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Ph.D. project proposal – short summary

Professionalism worldwide or: How to undermine the equivalence of the medical profession systematically [working title, March 30th 2015]

The medical market is globalized (Crone, 2008). This is evident for individuals and states, on the supply and demand side. Patients ask for interventions across country borders or even across entire borders of continents. Medical tourism runs on both, the global north-south axis and on the global south-south axis. Typical destinations of the medical industry are emerging countries such as South Africa, which offer quality health services at low cost. Thus, the number of medical tourists rose from 327,000 in 2006 to more than 500,000 people in 2009 - 4.5% of all tourists in South Africa expect a medical treatment, and 80% of these patients with tourist visa are from the poor neighboring countries such as Lesotho or Zimbabwe (Crush, Chikanda and Maswikwa, 2012, pp.1). It appears that migration of patients is not necessarily an individual (economic) consideration, but an option for states whose health systems do not meet the needs for medical and other health care professionals. In the health-care policy in southern Africa, for example, medical tourism has been on the political agenda for a while (SADC, 1999). For example, in 1999, the SADC states whose health systems have the greatest relative demand for medical staff (WHO 2006, pp.12), agreed "to facilitate the establishment of mechanism for the referral of patients for tertiary care" (SADC, 1999, pp.5). However, the medical market is also highly competitive and insofar politically interesting for nation states or macro-regions (Willets and Martineau, 2006), as so the guarantee of a comprehensive health care (Moran, 1999). Consequently, the data of the World Health Report 2006 confirm a direct, positive relationship between the health outcomes of the population and the density of health workers nationwide (WHO, 2006). In capitalism, therefore, the health system on a global scale forms a core-periphery structure (Elling, 1994).

So does the supply side. In 2006, 4.3 million professionals were missing worldwide. The absolute highest demand was estimated in the poor and poorest countries such as Bangladesh, India and Indonesia (WHO, 2006:12) even though these countries educate a large part of the worldwide, highly mobile medical profession. For example, in OECD countries about 15% of immigrant physicians migrated only from one country, India (OECD, 2007, pp.163).[1] The World Health Organization demonstrated the relatively highest demand for medical personnel in the SADC countries such as Botswana, the OECD countries determined no critical need for medical personnel (Dovlo, 2005; Liese, Blanchet and Dussault, 2003; OECD, 2013; Padarath et al., 2003; WHO, 2006). In a world society level, in politics (and ethics!) is not obvious, how e.g. doctors are included, that are able to perform modern medicine under the most unfavorable conditions or who are remunerated financially from patients. It appears: On a global scale, the cleavage of health systems occurs supranational, shown in a 'European' healthcare system (Kuhlmann, 2011; Skar, 2001) or in a healthcare system of 'sub-Saharan Africa' (Gilson and Mills, 1995). Similarly, the profession of medicine, which has a long tradition of migration movements (of people, machines, techniques) (Bach, 2008), i.e. works beyond territorial boundaries of nation-states and macro-regions – theoretically – could embody power relations at the world level. Professions historically arose from the expansion of welfare states (Bertilsson, 1994), but many states are not self-evident organized as welfare states, and also professionals cannot be subsumed under (welfare) states.

On a global scale, the **sociology** has not been investigating in professions as an object of study. As a result, the explanatory potential of profession theory is limited to the nation state[2],

[1] Approximately 35,000 doctors had a foreign citizenship in Germany in 2013. That was approximately 15% of the total number of employed physicians in Germany in 2013 (BAK, 2013).

[2] In the global and/or transnational sociology, professions are discussed sporadically (see Faulconbridge and Muzio, 2012), for example as actors in the regulation of valuable goods or regulatory standards across coun-

although – at least – empirically has been observed that about a third of the workforce is professional in the relatively wealthy nation states (Cohen and Kennedy, 2013, pp. 74). How could the sociology describe global power relations, which are embodied by professions? How could professionalism as a concept of domination be theorized, that not (just) appeal to the perspectives outlined above, for example, to relatively poor countries (and their 'right' of physicians) or relatively wealthy countries (and their 'supply' of physicians)? Could professionalism - in theory – function as a dimension of social inequality in the world for example, for those professionals who were not placed in strong (welfare) states, as is the case for many migrants?[3]

My **thesis** is that professionalism is a dimension of social inequality in the world, and has an effect of structural disadvantages for racial dominated as a (non-)intended consequence. Following the (critical domination theory) tradition of the French epistemology, I claim that professions are belief systems (Brante, 1990, 2010, 2011) with antagonistic relationships within it[4], i.e. those abstract and (seemingly) neutral symbol systems, which are embodied by professions, institutionalize social inequalities in global scale ways. I call this dimension of social inequality (provisionally) expert authority or professional authority/professionalism and mean - spoken with the profession sociologist Eliot L. Freidson (1970a) - an authority that "is based on persuasion grounded in a common universe of discourse, a shared set of paradigms" (pp. 109). The World Polity Theory (Meyer, 1980) conceptualizes professions as powerful players in the modern, secular world order (Scott, 2008). Nevertheless, a systematic study of professions as institutions of social inequality on a world scale remained until now. The latter is the aim of this Ph.D. project.

In theory, professions from a world-society perspective, so far, have been described insufficient, i.e. there exists a **theoretical gap** in research on global power relations through professionalism, which is systematically. World domination on the one hand has been addressed by the sociological research on inequality, with concepts such as an institutional racism (Feagin and Feagin, 1986 [1978]) or a dominance of majority societies (Omi and Winant, 2015 [1994]) with their concepts of ethnic boundaries (Wimmer, 2008) that are rather suitable to explain global inequalities, which are caused by (national) societies (Weiß, 2010). However, I consider systematic references to the Racial Formation Theory (Omi and Winant, 2015 [1994]), because Michael Omi and Howard Winant define racial domination as an "extension of racial meaning to a previously racially unclassified relationship [or] social practice [...] in large-scale ways" (p. 110), i.e. theories of power, that emphasize power relations within symbol systems (such as Omi and Winant, 2015 [1994] in the discussion of instabilities of race policies in the US in chapter 5 "racial politics and the racial state") are useful to the theory building here. On the other hand, global power relations in capitalism have been explained by Marxist approaches such as the research on racism in the labor market (Bonacich, 1972; Bonacich, Alimahomed and Wilson, 2008; Miles, 1982). (Neo-)Marxist concepts theorize social inequality of ethnic minorities primarily as economic exploitation. Erik Olin Wright states that "domination-centered concepts of class tend to slide into the 'multiple oppressions' approach to understanding society. Societies, in this view, are characterized by a plurality of oppressions each of which are rooted in a different form of domination – sexual, racial, national, economic, etc. – none having any explanatory priority over any other. Class, then, becomes just one of many oppressions, with no particular centrality to social and historical

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tries (see Quack, 2007). Studies on the description of social control, which professions exercise (see Kuhlmann, 2011), are examined in the comparative sociology (see Kuhlmann and Allsop, 2008; Kuhlmann and Saks, 2008).

[3] Through gender-sensitive lenses professionalism could be described as 'heroic' (Witz, 1990, 1992; Davies, 1996; Wetterer, 1995; Kuhlmann, 2008) or 'conservative' (Walker, 2001). As an explorative, reconstructive empirical study, this Ph.D. project aims not to analyze gender-dimensions comprehensively. Instead, in the empirical part of the study, I will, however, appeal to (secondary) literature, that explains inequality for female professionals (Witz, 1990, 1992; Wetterer, 1995; Kuhlmann, 2008; Walker, 2001, 2003, 2005).

[4] The ability to compromise exists, but – in conflict theory – the opposite of antagonism would be designed as harmony, not compromise.

analysis" (pp.57). In this sense (neo-) Marxist profession theory (Parkin, 1983) argues that professionals do not get their pay as a result of its success, but as a prerequisite for being able to contribute to this. Karl Marx writes: "it is for the economic certainty" of the relationship between the professional and the client "quite indifferent [...] whether the doctor cured, the teacher is successful in his teaching" (Marx, 1983, pp.381). This means that professions as 'private services' are "no subject to the reproductive contexts of capitalism "(Stock, 2003, pp.186). Quite the contrary applies: Professions have an out-sophisticated position "secured by the political and economic influence of the elite" (Freidson 1970b, pp. 72). In short, Marxist explanations of domination by professionalism seem more appropriate for welfare states and are not of interest for this Ph.D. project, that investigates among others in a historically study of the (global) profession of medicine.

A problem in theory e.g. in research on inequality cannot be solved by making inequality for the immediate occasion and starting point of theory. Empirically, social inequality is not in question. Instead, a question arises when we think of how exactly distributions of resources and goods in a modern society are done which break with "whatever scale criteria of equality among a justice point of view" (Bommes, 1999, pp.24). One **result** of this Ph.D. project could be an attempt to prepare a theoretical model that describes professionalism as a dimension of social inequality in the world. I, myself, study this social inequality empirically, by following the research questions: How could the sociology explain the history of the health system in global scale way, with an analytical focus that accentuates the relations between Western Europe and southern Africa? For what power relation in the allocation of (valuable) goods is the appeal to professionalism the appropriate standard? And, how exactly is professionalism a justification of social inequality in the world, which undermines the position of such professionals that are not positioned in the context of relatively wealthy countries?[5]

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[5] The interview study with migrated physicians, which I did in two macro-regions (southern Africa, Western Europe) - in South Africa and Germany -, shows that professionalism is an independent dimension of legitimized (prolonged and systematic) power relations in the world. The contrast of (social) positions of different 'cases' in respect to those inequality 'dimensions' such as the labor position, the financial situation, the partnership/ family position and the legal situation in the countries of origin and countries of 'destination', etc. shows that only the way the profession works explains a crucial difference to the class position.

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