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ORIGINAL ARTICLE

Perils of Professionalization: Chronicling a Crisis and Renewing the Potential of Healthcare Management

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Abstract

This paper critically examines efforts to "professionalize" the field of healthcare management and its corresponding costs. Drawing upon the scholarly critiques of professionalization in medicine and the broader field of management, this paper seeks to explore the symbolic role professionalization might play in the psyche of its constituents, and specifically its function as a defense against uncertainty and anxiety. This psychodynamic heuristic is then deployed to put forth the hypothesis that an ongoing crisis of professional identity continues to both propel and impede professionalization efforts in healthcare management, giving rise to a litany of standardization pressures that ultimately limit the field's potential. To mitigate these pressures, the call is made for rekindling healthcare management's moral, political, and existential aspects. Specifically, this entails engaging with the deeper themes that flow through the field: the experience of illness and what it means to suffer, the experience of life and what it means to have hope, and the experience of death and dying. It also entails squarely confronting questions of power, poverty and disease, and the pursuit of justice.

Keywords History of healthcare management · Professionalization · Professional identity · Healthcare management education · Accreditation · Critical scholarship

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Introduction

Since its inception as a stand-alone field nearly a century ago [26], healthcare management has enjoyed rapid growth. Buoyed by an ever-expanding healthcare industry, specialized undergraduate and graduate programs continue to proliferate [110, 118], as do the number of healthcare managers returning to college to enhance their careers [37, 77].[1] Meanwhile, membership in professional associations has swelled, signaling a shared and increasingly global identity among scholars and practitioners alike [56, 122, 123]. More broadly, a steady stream of issues calling for managerial oversight and guidance—advancing medical technology, shifting consumer demand, rapidly aging populations, intensifying fiscal pressures, and larger and more complicated organizations—virtually ensures continued growth of the field for years to come [12, 14].

Yet with such growth come consequences. This paper critically examines one such consequence known as "professionalization" of the field. Classically defined as the standardization of jobs through systematized knowledge, prescribed training, and exclusive jurisdiction [125], professionalization has since taken on a pejorative quality in the critical scholarly literature to signal how occupations erect hierarchies, shape beliefs and experience, and above all assert control [1, 61]. This paper builds upon the critiques of professionalization in medicine [36, 108] and the broader field of management [32, 33, 49] to reveal the mechanisms with which healthcare management wields its power. The argument is made that while professionalization is in some sense an inevitable response to a changing environment, it is also willfully reinforced by efforts to standardize education and practice that come at significant cost to the critical and creative aspects of the field. Furthermore, to understand the sheer persistence of such efforts—often in face of increasing criticism [54, 66, 71, 85, 86]—the hypothesis is put forth that what drives professionalization in healthcare management is not simply the raw pursuit of power, but also an underlying and still under-acknowledged crisis of professional identity. Seen from this vantage, professionalization is, at bottom, an incessant attempt at circumscribing what (and who) healthcare management is amid inherent doubt. Propelling this doubt, moreover, is not just a "professional power play" masking ideological struggles [86], but having to live such struggles on a daily basis alongside other vexing themes: the experience of illness and what it means to suffer, the experience of life and what it means to have hope, and the experience of death and dying. Far from mere clinical concerns, these themes pervade the landscape of healthcare and belie the very notion of "management". They also represent an unmet opportunity for professional growth.

The critical perspectives put forth in this paper are not entirely new to healthcare management [85, 86, 93]. Virtually absent, however, are any proposals to mitigate professionalization's perils. Hence this paper seeks to lay a preliminary pathway beyond critique and toward change. Before charting such a path, however, the

[1] As of the early 2000s, there were over 300 healthcare management programs in the US alone [120] and an estimated 41 master's degree programs in the UK [121]. For a comprehensive list of graduate programs worldwide, see [121].

paper first outlines healthcare management's professionalization efforts in relation to those of medicine, so as to better contextualize the current state of affairs. This is then followed by an account of the psychological motives hypothesized to underpin professionalization efforts, and specifically the defensive function such efforts serve against uncertainty and anxiety that invariably infuse day-to-day managerial life. These motives, in turn, are shown to coalesce around a crisis of professional identity that is both protracted and endemic to the field. Far from hindering healthcare management, however, this crisis is framed as an opportunity to confront the bigger problems and responsibilities to which the field is called. The paper thus concludes with offering a preliminary proposal for renewing healthcare management by foregrounding the field's moral, political, and existential aspects.

Before proceeding, some caveats are in order. First, although contesting professionalization, this paper is not intended as an affront to notions of "professionalism" that have been shown to inspire commitment and integrity in various industries [76], and particularly in healthcare [21, 25]. Indeed, if professionalism is a source of meaning and solidarity [54], professionalization is a threat to meaning and a form of occupational control.[2] Similarly, this paper does not debate whether healthcare management warrants the designation of a bona fide "profession" [25], but instead aims to problematize the more general tendency to professionalize the field by illuminating the underlying psychological motives involved and their connection to notions of professional identity. Third, and in keeping with the inherently interdisciplinary scope of healthcare management, this paper draws from a handful of perspectives that span the sociology of professions, the psychoanalytic study of organizations, and the burgeoning scholarly movement known as "critical management studies". While this theoretical eclecticism is not without risk, it is intended here to serve an integrating function, and specifically to shed novel light on the quest for professional power and its connection to deep-seated defenses against uncertainty and anxiety.[3] Fourth and finally, due to the author's location in the US, the views herein are predominantly (though not exclusively) US-based and thus may not reflect the views of other countries or regions of the world. The hope, however, is that the insights offered are applicable to contexts outside of the US, especially insofar as these contexts also grapple with the machinations of professionalization increasingly affecting not just healthcare management, but various occupations and forms of work [84].

[2] In a recent study of mid-level managers in the NHS, Hyde et al. [54] note, "[p]rofessionalism and an appeal to an (albeit sometimes compromised) identity as a practitioner was, for our managers, the most effective form of resistance to what they perceived as a drift away from patient care and toward the domination of a business rationale" [p. 72]. A similar framing of professionalism as an antidote to market influence can be found in medicine [95]. This paper revisits the distinction between professionalism and professionalization in the conclusion.

[3] Furthermore, this psychodynamic heuristic carries the added benefit of grounding otherwise abstract theorizing in the everyday tasks of healthcare management; tasks which are no means trivial.

A (Brief) History of Professionalization and Its Discontents

The history of professionalization in healthcare management cannot be understood without reference to the history of medicine as a whole. In his widely acclaimed book, *The Social Transformation of American Medicine,* sociologist Paul Starr (1982) documents the processes by which US doctors achieved professional sovereignty. "In the nineteenth century, the medical profession was generally weak, divided, insecure in its status and its income, unable to control entry into practice or to raise the standards of medical education" [108: pp. 7–8]. All of this changed, however, with the twofold forces of industrialization and urbanization that mark the transition to the twentieth century. "[A]s larger towns and cities grew, treatment increasingly shifted from the family and lay community to paid practitioners, druggists, hospitals, and other commercial and professional sources selling their services competitively on the market" [108: p. 22]. Doctors, in turn, seized upon this opportunity by dictating treatment protocols, enforcing credentials, and above all wielding power and influence over government policy. In a word, they "professionalized"—an endeavor guided as much by cultural and political forces as by the changing nature of capitalism [36].

Ironically, and at core, medicine's professional sovereignty was achieved through fostering dependence, and specifically exclusive dependence upon doctors for their knowledge and expertise. While such dependence was at times legitimate and rooted in a command of science and evidence-based treatment, it was also an exercise of power. As Starr (1982) observes, "[t]he dominance of the medical profession…spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant and often incompletely equipped" [108: p. 5]. As a result, "the profession has been able to turn its authority into social privilege, economic power, and political influence" [108: p. 5].

The professionalization of healthcare management follows a similar trajectory albeit with a significant twist. Like the tasks of medicine, the tasks of healthcare management—planning, coordination, budgeting, and reporting—existed long before falling under a designated role requiring specific expertise [85, 110]. Catalyzed by the economic constraints of the Great Depression, an influential report by the US Committee on the Costs of Medical Care in 1932 provided what would soon serve as formal justification for the field:

> Hospitals and clinics are not only medical institutions, they are also social and business enterprises, sometimes very large ones. It is important, therefore, that they be directed by administrators who are trained for their responsibilities and can understand and integrate the various professional, economic, and social factors involved [quoted in 98: p. 3].

As would be expected, these emerging "administrative professionals" jostled for status and recognition by framing the healthcare organization as a business and using businesslike terms to explain day-to-day operations [26]. Similarly, terms such as "executive" and "leader" began entering the lexicon with increasing

frequency, elevating the status of what was once deemed mere "administrative work" [69, 70]. Underscoring such efforts were calls for specialized training rooted in business pedagogy and housed in universities. "The country has drifted into its present chaotic condition because there was nobody whose business it was to furnish guidance in matters of medical administration," bemoaned S. S. Goldwater [47: p. 26], then head administrator of Mt. Sinai Hospital in New York and global authority on hospital administration. "Incomparably the best way to treat the matter is to have the study of medical administration organized and directed under university auspices" [47: p. 26].[4]

In all of these maneuvers, the espoused logic was the same: management, like medicine, equated to rationality; therefore, the emergence of healthcare management was a rational and wholly sensible response to a changing healthcare environment. The twist, of course, was that this newfound professional sovereignty was sculpted in the shadows of medicine, lending it a tenuous quality. From the perspective of medicine, healthcare management was often perceived with suspicion, at best a "necessary evil" and "second-class citizen" to frontline clinicians, and at worst the cause of increased inefficiency and escalating costs [60, 126]. In the halls of the academy, scholars of healthcare management suffered a similar fate; perennially unsure of whether they belonged in a business school, a school of public health, or a stand-alone program [46, 48], many sought professional affiliation within their "home" disciplines (where they completed their Ph.Ds.) instead of the amorphous and often unwieldy academic departments of healthcare management [118]. Try as one might, "There is no unique body of knowledge on which the [healthcare management] profession is based, and no mechanism for credentialing to restrict practice" [45: p. 147].[5]

Curiously, despite growing recognition of the abovementioned issues [82, 86], scholars and practitioners of healthcare management continue to underscore professionalization efforts [5, 73]. "Health administration faculties must demonstrate in a new and compelling way that there is a coherent body of knowledge," proclaims Warden [116: p. 310], "[o]therwise, the doomsayers who assert that physicians are taking over could be right". While Warden's candid reference to a power struggle with medicine is itself noteworthy, the statement as a whole arguably signals a new and more desperate turn of events. Marking this turn is not just the issue of power increasingly thrust into the open (for a historical parallel, see [50]), but the broader theme of medicine's diminished professional sovereignty vis-à-vis management over the past few decades and under the various guises of managed care, managed competition, and more generally management-led reforms targeted at "getting more for less" [30, 65, 82]. The persistence of professionalization efforts in healthcare management is thus, in part, an attempt to obfuscate theses broader market forces at

[4] Parallel calls for specialized training can be found in the UK with the national investment in healthcare management education beginning around the late 1940s [100].

[5] Moreover, as Weil [117: p. 76] notes, "The evidence worldwide is that health management is not as mature a profession as medicine, law, and nursing, nor do health management programs generally have much independent academic autonomy within their universities".

play; forces that healthcare managers have a direct role in guiding and perpetuating [20]. Put simply, by asserting healthcare management's professional sovereignty and claiming it on a par with medicine, scholars and practitioners might conveniently avoid having to confront and take responsibility for this market encroachment, since like doctors, healthcare managers are "professionals" whom one should trust.[6]

Underlying Identity Crisis

To be sure, professionalization allows for a certain amount of consistency [125]—a "language" that, while potentially exclusionary, nevertheless enables those fluent to clarify reality. Similarly, professionalization ensures some level of accountability and legitimacy, which is all the more important in an age of proliferating for-profit colleges [28] and dubious "degree mills" [31]. But just as sociologists have observed with medicine [36, 108], professionalization can also become extraneous and constitute an overreach of power. Moreover, from a psychodynamic perspective, professionalization might play a symbolic role in the psyche of its constituents, and specifically function as a defense against uncertainty and anxiety. In the sizable cannon of psychoanalytic scholarship on organizations, for instance, mechanisms of defense are shown to serve a binding or "organizing" function, propelling employees to act in a cohesive albeit rigid manner that often puts organizations at risk of dysfunction [38, 53, 59, 64, 79]. Drawing from this literature, we might assume that professionalization efforts in healthcare management portray the common mechanism of defense known as "reaction formation," defined in economic terms as the conscious assertion of an idea equal in strength to its opposite in the unconscious (with the former constituting a replacement of, or "reaction against," the distress caused by the latter [67]). It is worth speculating, for instance, whether the strong tendency to exude excellence and exceptionalism by healthcare organizations and healthcare leaders [29] functions to conceal a lack of exceptionalism often experienced on a daily basis by clinicians and managers alike [41].

We witness a similar dynamic at play in the widespread avoidance by healthcare managers of the epidemics of stress, burnout, and "compassion fatigue" now plaguing frontline clinicians [74, 88, 101] and arguably symptomatic of broader industry-wide malaise [42]. While evading these issues may seem understandable in light of the direct hand managers have in coordinating and allocating "resources" (thus making them vulnerable to blame), it might also signal unconscious commitment to a cover story of sorts [52]; one comprised of abstract managerial notions of forecasting, process improvement, performance appraisals, and the like that conveniently abstract away from subjective sentiments. More generally, the symbolic significance of "having to manage" leaves little room for vulnerability [83], let alone

[6] It is thus remarkable, in retrospect, to note the prescience of historian David Rosner's [98: p. 169] observation made in late 1980s: "Administrators will now be working in a culture that often measures success by the extent to which one limits health coverage, shifts costs to the patient, excludes categories of patients because of inadequate coverage or because of race, or forces people out of expensive beds".

acknowledging the likelihood of similar sentiments among managers—what we might call "managerial fatigue".

Further evidence of this psychodynamic heuristic might be gleaned from healthcare management education whereby the sense of security and validation offered through accreditation appears in direct proportion to an increasingly precarious job market. Although employment opportunities in healthcare management are hardly scarce [14], accreditation too often—and too forcefully—reinforces the injunction that education must deliver a financial "return on investment," thus producing student-consumers with highly skewed expectations of short-term (economic) gain over long-term fulfillment [127]. The fact, for instance, that accrediting agencies in healthcare management increasingly partner with employers to determine what is needed in graduates [16] seems to miss (or at least not find potentially problematic) the corresponding fact that employers naturally want what will bring value to their organizations and not necessarily to broader society [87].[7]

In a related vein, professional associations often broker relationships with corporate sponsors under the espoused aim of enhancing networking opportunities, updating professional competencies, and more generally advancing "healthcare management excellence" [2]. Again, while prima facie justifiable, such efforts also unwittingly conspire to divert attention away from the contested nature of healthcare managers' daily work [54], which arguably throws into question the very utility of competency-based curricula and professional development [109, 113]. Moreover, like accreditation, competencies have encountered criticism for their "reductive connotations… [which] have focused educators on behavioral specification of individual traits, shifting focus towards policing of student behavior" [95, p. 166], and thus away from the considerably more complex—and constantly changing—social, organizational and political contexts in which such competencies must be applied [15, 94]. In the emerging literature on leader burnout, for instance, continued competency-building is perceived as futile in contexts defined by accelerated disruption and change. "[Leaders] complain they're 'efforting' too much," observe Lavoie and Riese [68], "working harder for weaker results in a 24/7 environment of crammed agendas and information overload". Seen from this vantage, the ongoing aim of healthcare management professional associations to measure, validate, and ultimately enforce competencies (increasingly on a global scale; see [57]) may prove disadvantageous to sustainable leadership, and at worst, set future healthcare managers up for failure.

[7] Indeed, accreditation agencies would hardly admit that managerialism is part of the problem with contemporary healthcare [82], nor still the commodification of education such agencies reinforce [127]. In a recent critique, Worthen (2018) deconstructs the "bureaucratic behemoth known as learning outcome assessment," which accrediting agencies in healthcare management now require [8, 17]. "This elaborate, expensive, supposedly data-driven analysis seeks to translate the subtleties of the classroom into PowerPoint slides packed with statistics—in the hope of deflecting the charge that students pay too much for degrees that mean too little" [127]. Worthen's (2018) critique connects with longstanding criticism of the actual accreditation process, which is often experienced as an end in itself as opposed to a means of encouraging reflection and improvement. Constituents complain, for instance, of a flurry of concentrated effort just to "pass," "get renewed," or "removed from probation" [72].

A parallel process in the broader field of management is instructive here. During the Great Recession, in the wake of predatory lending practices and dubious financial products that flooded the market, some began placing blame on business schools and their surrounding network of accrediting agencies and professional associations for producing performance-based graduates will little capacity for judgment, let alone empathy [13, 58]. While healthcare management is less likely to engender widespread distrust, the field is certainly not immune to public scrutiny [51]. A cautionary case can be found in the well-known and once reputable healthcare management professional association, Healthcare Research & Development Institute (HRDI), which was found by the Attorney General of the State of Connecticut to be an "anti-competitive, secret society—an elite and exclusive club—of premier hospital executives and select healthcare supply businesses" [97]. Forced to cease operations and pay a sizable fine, HRDI is certainly not an isolated case [39], nor exclusively a US phenomenon [96].

More generally, and taken together, the above psychological motives purported to drive professionalization efforts arguably point to a larger dynamic at play in healthcare management still largely ignored by proponents and critics of professionalization alike. That is, underpinning and uniting the dizzying array of accreditation requirements, competency models, and standardization regimes lies a recurrent if not altogether chronic question of what healthcare management is and ought to be, and by extension, who a healthcare manager is and ought to be. Drawing from prior scholarly critiques of professionalization [32, 33, 36, 49, 108], we may surmise that this crisis of professional identity persists because at root healthcare management, like all of management, "is intrinsically connected to practices associated with the domination and control of some over others—however humanistic and reasonable the latest form of leadership or team working might make it appear" [24: pp. 1–2]. But just how such practices get taken up and embodied on a daily basis suggests more than just the need for power. "[C]oncerns about identity are just as profound as concerns about survival," notes Whetten [124: p. viii], conveying at once the primitive origins of identity and the terrifying prospect of its loss. In healthcare management in particular, we capture a glimpse of this primitive quality in the crude and at times extreme manner in which professional identity is asserted [5, 73, 116]. Moreover, the prospect of loss (or professional extinction) seems potent enough to give rise to equally crude attempts at controlling the field byway of professionalization, rather than admit to a sense of identity confusion. Put simply, from the vantage of identity, professionalization amounts to a collective attempt at proving the field's adequacy amid inherent doubt.

Furthermore, while there has been longstanding scholarly interest in the nature of professional identity [6, 55, 91], rarely is the topic examined from the standpoint of underlying motivation, and especially compensatory motives as outlined above. From a psychodynamic perspective in particular, individuals may feel compelled to overly identify with a profession due to an unconscious need to project perfection onto an abstract ideal, so as to conceal an underlying lack [19]. The term "organization-ideal" has been coined by psychoanalytic theorist Howard Schwartz [103, 104] to denote how individuals fall prone to idealizing organizations to the point of losing their capacity to reason and think critically. In psycho-structural terms, the

organization-ideal operates as a pathological replacement for the "ego-ideal," which is an essential facet of mind that imposes internal standards derived from broader civilization [35]. The organization-ideal, while pale in comparison and limited to standards derived from the organization, proves deeply powerful in its ability to cover over imperfections, organizational dysfunction, and the broader environment, and in the extreme gives rise to blind obedience and absolute loyalty [103, 104].[8]

Building upon this important psychodynamic contribution, we may surmise that a similar identification process takes place within healthcare management. Specifically, what we might call a "professional-ideal" appears to eclipse critical reflection on the profession and surrounding environment, instead inciting a level of obedience and loyalty disproportionate to reality. Furthermore, the strength of this professional-ideal appears in direct proportion to a denied and repressed inadequacy, evidence of which can be found in the near absence of critical scholarship in healthcare management, which, while exceptionally attuned to the field's conceptual flaws and ethico-political implications [71], resides at the periphery and outside of mainstream journals, textbooks, and professional association conferences.

Now to be sure, the perceived inadequacy of healthcare management's professional status might seem obvious in relation to medicine's longstanding professional sovereignty. But following Schwartz [103, 104], it is precisely a hallmark of unconscious idealization that attention to the broader environment is diminished if not altogether ignored. In the least, the broader environment surrounding healthcare management is not critically assessed in a manner that might stimulate concerted debate on the nature and purpose of the field. Indeed, rather than acknowledge and thoughtfully engage with healthcare management's perceived inadequacy and underlying identity confusion, the field has largely resorted to compensatory motives; motives that in turn give rise to inflated and idealized projections un-calibrated with reality. Sorely needed are attempts at articulating and affirming an endogenous professional identity for healthcare management, one devoid of compensatory motives and idealized projections, and unique to the field's scholarly and practical domain.

Mobilizing Crisis

It is worth noting that professional identity crises are not entirely foreign to healthcare professions [9, 40] or interdisciplinary academic fields more generally [43, 99]. They become problematic, however, when overlooked or altogether avoided. Arguably the worst situation is one where crisis is not recognized; for in such a situation, as philosopher Simon Critchley [22: p. 34] reveals, "human beings sink to the level

[8] Schwartz's [103–105] impressive corpus of work delineates a number of case studies where organizations fall prone to reinforcing an organization-ideal rooted in the narcissistic desire for omnipotence. Drawing analogies with the child's tendency to powerfully cathect to an unconscious ideal of an all-loving, all-powerful mother, Schwartz demonstrates how employees across various industries—from aeronautics to journalism to higher education—defend against acknowledging their own vulnerability, finitude and mortality, and instead resort to deep-seated fantasies, with harmful individual and organizational repercussions.

of happy cattle, a sort of bovine contentment that is systematically confused with happiness". While healthcare managers hardly succumb to such an extreme stupor, systematic neglect of the deeper issues surrounding professionalization and professional identity suggest a false contentment of a different sort; one that might ultimately imperil the future viability of the field.

This section of the paper thus attempts to loosen the dominant discourse of healthcare management. For heuristic purposes, this attempt is divided into three areas: (1) challenging the "expert role"; (2) welcoming breakdowns; and (3) recognizing the unmanageable in health. Together, these areas constitute a preliminary proposal for mitigating the perils of professionalization by foregrounding the field's moral, political, and existential aspects. Far from eradicating healthcare management's professional identity crisis, however, the overarching aim is to reframe crisis as an opportunity for professional growth.

Challenging the "Expert Role"

As a profession that ascribes to evidence-based management and aspires to the status of an objective science [115], healthcare management engenders an aura of expertise that may not always correspond to day-to-day managerial life [81]. Socialization into this "expert role" starts early. It begins with how students interact with faculty, who are themselves beholden to accrediting agencies that impose standards and competencies, and latter ossifies as scholars and practitioners mature in their careers and identify with notions of excellence and exceptionalism [29]. Drawing from the discussion above, however, upholding the role of expert might play a defensive role, and specifically function to guard against uncertainty and anxiety endemic to the field. Moreover, upholding the expert role carries significant interpersonal implications; for if someone is the expert, then someone else is the novice who can hold all of the expert's insecurities [10], in turn fostering a psychological dependency just as pernicious, one may argue, as overt relations of managerial dominance and oppression [102].

To counteract this socialization process and its undue effects, healthcare managers might do better to model *not knowing* to their students and subordinates, which in turn might redress the imbalance of managerial power. In particular, what students and subordinates bring to healthcare management is an openness and honesty; they come as caregivers and patients—not experts—and they exude a curiosity barely decipherable above the cacophony of competency models, performance objectives, and overstuffed curricula that serve as the material artifacts of professionalization. More generally, they come with a human fallibility, which goes hand-in-hand with the ability to listen and learn.

Resistance to listening and learning in a healthcare setting is arguably deeply ingrained, rooted in entrenched fears of intimacy and perhaps even primitive anxieties of contamination and death [79]. But it is also rooted in the entirely rational worry of time, and specifically of taking too much time that truly caring for a person—not a disease—requires. The same arguably applies when caring for employees and not abstract organizations; both are taxing endeavors with no clear result,

let alone end. And yet, it is precisely because of this fact that they are all the more needed, especially in work environments increasingly plagued by stress, burnout, and "compassion fatigue" [74, 88, 101].

Moreover, being able to model not knowing allows for the possibility of being stirred by the stories of others, which in turn fosters deep empathy and brings meaning to one's work [80]. Research suggests that one's competence is challenged when truly listening, which in turn shifts one's perspective and allows one to see situations and experiences from a different point of view [119]. Furthermore, the immediacy and vitality of such experiences prove essential to the provision of care; for just as knowing the diagnosis does not equate to knowing what is most needed for the patient [106], mastering the competencies of healthcare management and becoming the "expert" does not equate to knowing what is most needed for an organization or the community it serves. Indeed, apprehending such needs may well require what psychoanalysts [11]—borrowing from the poet John Keats [63]—call "negative capability," a paradoxical capacity to both take up one's professional role and to actively tolerance uncertainty and confusion, even embracing the latter as a possibility for change. Ultimately, by modeling to students and subordinates not knowing, questioning, and listening, healthcare managers may in turn model what arguably cannot be taught: how to care.

Welcoming Breakdowns

Mitigating the perils of professionalization also entails appreciating the tensions and breakdowns invariably at the heart of managerial life. Standardization, for instance, leaves no space for the friction that arises from competing ideas; a friction that often sparks creative thinking [4]. Rarely, for instance, are conflicts among competencies in competency-based curricula given much thought. Akin to the tendency to reduce competencies to individual behavioral indicators [95]—a tendency that risks diluting the meaning of competencies and gives off the false impression that what cannot be measured is somehow irrelevant—refusing to grapple with how and when competencies might collide in practice presents a missed opportunity for critical reflection, let alone an appreciation for a breakdown in competencies that might lead to growth [62].[9]

A renewed healthcare management would thus not shy away from tensions and breakdowns, but instead welcome them as a catalyst for change. One area particularly ripe for such frictional engagement is healthcare management's ideological underpinnings. Classically defined by Thompson [114: p. 56] as systems of meaning that "serve…to establish and sustain relations of domination," ideology in a healthcare management context pertains to ways in which the field reinforces, while at the same time conceals, broader social structures that perpetuate

[9] For instance, in what is arguably the "gold standard" competency model of healthcare management devised by the American College of Healthcare Executives (ACHE) [3], the sub-competency of "patient perspective" will likely clash with the plethora of sub-competencies falling under "business skills and knowledge," especially when financial management places limits on access to care.

health disparities and inequalities. While critical scholarship has made significant strides in exposing the field's ideological complicity with power [23, 71, 78], accounts of just how such ideology is lived—and struggled through—on a daily basis are sorely needed. For instance, it would be worthwhile to grapple with how healthcare managers, through their very appeals to professional sovereignty, obfuscate their own dependence on forms of management that fall outside the profession's purview but nonetheless sustain its existence [18]. As Glenn [44: p. 183] observes, "caring has been organized around spatial and conceptual separation between public and private realms":

> The public sphere of the market (economy and politics) and the private sphere of family and household are imagined to be discrete arenas that serve different purposes, perform different functions, and operate according to different principles. Success in the public sphere is thought to require people to be independent so that they can engage in competition and pursue self-interest; this conception requires the exclusion of dependency needs from the public sphere and their sequestration within the so-called private sphere [44: pp. 183–184].

Building upon Glenn's (2010) observation, grappling with the field's dependence on "unofficial" of "informal" forms of management might, in turn, open up the possibility for envisioning new ways of organizing care modeled from—and perhaps even spearheaded by—the "private sphere"; ways of organizing that, in turn, might begin the long and arduous work of upending the field's ideological complicity with "relations of domination" [114: p. 56].

A similar friction-cum-opportunity can be found among the exploitative labor dynamics in healthcare, chief among which is the push to keep wages low by finding workers with the fewest rights (often immigrants) to fill proliferating entry-level, direct care positions [34]. In the US in particular, the "home health aide" is one of the fastest growing occupations in healthcare despite being rated by *Forbes* magazine as one of the top 25 worst jobs in America [75]. In addition to dismally low salaries (often below the federal poverty level for a two-person household) and a paucity of paid vacation, sick leave, and health insurance benefits [128], home health aides must endure physically and emotionally taxing work, leading to high rates of injuries and psychological stress [111].

This grim reality stands in stark contrast not only to the relatively plush work conditions and occupational status of healthcare managers [14], but also to research that consistently demonstrates the importance of job control on employee wellbeing, and particularly giving employees discretion over how they go about their work [89, 107]. Ostensibly, the field of healthcare management is ideally placed to address these exploitative labor dynamics insofar as they erode the very initiatives premised upon improving employee relations that are consistently championed by healthcare organizations. So far, however, critical scholarship has merely raised the alarm of complicity with the proliferation of such "unhealthy" healthcare jobs [90] without offering pathways for praxis. Scholars and practitioners would do better to ponder what it means to care when broader economic and social determinants to health are often ignored or considered outside the field's scope. In so doing, the field could reframe its complicity as a form of responsibility, and particularly a commitment

to anticipating and experimenting with more egalitarian employee relations that, in turn, serve as a model for other industries.

Recognizing the Unmanageable in Health

In addition to jettisoning the expert role and welcoming breakdowns, a third avenue for offsetting professionalization's perils and renewing the field's potential lies in engaging with healthcare management's existential dimensions, and particularly the day-to-day experiences that exceed one's managerial grasp. Long avoided by both proponents and critics of professionalization alike, these dimensions comprise (in part) the experiences of illness, suffering, and dying that press upon the limits of human agency and medical progress, yet also make life meaningful and worthy of dignity. Indeed, healthcare is one of the few industries in society where a person's dignity can be if not "managed" then at least maintained amid inevitable frailty and immobility, incontinence and forgetfulness, and even helplessness and dread. Thus at its best, healthcare recalls what it means to be human—and through this, what it means to go on living, working, and caring in the face of the unmanageable.

Now of course, any attempt to generalize human experience in healthcare proves deeply problematic, especially in a postmodern landscape suspicious of universals and absolutes [7, 27]. But grappling with healthcare's existential dimensions need not be a call for naïve humanism or simple optimism. Instead, the human in healthcare is rich with tragedy as well as torment, and laden with inequalities suffered not just in life, but also in death and dying [92]. Thus what proves particularly noteworthy about healthcare is its sheer existential complexity; a complexity healthcare managers must invariably navigate as they steer among the limits of what can be managed, on the one hand, and the broader issues that beckon a radical rethinking of management, on the other (i.e., decoupling the relation between poverty and disease, or the broader structural inequalities that determine sickness and health). The field's peculiar mix of denial and complacency in the face of these matters—denial of the unmanageable and complacency toward the manageable—signals a missed opportunity not only to harness this complexity, but also to foster newfound meaning of what it means to manage health; one that is not so much about managing as about a deeper appreciation for the ways humans need management, as well as something more. Health, in turn, becomes about something far more nuanced than curing or prolonging life.

In the broadest sense, and taken together, the above preliminary proposal for mitigating professionalization's perils and renewing the field's potential—challenging healthcare management's expert role, welcoming breakdowns, and recognizing the unmanageable in health—affords a welcome view of the field's professional identity crisis. Such crisis, when squarely confronted, might function to stave off not just "bovine contentment" [22], but also the tendency to falsely idealize competence and expertise at the expense of critical and creative inquiry [103, 104]. Put simply, the question of what (and who) healthcare management is should remain at the forefront of daily life, so as to encourage open-ended reflection and experimentation that, in turn, might foster a professional identity unique to the field.

Conclusion

This paper has sought to illuminate the psychological motives underpinning professionalization efforts in healthcare management. It has also sought to reframe professionalization in the context of professional identity, and specifically the open question of what healthcare management is and ought to be. The suggestion that the field's underlying identity confusion signifies both crisis and opportunity has served, in turn, as an invitation for exploring new avenues for healthcare management, unconfined by the dominant discourse and grounded in aspects of the field arguably overlooked yet ripe for inquiry.

Caution must be given, however, to the above-mentioned ideas, and particularly to any proposal that purports to mitigate professionalization's perils. For starters, scholars and practitioners of healthcare management may actually prefer to identify with professionalization efforts, finding their potential benefits to education and practice undervalued in this paper [5]. Clearly, more dialogue is needed on both the benefits and drawbacks of professionalization, and what might prove helpful in guiding such a discussion is the distinction between professionalization and professionalism made at the outset of this paper. In medicine, for instance, professionalism is often framed as a countervailing force against an increasingly compromised relationship between doctors and industry. As Reid [95, p. 162] observes, "[t]he professionalism movement emerged as a re-assertion of the ideals of medicine against the corrupting influence of financial incentives, both from managed care (in the U.S. context) and from drug and device marketing". Others have framed medical professionalism as a reassertion of the social contract between profession and community [112]. Arguably, one might read in this literature an implicit call for healthcare management to reassert—or assert for the first time—its own version of professionalism, one that might function to reign in the excesses of professionalization and, like medicine, actively shape healthcare management's relationship to broader society [54].

Furthermore, and related, the exploratory nature of this paper warrants further elaboration and debate, as well as in-depth investigations into how healthcare managers identity with their professional roles. Moreover, just as professional identity need not be constrained by any one meaning but comprise a plurality of meanings [6], so too is the preliminary proposal for mitigating professionalization's perils decidedly open to negotiation. It is worth mentioning, however, that such a proposal is not intended as merely normative; that is, it is not simply a prescription for what healthcare managers "should be doing," but rather what healthcare managers already do on a daily basis, yet covered over by various defensive behaviors that prove detrimental to both intellectual vibrancy and professional growth.

Despite the above limitations, one hopes the ideas offered here serve as an invitation for further inquiry into the nature and purpose of healthcare management. Just how one goes about mitigating professionalization's perils and renewing the field's potential will necessarily remain open and contestable. Arguably uncontested, however, are the consequences of carrying on oblivious to the bigger

problems and responsibilities to which the field is called. In the final instance, healthcare management risks devolving into mechanics, and the field at large risks growing unworthy of society's care.

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