in Crossman's words, "a contemptible report". Social work influence was a major factor in the way in which the report was nevertheless translated into the Local Authority Social Services Act 1970.

What is the significance of professional power in policy making and administration? Firstly, professional influence means that on many issues the decisions which are made serve professional interests rather than the public interest. Secondly, it leads to services organised according to professional skills and ideas rather than according to client needs. Thirdly, it means that certain elements and interests within the professions are able to dominate decision making because of their greater prestige and status.

It is not difficult to find evidence for the first point. It is the determination of the medical profession to preserve the independent contractor position of the GP which has prevented the development of an integrated health service—and from that failure many of the most vulnerable groups in society continue to suffer. At the level of District Planning in the NHS the medical profession has an effective veto over developments it does not like. Things can only get done with professional approval. The fact that areas which were short of doctors in 1948 are still relatively short today is a tribute to the power of the medical profession to prevent a rational policy for the distribution of professional staff. On the basis of a narrow professionalism, teachers have successfully opposed any moves by the Department of Education and Science for increased parental participation in pre-school education. Sinfield's comment

on the Seebohm report aptly captures the significance of social work influence on its proposals—and so on the legislation which carried them into effect. "A citizen reading the report" he wrote, "might indeed conclude that it had more to do with the work satisfaction and career structure of the professional social worker than it had to do with his own needs or rights in the modern welfare state" (A Sinfield, *Which Way for Social Work?*, Fabian Society, 1969).

The second criticism that professional influence leads to services organised according to professional skills rather than client needs is equally easy to support. On many occasions Crossman attacked the move in the 1960s to large District General Hospitals as being primarily for the convenience of the consultants. The convenience of the consultant, Crossman pointed out, was given very high priority; the convenience of the patient and the family who wished to visit him a very low priority (R H S Crossman, *A Politician's View of Health Service Planning*, University of Glasgow, 1972).

Again, one of the most damaging divisions in our social welfare system is the division of responsibility between health and personal social services—a division which for many needs groups is arbitrary and illogical. It is the direct result of the relevant professional groups insisting that services be organised around their skills rather than around patient needs.

The third indictment of professional influence is that it gives certain professional élites a dominant position so leading to biased, unbalanced development within services. Hospital medicine dominates the NHS because hospitals, according to dominant professional ideologies, are where real medicine is carried on. Within hospitals the stress has been on high technology medicine rather than on caring services—because caring is a low status activity within the medical pecking order. It is clear that the influence of the medical profession, and particularly that of consultants in prestigious specialisms has helped perpetuate cin-

derella sections in the NHS.

The same charges can be laid against social workers. They have effectively dominated discussion about the development of personal social services having persuaded the policy makers that theirs is, in some way, the vital role. One important result has been that little thought has been given to the role, function and training of other kinds of auxiliary and ancillary staff. Professional influence has narrowed thinking about the development of social care services.

The purpose of this section has been to raise the issue of the nature and extent and importance of professional power and influence in policy making. The argument has been that such influence is to be regarded as problematic. Professional influence and advice is interested rather than by definition altruistic and objective. It needs critical evaluation.

### **power to define needs and problems**

A crucial element in the power and influence of the professions in policy making and administration is acceptance of professional definitions of needs and problems. Professions, it is assumed, know about these things. Their definitions are scientific, objective, expert and reliable.

Until very recently the medical profession successfully defined health in terms of health services. Health services were the crucial element in the maintenance of health—or so it was asserted and believed. Increasingly, that professional definition is being challenged as the importance of way-of-life factors is reasserted. Again, until recently the medical profession's definition of the needs and problems of the mentally handicapped was accepted without question. Now, increasing numbers of experts would accept the partial nature of that definition and would agree that its effects on policy have been damaging.

Another influential problem definition which expresses no more than a half

truth is that the central problem of the National Health Service is one of shortage of resources. That is the definition which the medical profession has successfully propagated—so divesting itself of all blame for the shortcomings of the service. The central issues of clinical freedom and how resources are actually used remain safely off the agenda.

In the field of housing and town planning the definitions of the professionals rather than the definitions of those who live in houses asserted to be unfit have carried the day. A mass of evidence now exists to show the gap between consumer and professional definitions but the power which accrues to the professionals—environmental health officers and town planners—from the supposed scientific, professional nature of their definitions is immense. Thousands of people who were quite happy with their housing have lost it and been forced to move because of the professionals' power to define their housing as unfit.

There are, in essence, three reasons why the professional power to define needs and problems is problematic. Firstly, the professional's view of the world is narrow. Definitions of problems tend to be in individual rather than in structural terms, they tend to be in terms which bring the problems within the legitimate bounds of professional concerns—alcoholism and addiction come to be defined as diseases, pregnancy as illness, delinquency as maladjustment—and these definitions become enshrined in policy. The structural, political nature of problems is overlooked because that places them beyond the bounds of even the most imperialist professional's concerns.

The second reason for anxiety is that when professional definitions carry the day, the client view is likely to be neglected or ignored. Without such a perspective the "problem" at issue is unlikely to be adequately grasped or effectively tackled. The reality of the situation as it appears to the client must be the starting point for any successful attack on the problems posed by, for example, the presence of a mentally

handicapped child in the family, by physical handicap or delinquency. Professional definitions, because of a spurious confidence in professional expertise and its objectivity, tend to ignore client and consumer views.

The third objection to the influence of professional definitions of needs and problems is that such definitions are partial and partisan. As Eliot Friedson puts it, "Consulting the profession the state obtains not only expert opinion on how to serve the needs the public perceives but also partisan opinion about what the public's needs actually are irrespective of lay opinion" (E Friedson, *Profession of Medicine*, Dodd Mead, 1970).

### **power in resource allocation**

Professional power in resource allocation is of various kinds. There is the influence which professionals exert over decisions about resource allocation by central and local government. There is also the power and influence exerted at the organisational level when professionals make decisions about resource use. Finally, there is the point at which individual professionals meet individual clients and allocate or refuse them resources of various kinds. At all three levels, professional power in resource use is substantial and is often exercised with few political or bureaucratic constraints.

The way the hospital sector has increased its share of NHS resources since 1948 is a tribute to the power and influence of the medical profession at the level of central government planning. Crossman's attempt to shift resources towards services for the mentally handicapped called forth a memorandum from the Chief Medical Officer saying such a proposal would lead to a major row with the consultants (R H S Crossman, *The Diaries of a Cabinet Minister*, Vol. III, Hamish Hamilton and Jonathan Cape, 1977). Little therefore came of it.

In the NHS, as Brown points out, it is the doctors' decisions which "effectively

commit most of a health authority's resources" (R G S Brown, *Reorganising the NHS*, Blackwell and Martin Robertson, 1979). The Department of Health and Social Security takes the view that "doctors and other professional providers of services have individual professional freedom to do what they consider to be right for their patients. Thus, in each individual doctor-patient situation, it is the doctor who decides on the appropriate priority" (quoted in R Klein, "The Doctor's Dilemma for Accountability", *Public Administration Bulletin*, No 17, 1974).

The doctor's clinical freedom gives him the right to prescribe whatever treatment he considers appropriate with only minimal checks. Checks on the prescribing practices of the GP are no more than residual; on the prescribing pattern of hospital doctors they are non-existent. The very great variations between the length of hospital stays for similar complaints in different hospitals shows the independence of consultants in the use of hospital resources. The consultant decides what is appropriate—whatever research findings may show about optimum lengths of hospital stay or the inefficacy of treatments.

Little is known about how resources are used in schools but it is clear that the head teacher has the power to make decisions, largely about staffing resources, which can be of substantial importance to the lives of the pupils. There can be smaller teaching groups for less able children or a wider range of options in the sixth form, for example. The more experienced, abler teachers can be allocated to the abler or less able children. It is almost impossible for anyone from outside to challenge these important decisions about resource allocation within the school.

Social workers, like doctors, have considerable freedom in how they use the important resource of their own time. Their decisions can also commit substantial amounts of departmental resources. How social workers interpret a care order may commit many thousands

of pounds over many years—and it is a professional decision.

The only financial resources which social workers control directly are those payments they can make under Section I of the Children and Young Persons Act 1963. The total sum involved is small—though often crucial to the survival and well being of a family. Research on social workers' power in this area makes it plain that the matter is regarded as a purely professional one. Details of the criteria for granting aid are never published so that clients can see them. There is no appeals system if aid is refused. The social workers' decisions are final.

There are at least four ways in which professional power in resource allocation is questionable. Firstly, whatever the supposed priorities of governments, the professionals are able substantially to determine how a service operates. Official priorities—in favour, for example, of cinderella groups in the NHS—can be negated by professional power over resource use. To a democrat that is intolerable.

Secondly, it means that resources can be deployed for professional convenience rather than to meet client need. There is considerable evidence, for example, that recent trends and developments in how resources are used in general practice—appointments systems, development of group practices, the decline in home visits, the expansion in the use of deputising services at evenings and weekends—have been for the benefit and convenience of doctors rather than patients. There is, however, little opportunity for anyone to challenge such behaviour.

Thirdly, professional control over resources negates planning and management. The attempt to use resources for maximum efficiency and effectiveness can be negated by professionals refusing to modify their practices—over length of hospital stays for example.

Fourthly, professional control of resources usurps the appropriate sphere of political decision making. Professional

control may be appropriate when decisions are essentially expert and technical but it cannot be justified when the decisions to be made are political and involve the distribution and redistribution of goods, services and opportunities between individuals, groups and classes. Town planners have secured and maintained considerable control over spatial resources through arguing that the decisions to be made were essentially technical. To anyone other than a planner, the scope and significance of such decisions and the number of people affected make them clearly political.

### power over people

Power in policy making and administration, power to define needs and problems and power in resource allocation is, of course, indirectly power over people but many professionals also wield more direct power of this kind. Generally it is power over the sick, deviant and delinquent and over those who, for other reasons, come within the purview of the social welfare system. Clearly someone has to make decisions on issues such as compulsory admissions to mental hospitals and on whether delinquents and criminals should, or should not, be committed to penal institutions and for how long. In the past such decisions have generally been regarded as matters of law to be judged by the courts on the basis of custom, common sense, instinct or experience. Increasingly the idea that there is an expertise on matters has been accepted and important powers have been passed to the professional groups claiming that theirs is the expertise. The powers are frequently very considerable and the safeguards which surround their exercise are normally extremely limited.

The Mental Health Act 1959, for example, made the decision about compulsory admissions to mental hospital a purely professional one. The role of the courts came to an end. Doctors assumed the major responsibility for the exercise of this daunting power.

There is no right of appeal for any patient

prior to admission, or for patients admitted under short term compulsory orders for 28 days or less. The Mental Health Act does not define many of the key terms it uses—mental illness, for example—so enormous discretion is left in the hands of the doctors and social workers who operate the Act. To all intents and purposes there is just no machinery for reviewing the decision to admit a patient compulsorily—only for deciding an applicant's fitness for discharge at the time of the review—and the position of professionals in the review system is open to a number of criticisms (cf P W H Fennell, "The Mental Health Review Tribunal: A Question of Imbalance", *British Journal of Law and Society*, 1977).

The other most significant transfer of power from the courts to professionals in recent years is that enacted in the Children and Young Persons Act 1969. The power of the social worker is greatest when the court makes a care order committing the child to the care of the local authority. It is the social workers who decide what such an order shall mean—return home for the child or commitment to a secure institution or something in between. The decisions are made behind closed doors; they are subject to few, if any, checks or safeguards.

Such powers assume the existence of the expertise to make decisions of this kind about how to change delinquents into law abiding citizens—and it assumes social workers possess it. There is no evidence for either of these assumptions. Power was granted on the basis of assumptions which were incorrect. The legitimacy of such extensive powers, and the absence of effective rights of appeal gives cause for considerable anxiety.

Teachers, too, have great power over those they teach, power to order their lives in the present and to influence them for the future—and it is an exercise of power which parents or lay politicians have very little ability to question or alter. Inevitably, if not deliberately, teachers label and categorise pupils—and this can produce the kind of subcultural

attitudes and values described so vividly by David Hargreaves in *Social Relations in a Secondary School* (RKP, 1967). The differences he depicts between the A and B streams and the C and D streams witness to the power of teachers over pupils. Teachers can also deliberately set out to inculcate particular patterns of attitudes—to authority, competition, cooperation, racial and sexual differences.

Clearly there are areas and issues in individual and social life where experts have to decide what action is needed, and to take it. What is worrying is when such power extends beyond the area of expertise to areas which are essentially suitable only for lay and political judgments—and many of the powers which professionals exercise over people are wide open to this charge.

### power over area of work

All professional groups aspire to control their own area of work—to regulate the behaviour of their members, to set standards of entry to the profession, to control training, to enforce a professional monopoly, to control the number of entrants to the profession. Different professions have secured such powers in varying degrees.

It is, of course, part of the professional case to suggest that the granting of such powers is an unmixed benefit to clients. That claim needs examination. All occupational groups are interested parties.

They have at least half an eye on the interests of their members as well as their clients. Claims for longer training and for an all-trained service may be for the public good, but such claims are also part of the professional gospel of self importance. Lengthy training may benefit clients, but it is also, in a credentialist-drunk world, a public statement of occupational importance.

Professional control of entry to the medical profession is problematic in a number of ways. It means, so it seems, a social class distribution of entrants

heavily biased in favour of social classes I and II which is one factor in the subsequent geographical maldistribution of doctors. The stress on the need for high intellectual ability to become a doctor has also, Horrobin argues, helped to bias the development of medicine in favour of technology rather than basic caring (D F Horrobin, *Medical Hubris*, Churchill Livingstone, 1978).

Furthermore, professional control of medical training continues to mean a pattern which reflects the high prestige sectors of medicine rather than the main emerging health problems of today. If the largest and most formidable problems which medicine now faces—mental illness, geriatric medicine, physical handicap and chronic illness—are excluded from the work of most teaching hospitals, then the doctors of the future emerge with a strange view of what medicine is really about—and ill equipped to practise it.

A professional monopoly, which is the goal of all self-respecting aspirant professions, is less than pure gain for the rest of society and is a useful example of the dubious effects of professional power to control the area of work. What is quite clear is that much of the work done by doctors, teachers and social workers does not require their lengthy training, professional skills or substantial salaries. A considerable proportion of the cases dealt with by a GP could be dealt with very competently by a trained nurse. Equally, lengthy training is not required for significant parts of the work which social workers undertake. All professionals, however, are reluctant to accept the help of aides and auxiliaries for fear of compromising their own position. The result is that scarce and expensive professional time is wasted on work which does not require professional skills.

Another disadvantage lies in the standard of service offered by people who are overtrained and overskilled for what they are tackling. GPs and social workers are united in one thing if in little else, and that is the continuous chorus of complaint they pour out about the trivial problems with which they are inundated. Such

supposedly trivial issues might well get closer attention from a less trained person. Those groups such as the elderly, who are not popular with social workers, might well get a better service from workers selected for their interest in old people and then given a specific training.

## conclusion

An understanding of the welfare professions depends first of all on grasping the central elements in their position in the operation of social welfare services. This is that the central element is the power they wield—in policy making and administration, in the definition of needs and problems, in resource allocation, over people and in the control of their area of work. That power has developed without any considered decision by governments or any thought of its significance or implications. What has evolved is a situation which is clearly extremely dubious for anyone concerned for democracy, individual rights, efficiency and equity in our social welfare services, or for anyone alert to the position of many of the most vulnerable and disadvantaged groups in society.

### 3. the current critique of the professions

In recent years there has been considerable critical discussion of the role of the professions in society generally and, more particularly, of their role in the social welfare system. To understand the professions, and therefore as a necessary prelude to developing a socialist policy, we need to be aware of the nature of that critique.

#### claims and achievements

At the heart of the critique has been a re-evaluation of the claims and achievements of the professional groups we have been considering—doctors, teachers, social workers and planners. Were their claims to expertise and to the ability to deliver good health, education, individual and community well being justified? In the light of the critique—from both inside and outside the professions—the professional claims emerge rather bruised and the achievements appear as rather less conspicuous than might perhaps have been expected.

Medicine has generated its own internal review. The verdict of one of its most distinguished critics, Professor Thomas McKeown, is that "At all stages of history doctors have overestimated the results of their intervention" (G McIachlan and T McKeown (eds), *Medical History and Medical Care*, CUP, 1971). What is increasingly clear is that health services are not a key determinant of health—and in the past it has generally and easily been assumed that they were. This has contributed to the medical profession's prestige. National, regional, sex and class differences in the incidence of heart disease and cancer, for example, suggest that the causes are ultimately environmental, that the roots lie in particular ways of life. If that is so, the role of medicine becomes less significant.

Evidence about varied and inconsistent diagnosis by doctors, unnecessary and over long hospitalisation, wide variations in hospital stay for similar conditions and the continued use of treatments shown to be ineffective, all suggest that

individual idiosyncratic judgments play a large part in what is supposedly scientific medicine. Such findings have helped weaken the standing of medicine in society. The development of a term—iatrogenic disease—to describe the ills produced by medical intervention suggests a new realisation that the results of modern medicine are not always benign.

Social workers are open to the same attack of high claims and limited achievements. They may not be solely or even mainly to blame for the succession of child care tragedies of recent years but most of the subsequent enquiries have produced critical comments on the roles played—or not played—by the social workers involved. In the field of mental health and compulsory admissions to mental hospitals, research shows social workers to be ill equipped by training or experience, lacking, as one authoritative investigation puts it "expertise which qualifies them to do anything except the most simple and basic tasks in the compulsory admission procedures" (P Bean, *Compulsory Admissions to Mental Hospital*, John Wiley, 1980).

At issue with social work, as with medicine, is the validity and reliability of the knowledge base which is claimed. Is there really a reliable corpus of knowledge about individual and social functioning which provides a solid base for social work intervention on lines of proven efficacy? There is no doubt that social workers help a lot of people; that is not the issue. The issue is the extent to which such giving of help is based on more than informed intuition, experience of the world, sympathy and common sense.

It is unnecessary to labour the point. In the past, the claims of the welfare professions to knowledge and expertise were accepted and not questioned. Today they are much more regarded as up for testing. Questions about the knowledge base and the expertise of occupational groups—doctors, social workers, planners, teachers—leads to a questioning of the powers and privileges which have been justified in terms of such expertise. An important



brick in the base of the professional edifice has been loosened.

### **failures of responsibility**

The professions have also come under attack in recent years for alleged failures of professional responsibility, that is for failure to pursue their work in ways judged by their critics to be fully professional.

There have been the scandals concerned with the running of long stay institutions for the mentally handicapped and scandals to do with the deaths of children for whom the local authority was responsible. What is striking and extremely disturbing is that conditions in long stay hospitals—Ely, Farleigh, Normansfield and the rest—were only revealed as the result of scandals. The medical profession played no part in bringing such shocking conditions to public notice. Those responsible failed to assume the responsibility to expose their conditions of work and to press in every possible way for the resources required to deliver a professionally acceptable service to the public.

In fact, none of the great social welfare scandals of the 1960s—conditions in long stay hospitals, the rediscovery of poverty, conditions in old people's homes, homelessness, the slum school—were publicised by the responsible professionals, a shameful failure in professional responsibility.

In the child care scandals, what came out of many of the inquiries was that well intentioned professionals failed in some way or other, even if for valid reasons, effectively to carry out their professional responsibilities. They failed to visit, to liaise, to coordinate; they failed to assert their rights and responsibilities in ways which might have better protected those for whom they were responsible.

Another failure in responsibility with which all professions can be charged is failure to evaluate their knowledge base and the effects of professional action. "We do not know", Horrobin wrote in

a spasm of professional frankness about medicine, "whether most of the things which we do to patients are better for the welfare of that patient than if we had done nothing at all. And on the whole most of us prefer to remain warmly ignorant rather than coldly knowledgeable about the situation" (D F Horrobin, *Medical Hubris, op cit*). That is true of all professions. Doctors, planners, teachers and social workers have all failed—or refused—to monitor the results of their activities in a way which is quite unacceptable in groups claiming a scientific base for their work.

A further charge of a different kind of failure of responsibility to which most professions are open, is that of a self centred focus in their work. Services organised around professional skills show the power and influence of professionals in policy making and they also display a failure to see things from the point of view of the client. Such a pattern of organisation may be logical for professionals, but often it does not meet the needs of clients and potential clients.

The real sufferers, for example, from the multiplicity of departments and services involved in the care and rehabilitation of the physically handicapped are the handicapped. So many departments and occupational groups are involved that effective coordination becomes a nightmare. Increasingly, too, major problems confronting our welfare system—the needs of the very elderly, the problems of the inner city, the needs of the physically handicapped, the rehabilitation of the mentally handicapped—require a multiplicity of professionals from different departments. It is difficult to avoid the feeling that professionals need separate departments for their own prestige and self-development rather than to provide the best possible service to clients.

The real weakness of professional notions of responsibility has been their narrowness. To see their responsibility purely in terms of responsibility to particular individual patients or clients is to take too

limited a view of the world and the role of professionals within it.

### **the claim for neutrality**

One of the historic strengths of the professions has been the belief that they could be regarded as neutral in the conflicts of economic and political life. That neutrality has been powerfully challenged in recent years. Work with individuals, it is argued, is not immune from political analysis. When so examined it is, almost by definition, conservative in its implications because work with individuals does nothing about "the system" and is therefore oriented towards symptoms. To regard ill health or educational failure, for example, as purely individual problems is to collude with the existing economic and social order. Not to challenge the society which by its nature contributes to such ills is to help to perpetuate it—and the problems to which it contributes.

Illich has argued, for example, that one of the functions—even if not an aim—of the pattern of medical provision which concentrates on the individual is to exclude the health denying properties of society from the agenda. What medicine does is to blur the health denying elements of life in modern industrial society in an anti-depressant, drug induced haze.

Professional neutrality has been attacked from another perspective too. Talk by doctors and social workers of "treatment" for the mentally ill and for delinquents suggests an activity which gives primacy to the client's interests and that what is being done is for his benefit. Critics would argue that it is society's needs not those of the mentally ill or the delinquent which are being served. Acts which are essentially political—acts to deprive individuals of liberty or acts designed to alter patterns of behaviour—are being disguised as technical and neutral by being handed over to professionals.

Activity which is politically neutral and

pursued for the general good will obviously gain the support of all people of goodwill. Once the neutrality of such activity is challenged then the supportive consensus cracks and the activity becomes exposed to new kinds of debate and questioning. Political neutrality can justify power. When that neutrality comes under fire, power and privilege begin to be questioned.

### **neglect of rights**

The charge that professionals trample on people's basic rights has been pressed vigorously in recent years in three main areas.

The 1959 Mental Health Act set out to free professionals to be truly professional. The rights of patients were given relatively little thought—at the level of legal rights or rights to adequate services. The fact that, as was seen earlier, compulsory patients have no right of appeal prior to admission gives ground for concern. If a patient does appeal to a Mental Health Review Tribunal the hospital can make available to the Tribunal information which is never disclosed to the patient—so he may lack full knowledge of the case against him. The onus on the appellant is to prove his normality—something which many members of the Fabian Society might find less than completely straightforward—rather than on the hospital to prove his mental illness. It is extremely easy for the consultant to interpret the appellant's pleas as part of his symptomatology—the fact he thinks he could manage to survive outside shows just how out of touch with reality he is, for example.

Another way in which the rights of mental patients are eroded by the professionals is the very great protection from legal action by patients which those working with the mentally ill secured under Section 141 of the 1959 Act. Under that section the basic civil rights of patients to complain about what is done to them while in hospital are substantially curtailed. A complainant has to seek the leave of the High Court to

pursue a grievance and leave will only be given if there is thought to be substantial ground for the complaint.

The powers of the professionals in relation to delinquents have come under attack as a result of the rising critical tide against a philosophy of treatment. If treatment is what it's all about, then the role of the professional becomes paramount. If the delinquent is in some sense "sick" his actual act of delinquency is no more than symptomatic of a deeper underlying malaise. He cannot claim that his act was trivial and that his punishment should therefore be brief and simple. Again, if the sole focus is the welfare of the individual, procedural safeguards are simply a barrier to the use of the most effective methods of re-socialisation. In the best interests of the child, therefore, procedural safeguards are widely neglected in the juvenile court. The very notion of treatment seems to make discussion about the rights of offenders, the procedures by which facts are established and so on, of secondary importance. Once the idea that what is being done, or should be done, is treatment is challenged, then the issue of rights re-emerges as central—as it has in recent years.

The other area in which it is alleged that professionals trample on the rights of clients is in the failure to supply information about a range of relevant issues and to secure a genuinely informed consent to what is being undertaken. Doctors are poor at telling people what is wrong and what can, or cannot, be done about it. The *Report of the Royal Commission on the National Health Service*, for example, showed that a third of inpatients and a quarter of outpatients felt they had been given insufficient information about their treatment and progress (HMSO, 1979). After decades of research on the fallability of verbal communication, very few hospitals make any effort to supply patients with basic written material about their complaint, the after effects of treatment, likely recovery period and so on. Parents of handicapped children make similar complaints—they are offered a few crumbs of information from the rich

professional table with no sense of a right to knowledge about their children's condition and needs (T Robinson, *In Worlds Apart*, Bedford Square Press, 1978).

To fail to supply basic factual information in a form which is accessible and comprehensible to the layman is normally dysfunctional to the task in hand and tramples on a basic right. The professionals, however, have shown little awareness of any problem.

### the service ideal

It is probably fair to say that in recent years belief in the service ideal of the professions has weakened considerably. In the 1970s the major welfare professions all did things which would have been unthinkable in the past. Hospital doctors worked to rule in pursuit of more money and a 40 hour week. For periods in 1975 and 1976 senior medical staff only treated emergency cases because they objected to the decision of the elected government of the day to remove private beds from the NHS hospitals. During 1979, several thousand social workers went on strike, some for many months. At various times teachers have left children unattended at lunch time as part of a programme of industrial action to further pay claims.

The rightness or wrongness of such action is immaterial to the point at issue. What the general public saw portrayed very vividly by the media was occupational groups, who assert an ethic of service, pursuing industrial action from which those in need of their services suffered. Other material concerns were obviously more immediately important than the concern to serve.

Within the medical profession there is a definite movement to clarify and narrow the responsibilities of the general practitioner. In 1979 a General Practitioner Working Group of the British Medical Association set out to re-interpret the profession's traditional ethic of service with a demand for extra payments for

out of hours services and for additional services over and above what the group regarded as normal GP services. The *Report* marks a retreat from the broad concept of service which has contributed so much to the GPs standing in the community and to the justification of his claims for a special status.

Ours, too, is a cynical society, less willing perhaps than in the past to accept altruistic behaviour at its face value. The pleas of the professions about the ethic which guides their work are less likely to be accepted as statements of fact but are more likely to be regarded as special pleas or as counters in a bargaining process. The ideal of service which the professions have always asserted as one of the major justifications for their position in society is being questioned.

### disabling effects

Illich, of course, is the great expounder of the view that the professions have profoundly disabling effects (I Illich, *et al.*, *Disabling Professions*, Marion Boyars, 1977), narrowing people's capacities to do things for themselves, creating dependency and so ultimately disabling people. Illich writes with dash and verve and an exciting mixture of error and exaggeration but there is enough substance in his allegations to give them currency.

Writing of the professionalisation of pre-school education and the stress among so many of the professionals that this is a professional task not properly to be undertaken by non-professionals, Lady Plowden suggests that "The confidence of parents in themselves as parents, in this rapidly changing society, where the urgent need is for confidence and security, has been lessened. It is 'they' in nurseries and schools who know best, from the earliest months and years of a child's life" (quoted in H Land, "Who cares for the family?" *Journal of Social Policy*, 1978).

Teachers can disable some of those they seek to teach—just as they enable others. It would be odd if they did not. Negative

attitudes to a child's background and experiences can do this, so can methods of classification which limit or downgrade a child's expectations of himself, so can hostility or lack of encouragement towards parental involvement in education.

Illich has expounded at length the "health denying effects" of the health professions. Childbirth has been medicalised and as a result "the desire, competence, and conditions for autonomous behaviour are being destroyed" (I Illich, *The Right to Useful Unemployment*, Marion Boyars, 1978).

People cease to feel the responsibility for maintaining their own health which they used to feel, or so it is argued. The result is the dependent, disabled patient making unnecessary demands on professional services because he has been schooled to the view that the doctor—and only the doctor—has all the answers to all his health problems.

The charge against social workers was neatly summed up by the *Daily Mail*, "By their very existence", it shrieked in a venomous attack, "they not only stop individuals doing things for themselves, they stop groups and communities doing things for their fellow citizens" (18 January 1980).

The argument is a double one. By freeing people from responsibilities which are rightly theirs, dealing with difficult children or coping with difficult elderly relatives for example, people become less able to cope with the other responsibilities which life brings. At the same time, the availability of public help deprives individuals and groups of both the incentive and the necessity to provide their own services. That this can be true is scarcely open to debate. The crucial point is the frequency and strength of such changed attitudes in society.

Certainly the standing of the professions has suffered from the attack on their disabling function. It has helped to encourage a critical rather than an accepting attitude towards them, even if erected

on a rather insubstantial foundation of assertion and allegation. What has given this attack added force is the fact that it has come at a time when it has become very clear that the success of the professionals is heavily dependent on active participation by their clients—for example in self-care in health or parental involvement and encouragement in education.

### **lack of accountability**

Central to the contemporary mood of scepticism and uncertainty about the powers and privileges of the professions is concern about their accountability. Just how responsive and accountable are they to popular, political and client influence and authority or are they in reality a law unto themselves? As the professions have impinged more obviously on more people's lives, the issue has become obviously important. The contrast between public financial support and the lack of clear public control has got rather too sharp for comfort. "Although the government is the main source of employment and remuneration for doctors, teachers and social workers", write Adler and Asquith, "the doctors' clinical freedom, the teachers' control over what is taught in the schools and how it is taught, and the social workers' decisions about what kind of help, if any, should be given are largely immune from any form of democratic accountability and control" (M Adler and S Asquith, *Discretion and Power*, Paper presented to SSRC Workshop on Discretionary Decision Making, Edinburgh, January 1979).

There are clearly strong arguments for professional autonomy. Much professional work is difficult if not impossible to supervise. Then there is the argument that only other professionals are competent to understand and assess professional work—in Lord Horder's immortal words "Only the doctor knows what good doctoring is". A third argument is that in a supposedly free society, the professionals *should* be autonomous to ensure freedom from the state. The problem is balancing a necessary or desirable freedom with the reality of

work in publicly organised, publicly financed services committed to democratically agreed public purposes. The current critique argues that the freedom which the professions currently enjoy—though in different degrees—is not fully compatible with their role in public services. Cases such as that of William Tyndale school (cf J Gretton and M Jackson, *William Tyndale*, Allen and Unwin, 1976), it is argued, show a degree of freedom for teachers which is incompatible with parental rights. Similarly the scandal at Normansfield Hospital (cf *Report of the Committee of Inquiry into Normansfield Hospital*, Cmnd 7357, HMSO, 1978) shows a breakdown of management and a clinical freedom which has clearly reached the level of licence.

Another area of discussion when the accountability of the professions is under consideration is the nature of the complaints and appeals machinery, its accessibility to potential and actual complainants and its efficacy in resolving complaints. In health, machinery exists, but is complex, cumbersome and, as it must seem to complainants, biased in favour of the professionals (See for example R Klein, *Complaints Against Doctors*, Knight, 1973; *Report of the Committee on Hospital Complaints Procedures*, HMSO, 1973; *Report of the Royal Commission on the NHS*, HMSO, 1979, chapter 11). In education and personal social services such machinery scarcely exists in a formal way.

If challenged, professionals will declare that their primary accountability is to their individual clients. Secondly, they argue that they are accountable to their professional peers. Neither of those defences will satisfy the enquirer who is not positively seeking to be satisfied. There are real, lively and pertinent questions about professional accountability which are being asked of all the major welfare professions. Such questions are important in their own right and as part of the broader questioning of the place of professions in a more educated consumerist, democratic society concerned about rights, effectiveness and efficiency in public expenditure, individual and

social development and the nature and exercise of power by groups within society.

**conclusion**

The current critique of the professions is a broad one. At its heart is a concern about power. Apart from a small, excitable and unrepresentative lunatic fringe there is little desire to abolish the professions. What is increasingly widespread is a desire to re-examine their role and work out a more appropriate relationship between the professions and society than that which currently exists.

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## 4. towards a policy for the professions

The second and third chapters surveyed the nature and extent of the power of certain professional groups in social welfare services and then explored the main lines of the current critique of the professions. What is clear is that the charges levelled against the professions are numerous and serious. They stand accused of using their power and influence in policy making and administration to further service developments which serve professional interests rather than the public interest. The views of need and the definitions of problems which they proclaim as objective and scientific are indicated as narrow, partisan and value-laden. Professional power over resources is used, it is suggested, to serve professional interests rather than to further democratically agreed priorities and plans. The power which professionals exercise over people is often exercised without due process or any effective right of appeal. Professional control over the area of professional work perpetuates a particular model of work, a particular type of entrant and a type of training determined by elitist elements in the professions rather than by client need.

These results of professional power are not the products of any conscious evil designs. Professionals do not set out deliberately to plan services which serve professional rather than client interests, or to negate agreed priorities, or to secure powers over people which critics regard as oppressive. What leads professionals to pursue the policies which provoke such accusations is a particular view of their role, competence and reliability which forms the basis of an alliance with government in their respective fields of work. Governments in welfare states need expertise and disinterested advice. The professions put themselves forward as able to meet this need and governments accept the claim uncritically. They do not realise, neither do the professions, that what is being offered is partisan advice based on opinion rather than on agreed fact.

What is being criticised here is, in fact, the basic model of professional work. Professional advice gains credibility be-

cause of its supposed scientific nature but that is open to question. The paternalism of professional activity is attacked as leading to the neglect of clients' rights and to their disablement. The political neutrality of the professions is unmasked as fundamental conservatism. Accountability to the professional peer group is challenged as an excuse for avoiding genuine accountability and as effectively insulating the profession, physically and psychologically, from comments and judgments of clients and users and of avoiding working out what professional responsibility means in publicly financed services. What is at issue essentially is the relationship of the professions to society, to their clients and—less obviously but very importantly—to other professionals. What is required is a new model of professional work and a strategy for its attainment.

The only model which is both functional to the role which the professions play in our kind of society and which is acceptable to democrats and socialists is that of partnership—partnership with clients, partnership with society and partnership with other professionals.

Such a partnership model will obviously mean different things in different professions and only its general outline can be sketched here. It means professionals accepting patients, clients or parents as partners in the task of medicine, social care, planning or education. This means a sharing of information, a discussion of what is being done and why, and an acceptance of the lay person's right to a say in the decisions which have to be made. Decisions about the amalgamation of practices, alteration of surgery hours, the adoption of appointments systems, or changes in arrangements for emergency cover, for example, would be made only after discussion with patients. Equally, in education, matters of school organisation, streaming and unstreaming, banding or setting, or the introduction of new reading schemes, for example, would be the subject of discussion between teachers and parents. Partnership means shared decision making, mutual respect and shared responsibility. It means that the

professional moves much closer to his clients. They become his key reference group as important as his professional peers.

The idea of professional work as a partnership with society means no more than an explicit recognition of the reality of work in publicly financed services designed to further public purposes. In such a situation ideas of professional autonomy fit ill with the reality of the situation. Professionals cannot avoid a close relationship with the social purposes of the state, for it is the state rather than the individual which becomes the client; the state declares the need and pays for it to be met. What professionals have so far been reluctant to face is the responsibilities which follow from such a position—responsibilities in resource use, in the furthering of publicly agreed priorities even if they generate little enthusiasm in the profession, in accepting the legitimacy of management action to set boundaries to the extent of professional freedom.

Partnership with society means greater professional acceptance of political authority and the rights of government to determine priorities and to fix the basic terms of the professional work. Such greater professional identification with public purposes will be in direct and creative conflict with the new partnership relationship with clients, because that will lead professionals to a much closer identification with the services in which they work and so to a much more critical approach to the levels and standards of service provision. At the same time, partnership means that the professions become more closely involved with serving public purposes and more critical of public action on behalf of their new partners, their clients.

Increasingly, successful professional intervention in one sphere of life depends on collaboration with other professionals—in the care of the mentally handicapped, the chronic sick, the elderly, children in trouble, problems of poverty and the inner city. Professionals, however, are socialised in isolation from each other to the performance of narrowly defined

tasks. They tend to see their own skills as the key ones around which others should be organised. The fact that social welfare services are organised around professional skills rather than client needs shows the strength of professional independence.

Partnership with clients and society must be complemented by partnership with other professional groups—doctors with social workers, social workers with teachers, teachers and social workers with planners—and so on. The tripartite nature of the model of partnership which is being suggested has important balancing effects on professional work. The partnership with society, which could lead to the total subordination of a profession to public purposes, is balanced by the profession's partnership with individuals, so the profession does not become simply the slave of government. Similarly, stress on the partnership of a profession with other professions can be a check on the potential exclusiveness of an emphasis on professional partnership with individual clients.



# 5. the strategy for a new relationship

It is not too difficult to produce a new model for professional work. What is rather more difficult—as with all schemes of social reform—is to devise a strategy for change and to secure its implementation. There are two obvious initial problems. The first is that those with power and privilege are generally less than eager to assent to their dilution or removal without protest or resistance. Secondly—and almost as important—those who have never had power or influence in relation to professional services—clients and patients, parents and slum dwellers—are reluctant to assume them with any vigour or enthusiasm. A partnership model of professional work depends on change in such attitudes.

There are, however, some signs of hope. In the social services which are our main concern, trends in thinking and in some pioneering experiments suggest the need for rethinking the traditional role of the professions. Stress on self-care in health places the individual in a potentially new relationship with the medical profession, one of shared responsibility. Research findings about the importance of parental encouragement to children's educational success challenge the traditional separation between home and school and create important educational reasons for greater parental involvement with children's schooling. In the broad area of social work, the development of a wide range of self help groups—alcoholics, the mentally ill, parents of mentally handicapped children, single parents, for example—shows just how much people with similar problems can do to support and help each other. Such groups want and need a quite different relationship with social work staff; they have become partners in meeting their own needs.

Some members of all the professional groups which have been discussed have discovered the very tangible benefits of seeking a new relationship with those seeking their services. Doctors have sought to educate their patients about when and why to call a doctor, about what he or she can and cannot do. Taking time to explain a symptom or a treatment and likely reactions has been shown

to reduce what were previously regarded as trivial consultations, but which were in fact the product of a particular model of medicine. Social workers, too, have found that a frank explanation of what they can and cannot provide reduces demands which they cannot meet—and so their own dissatisfactions. It has been shown that Patients' Committees, active and lively Parent-Teacher Associations, groups of local users of social services can be a help rather than a threat to professional work.

So there are trends and developments within the professions and the services in which they work which suggest the possibility of new models of professional work. So, too, do some aspects of broader social change. In the last dozen years authority relationships of all kinds have been challenged. There is less deference to authority of all kinds—partly because of the spread of education, partly because authority of all kinds has been so often exposed as fragile, incompetent or corrupt. One specific aspect of this challenge is the growth of a critical consumerism in the commercial field and this has naturally washed over into the social welfare field. Increased concern among politicians and administrators for efficiency and effectiveness in resource use in a situation of non-growth has made them more curious about how professionals use resources and the rationale for particular patterns of resource use. Efficiency and effectiveness provide a legitimate rationale for managers to ask critical questions about what is being done, how and why. And the high cost of professional services in staff training, salaries and support is leading remorselessly to the question of whether professionals are really worth that much more than lesser trained or untrained staff.

There may be hopeful glimmerings of possibilities of change. What is needed is to take advantage of the favourable signs and trends and push forward vigorously with developments calculated to further the desired partnership.

One important development which

government could foster is the growth of *ad hoc* institutions for lay involvement in the government of organisations which have hitherto been dominated by professionals. It is at the level of the school, the social services area office, the group practice or the health centre that the activities of the welfare professionals impinge most directly and immediately on those using their services. It is at this local level that the traditional machinery of democratic control through Parliament and local council is least effective. It is where professionals and people actually meet that both parties have most to gain from institutions to allow discussion of common issues.

Simply creating a rash of patients' committees, *ad hoc* committees of planners and residents, parent teacher associations or more representative school governing bodies is obviously not going to create overnight a new relationship between doctors and patients or parents and teachers, planners and the public. There is going to be hostility, suspicion, apprehension, deference and uncertainty at the start and these will only disappear gradually. What it does do, however, is to make possible the evolution of a new relationship.

### **the benefits of cooperation**

How are such developments to be encouraged? Firstly, the benefits to professionals and service users can be clearly spelled out by the appropriate government departments to professional associations and to and through, for example, Area Health Authorities, Family Practitioner Committees, local Education Authorities, Social Services Committees. There is a strong case to be made for the practical advantages to all parties in seeking a new relationship. It has never effectively been made and this is a first step.

A second step is to provide tangible encouragement and incentives to such developments. Small grants to be spent for the benefit of the school, the group practice or the social service area could

be made to patients' committees, new style school governing bodies or social services users' committees once they were established. If these grants increased year by year, on condition such representative bodies were functioning, so that an increasing proportion of the agency's budget was subject to the control of the *ad hoc* representative body this would provide a powerful incentive to even the most unenthusiastic professionals and clients to get together. Such funds would remain at the level of amenity funding rather than being a substantial proportion of the organisations' running costs, but such provision would provide tangible incentives to all parties to cooperate. A small increase in pupil capitation allowances to be released to schools showing evidence of an active relationship with parents for the PTA or the school governing body to spend, or a small grant to be made available to the patients' committee for improving the group practice or the health centre amenities would be a real spur to development.

There is much to be said for moving forward through persuasion and incentives. There is no reason, however, why provision for such representative bodies should not be included in legislation. There is statutory provision for all schools to have managers or governors and the principle could be extended to other services and developed so that the bodies became genuinely representative of those actually using the services.

The aim of creating *ad hoc* participative institutions is, in the first instance, to create a forum for discussion of common problems between professionals and service users. It cannot be more, given the constraints imposed by the existing systems of local government and health service administration. And establishing such institutions, simple though it may sound, is in fact a major undertaking.

Evidence from one early patients committee, for example, suggests that it can take several years to establish a body which can claim to be moderately representative and has attained a measure of self confidence (I Shaw, *Patient Partici-*

*pation in General Practice*, Welsh Consumer Council, 1978).

A second line of policy which must be pursued by any government concerned to establish a new model of professional work is the establishment of more effective and accessible complaints and appeals systems for those who are dissatisfied with their treatment in professional services. In no area of social policy is there machinery which could at present be considered adequate. Of the professional welfare services—health, education, planning and personal social services—only the NHS has a formal complaints system. As was pointed out earlier, its various elements have been thoroughly examined in recent years—and found sadly wanting. The system is complex and the procedures are lengthy while its scope at the level of general practice is restricted to breaches of contract, so excluding from consideration many of the issues which most worry patients.

### **a complaints procedure**

What is needed is a simple, accessible, informal system for dealing with complaints, including complaints about the exercise of professional and clinical judgment, in all services. It would deal with complaints about the nature of the service offered as well as appeals against refusal of service. Each Area Health Authority, Local Education Authority, Social Services Committee and Planning Committee could establish such a body with a panel of members from which particular appeal committees would be constituted. The chairpersons of such committees should be laymen with some knowledge of the field. The relevant profession should be represented but lay representatives should be in a majority to counterbalance the natural deference shown by laymen to professionals. Experience has shown that appeal systems which do not provide representation for appellants are unsatisfactory so some guarantee of representation would be necessary.

Such a system would need to be supported by informal conciliation machinery

within departments which sought to satisfy complainants so that they felt the need to involve the formal machinery only in exceptional circumstances. There would also need to be a broadening of the terms of reference of the Parliamentary Commissioner for Administration, the Health Service Commissioner and the Local Ombudsmen so that they could both take direct complaints from people with grievances, move beyond narrow issues of maladministration and examine complaints against the exercise of clinical judgment.

There is no satisfactory easy way of informing people about their rights of complaint and appeal because, for most people, occasions of complaint are rare. A relationship of partnership between professionals and clients should lead to a greater acceptance of the laity's right to complain while at the same time making for the easier resolution of difficulties through discussion at *ad hoc* participative institutions. But the principle of a right of complaint and appeal is important. It is recognised and expressed with reluctance in the present protective maze which surrounds professional services. That maze does nothing to help a constructive relationship between professionals and those who use their services.

A third development which could contribute to the new relationship between the professions and society is the establishment of a body such as a Parliamentary Select or Standing Committee for the Professions, or some kind of permanent Council for the Professions. Rudolph Klein has suggested the need for such a body on a number of occasions. The aim would be for a body of appropriate membership, with a lay majority and necessary staff, regularly to collect and publish material about chosen aspects of professional organisation and practice such as complaints and appeals procedures, methods of monitoring standards of work, how the professional associations were exercising their various powers and responsibilities. Such a body could subject professional organisations and practices to the kind of

critical and pointed questioning which they so easily escape at the moment. It might, for example, carry out a regular review of each major social welfare profession looking at the patterns and relevance of training and education, the degree of flexibility in adapting to new needs, its readiness to accept research findings, its efficiency and effectiveness and the extent of consumer satisfaction or dissatisfaction with the service being provided. If government is to attempt to work out a policy for the professions there is clearly a need for some kind of public or parliamentary body to oversee such a policy. A Select or Standing Committee would root the issue firmly in the political field which is where it needs to be located.

A fourth development which is a prerequisite of a new model of professional work is a new attitude by government to the professions. Governments have been over deferential in recent decades to professional claims to expertise, independence and authority. Discussion with professional bodies has on many occasions approximated far too closely to negotiation. Governments need to accept again the legitimacy of political authority and control and the dubious and illegitimate nature of the pleas of interested parties of all kinds for special privileges. Government and lesser political and managerial bodies are often excessively reluctant to assert the legitimacy of their authority. The Committee of Inquiry into Normansfield Hospital tackled this issue of the relationship between professional and political authority head on. "Health authorities", it concludes, "have a right, and indeed a duty, to stipulate, if they feel it necessary, the pattern of life that they wish to provide in the hospitals for which they are responsible (this particularly applies to long stay hospitals); and it is equally their duty to take disciplinary action against any employee who deliberately thwarts their intentions. . . . They should not allow themselves to be confused, still less stopped in their tracks, by the use of such terms as 'clinical responsibility'" (*Report of the Committee of Inquiry into Normansfield Hospital*, HMSO 1978, Cmnd 7387).

Against professional claims—implicit or explicit—that their obedience is to some higher authority, politicians and managers can assert their own obedience to the democratic will of the people mediated through Parliament or the processes of local government. They can, and should, take to heart the views expressed by the Taylor Committee on the justification for lay involvement in all aspects of the life of the school. "A school", the Committee pointed out (and they could have said the same of a health service, a personal social services department or a planning department) "it not an end in itself; it is an institution set up and financed by society to achieve certain objectives which society regards as desirable" (*A New Partnership for Our Schools*, HMSO, 1977). That statement is a complete justification for the assertion of political and managerial authority over professional special pleading.

### asserting political authority

Government needs to take the offensive against the professions and publicise some of the arguments about failures of professional responsibility, neglect of people's rights, the relationship between professional claims and achievements, the rather tarnished nature of the service ideal, the way in which professionals refuse to accept accountability to anyone except their peers. Too often the professions are allowed to escape the kind of close questioning to which governments should expose them. The professions have no monopoly of wisdom about priorities or service organisation and no inherent right to set their own terms of work. These things need to be said—and governments are unduly reluctant to say them.

While asserting the primary of political authority government should also encourage the professions to set their own house in order. Professional self regulation can make a contribution to maintaining the standards of professional work but sadly no profession has shown anything but the most lukewarm interest in monitoring and maintaining the standard

of work of its members. Professional self audit could contribute to a new relationship between profession and society through inducing a new professional self consciousness about resources used and the distributional implications of the decisions made and about the need for cooperation with other professionals if client needs are not to be neglected. Self audit shows a serious commitment to improving and maintaining standards of work. Only professional bodies can audit some aspects of professional work. Government should encourage the professional bodies to see that the standing of the profession depends on the quality of its members' work and that all its members—and the public—stand to gain by the review of performance from which professionals have too long been immune.

In the United States the Professional Standards Review Organisations provide a potential model for a system of self audit in medicine and other fields. There is a National Professional Review Council which has various statutory duties—to establish local norms of diagnosis and treatment, to establish norms for the length of hospital stay and to provide for the review of these for individual patients, to construct "profiles" of the work of individual doctors and institutions. The aim is simple and unexceptionable—to see that all medical treatment given is medically necessary and is of an appropriate standard of quality and care. It is a job which needs to be done and which is best tackled by professional bodies of some kind. But government needs to make it plain that if the professions are not prepared to cooperate in this task it will have to create its own methods of audit and supervision.

## conclusion

There are no easy solutions to the problems posed by the position of the professions in modern society. It is one particular aspect of the relationship between technical and political power which Daniel Bell has described as "one of the most crucial problems of public policy" (D Bell, *The Coming of Post Industrial Society*, Basic Books, 1973). Enough has,

however, hopefully been said to show that the power wielded by the professions has often worked to the detriment of those they purport to serve. Their relationship with their clients and society needs rethinking both on pragmatic grounds of service effectiveness and on the grounds of democratic principle.

The professions have, in the past, sought to assert themselves as somehow above and beyond normal government control because of obedience to some higher ethic. Such claims cannot be accepted. In a democratic society, the professions have no claim to political immunity. Accountability to those using their services, and to those who manage the services in which they work, and to the political bodies which employ them has to be re-established. Some suggestions about how this process might be begun have been outlined but clearly different institutions and procedures are needed in different services.

Something can certainly be achieved through the establishment of new *ad hoc* representative institutions, the improving of complaints and appeals systems, the creation of a Select Committee or Council for the Professions, the reassertion by government of the legitimacy of political and managerial authority and the stimulation of critical self audit among the professions themselves.

Much can be achieved by education, persuasion, encouragement and incentives but at the end of the day the obstinate assertion of privilege at the expense of the general good cannot be tolerated. Compulsion may be necessary if governments are to fulfil their responsibilities. Ultimately, however, the need for changes in the position, powers and privileges of the professions cannot be isolated from the need for more general radical change in society. Writing about the resolution of the relationship between the medical profession and society, George Bernard Shaw was quite clear that "The social solution of the medical problem depends on that large, slowly advancing, pettishly resisted integration of society, generally called socialism" (G B Shaw, *The*

*Doctors' Dilemma*, Constable, 1947). If the professions are to be genuinely socialised, society itself has got to change radically but it is certainly possible to begin that process of genuine socialisation here and now.

[The text continues with faint, illegible text, likely bleed-through from the reverse side of the page. It appears to be a continuation of the author's argument, possibly discussing the role of the state and the responsibilities of various professions.]

[The text continues with faint, illegible text. It seems to be a further elaboration on the author's points regarding socialization and professional reform.]

## Conclusion

[The text continues with faint, illegible text under the 'Conclusion' heading, providing the author's final thoughts on the subject.]

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## **socialism and professionalism**

The values of socialists and of the public generally are often incompatible with those of professional groups. In this pamphlet Paul Wilding examines the autonomy enjoyed by professionals in the social welfare field—teachers, doctors, planners and social workers—and the conflicts that arise when that autonomy, based on a narrow expertise, is used to influence policy in the essential political areas of resource allocation between groups, policy definition and direction and the power over individuals both within and outside of institutions. These conflicts are increasingly pertinent to society as a whole as public demands for the accountability of institutions, organisations and groups grows. The author concludes by putting forward proposals for a partnership strategy for laity and professionals.

## **fabian society**

The Fabian Society exists to further socialist education and research. It is affiliated to the Labour Party, both nationally and locally, and embraces all shades of socialist opinion within its ranks — left, right and centre. Since 1884 the Fabian Society has enrolled thoughtful socialists who are prepared to discuss the essential questions of democratic socialism and relate them to practical plans for building socialism in a changing world. Beyond this the Society has no collective policy. It puts forward no resolutions of a political character. The Society's members are active in their Labour parties, trade unions and co-operatives. They are representative of the labour movement, practical people concerned to study and discuss problems that matter.

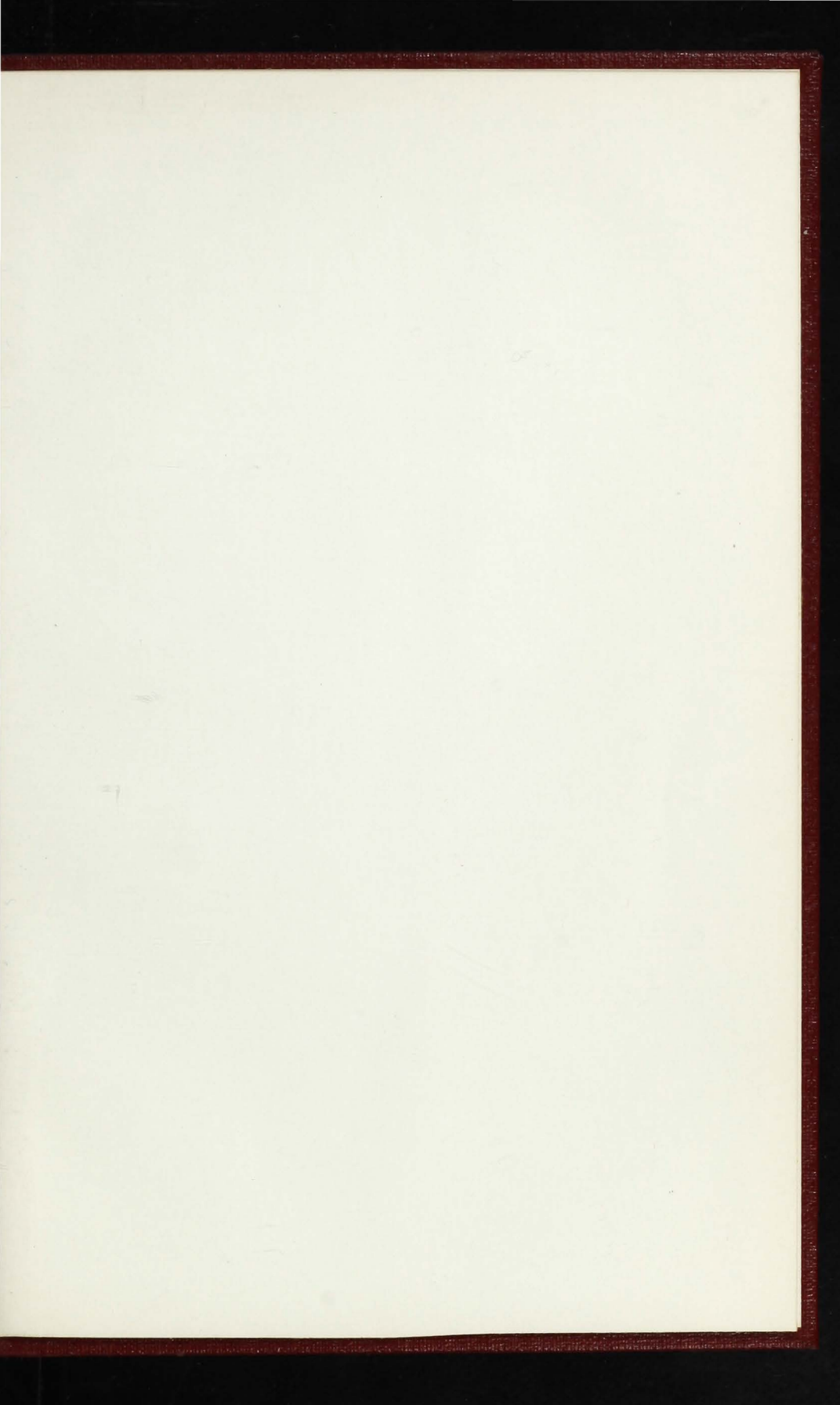
The Society is organised nationally and locally. The national Society, directed by an elected Executive Committee, publishes pamphlets and holds schools and conferences of many kinds. Local Societies—there are one hundred of them—are self governing and are lively centres of discussion and also undertake research.

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## Professionals and professionalization

The values of professionalization are not uniform, and often diverge from the values of professionalization. In the past, the main reason for professionalization was to enhance the status of a profession. The professionalization process is a process of socialization, and the professionalization process is a process of socialization. The professionalization process is a process of socialization, and the professionalization process is a process of socialization. The professionalization process is a process of socialization, and the professionalization process is a process of socialization. The professionalization process is a process of socialization, and the professionalization process is a process of socialization.

## Public society

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March 1891

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