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Professional Responsibility

The Fundamental Issue in Education and Health Care Reform

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Foreword

There is much debate in the American society about the proper roles of the government and the market in organizing economic life. Far less attention is accorded to the world of organizations that live in the interstices between government agencies and profit-seeking corporations. These include the organizations John Maynard Keynes (1926/2004) characterized as "semi-autonomous bodies within the State—bodies whose criterion of action within their own field is solely the public good as they understand it, and from whose deliberations motives of private advantage are excluded" (p. 37). A century earlier, Alexis de Tocqueville (1835/1945) spoke of the American passion for voluntary associations in similar terms. Prominent among such semiautonomous, voluntary, and nonprofit-oriented organizations in the modern world are the professions and their attendant associations.

This ambitious book approaches the study of these organizations from a variety of disciplinary perspectives and with a range of methodological perspectives. It aims quite properly to raise more questions than it answers, and that is exactly what is needed. The question of the proper role of the professions in a democratic society—and of universities as their "gatekeepers"—always provokes ambivalent reactions. One side of the coin was well captured by Adam Smith (1776/1976): "People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices" (p. 144). Universities, which provide the only means of access to most professional work, are often seen as mainly agents of exclusion, protecting the "rights and privileges," as the old-fashioned language of degree conferrals, on behalf of traditional elites.

But the other side of the coin is also easy to invoke. A patient seeking advice on whether to undergo heart surgery is generally happy to see that diploma on the wall—and to know that the "right and privilege" to cut open people's chests is restricted to people whose skills have been honed and tested. Just as important, the patient wants to believe he can trust that the surgeon's recommendation is based on her best medical judgment, free of any calculation about her own bottom line, and a robust professional ethos can help ensure that.

We thus encounter a clearly framed but also limited debate about the ideal and the actual role of professionals in our society—consumer protection versus monopoly privilege and power. And the reader will find among the distinctly independent-minded authors in this volume differences in view about the strengths of the arguments on either side of this dilemma. This is all to the good, because the diversity of views provides space for readers to make up their own minds.

But the stakes raised in this volume go well beyond this traditional debate. Near the heart of the matter is the question of how far the social responsibility of the true professional extends. Does fidelity to the needs of the individual patient or student or defendant mark the limit of professional responsibility? Or must professionals, individually and collectively, reach beyond that duty to the client to act constructively to address community needs related to their work? Here again one can detect differences of view among the authors about the risks and benefits of expanding the voice and influence of "elite" professionals in social policy-making.

A further challenging preoccupation of the authors is the substantial changes in the institutional settings in which professionals' work takes place. The individual legal or medical practice, like the traditional presumption that an individual teacher can presume absolute autonomy behind his classroom's closed door, is rapidly passing into history. As professionals increasingly work inside of larger organizations, the challenge of reconceptualizing concepts of autonomy and professional judgment within the framework of complex organizations looms large (see particularly work by Steven Brint and Paul Adler). Several pathways toward resolving the resultant tensions come in for rigorous and constructive examination here.

The result is a volume that provides a rich grounding for thought on these important and difficult issues.

In the remainder of this foreword, I would like to put forward an analytic framework that explicitly connects the challenges faced by professional organizations with challenges faced more generally by organizations whose aim is not maximizing their own bottom line but pursuing some conception of the common good. I should make clear that, while there are threads connecting the following analysis to the themes of this book, the remarks that follow are my own and are not explicitly advanced elsewhere in the volume. Let me then return in the remainder of this foreword to an observation I made at the outset: the professional association is not unique among the institutions that occupy the space between the state and the market.

In the traditions of both classical and neoclassical economics, the thought about the distinction between the private and public realms has been organized around the idea of "market failure." Under certain idealized conditions, market institutions yield "optimal" results. Much public policy discussion proceeds from the assumption that when prevailing conditions are reasonably close to this abstract ideal, it makes more sense—yields better results in practice—to rely on the profit motive and the pursuit of private interest to organize production than to rely on government to supply goods or services directly. Government, on this view, does best in such cases when it is limited to a background role—an essential one—by developing and enforcing the rules of private property and contract. Even when the market is significantly imperfect, governmental institutions may do better to play a "market

perfecting" role by enforcing antitrust laws, distributing objective information, regulating the behavior of suppliers (as by inspecting restaurants for health and safety), and the like than it could do by replacing the market with governmental provision.

In other areas, market institutions fail altogether in supplying goods or services that most members of society want or need. This is the realm of "public goods," of which one classic example is national defense. A private company cannot "sell" protection from attack to those who are able and willing to pay while withholding it from those who won't pay: either you have an army or you don't. Similar cases like public fire departments (nobody favors having a private fire department that stops to check if the bill is paid up before putting out the blaze) call for replacing the market with governmental supply of services.

Some of the most challenging cases arise when public goods and private commerce become entangled. The quality of the air we breathe—and of the environment more generally—is plainly a public good. It's not easy to imagine selling clean air to those who are willing to pay for it, while leaving the air dirty for the neighbors (except possibly for the privileged few who can "buy" clean air on mountain tops). But, as we have become increasingly aware, ordinary market-driven economic activity has large consequences for environmental quality. The unaided market does not give buyers or sellers an adequate material incentive to identify and curtail such negative consequences, which are said to "spill over" from the market transactions. The existence of such spillovers provides a firm basis for governmental action to regulate (or even in some cases to outlaw) otherwise productive activity that has such pernicious consequences.

In all these cases, we think of government as the suitable tool for responding to market failure, and often we think of these two classes of institutions—private firms and government agencies—as dividing up the institutional space between them.

There is though this third class of institutions—a third sector, it is sometimes called—that falls between governmental action and private commercial transactions. These are typically cases in which we don't trust the profit motive to guide producers to socially desirable outcomes but where we have doubt that conventional government regulation or direct governmental service provision will adequately address the problem. The major institutional types that occupy this intermediate, neither-fish-nor-fowl space include both the professions and their associations and not-for-profit (NFP) organizations, and more particularly what are called "commercial nonprofits." These are organizations that earn significant revenues from the sale of services or goods (hence commercial), but where those who control the institution are not supposed to profit personally from those sales. Instead, all revenue in excess of cost is to be reinvested in improving the institution's performance. One major point of this foreword is to call attention to the commonalities between these two classes of institutions in the functions they serve and the difficulties they face. It is no accident that many professionals in fields like education and medicine work in not-for-profit institutions.

What characterizes these cases where we don't trust the profit motive but have reservations about government provision as well? I follow Burt Weisbrod (1988) in suggesting that these are typically cases where the quality of the service being

provided is very difficult for the consumer to judge in advance of using the service and where reliable "feedback loops" to allow the unaided market to self-correct away from bad performance are unavailable or unacceptably risky. In such circumstances, the consumer has little choice but to place herself at the mercy of a competent and well-motivated professional to a significant degree. These are markets that require *trust* as a fundamental feature and where (because feedback loops are weak) the motto "trust but verify" cannot really apply. Government regulation can help in these circumstances, but for the same reasons that the consumer can't judge the quality of provision well, neither can the government.

It should be obvious that education and medical care are both classes of service to which these criteria apply. As any veteran of admissions tours and college brochures knows, it is extremely hard to make a judgment of the quality of a college by looking at it, and even after experiencing it, it will be a long time if ever before one will really be able to judge confidently how valuable the experience proved to be. Moreover, since the typical person will only go to college once, the opportunity to learn from experience is very limited. In medicine, there is plainly great uncertainty facing a patient who needs to judge whether a doctor's diagnosis and recommended course of treatment are warranted, and even after the fact it's often impossible for the patient to know whether a different treatment would have been more effective.

As the Nobel prize–winning economist Kenneth Arrow (1963) noted in his path-breaking article, "Uncertainty and the Welfare Economics of Medical Care," "trustworthiness" is by its nature a quality that cannot be bought and sold on a market. ("I promise you that if you pay me better I will become the kind of person who is not motivated by money.") As the chapters in this volume make clear, this concern with trust in the doctor–patient and teacher–student relationship permeates thinking about the professions. It is helpful, I believe, to notice that the same considerations arise at the institutional level in the case of higher education and of hospitals, and it is striking to note the prevalence of NFP colleges, universities, and hospitals.

It is also striking that the same worries about professionals abusing the trust relationship through collusive or self-seeking behavior arise in the context of NFP organizations as well. Regulations that aim to prevent nonprofit suppliers from extracting personal profit from their work are hard to frame effectively and very hard to enforce. Weisbrod in fact coined the term FPID (for profit in disguise) to label this kind of case. Trust bonds are easily undermined, and nonprofit suppliers, like professionals and their associations, have a tough challenge in establishing and sustaining a reputation for trustworthiness, especially in a time of rapid institutional change and widespread cynicism.

And just as professionals feel encroached upon by the pressures of the market, so too do we see the rapid entry of for-profit suppliers in higher education and in the hospital industry. At least in higher education, the absence of a trust relationship with a for-profit institution has an important influence on the nature of the "product" such an institution can credibly market. Thus, the benefits of a liberal arts education are very hard to measure or demonstrate in general; it is even harder to try to support a claim by a particular institution that it is doing this work well. It is unsurprising, therefore, that we see very little entry of for-profit suppliers into this market; instead,

these businesses focus on supplying vocational education, offering shorter-run and more easily verified benefits in terms of jobs and wages. A worrisome consequence of this development is that traditional colleges and universities are increasingly pressed to measure themselves by the standards the for-profits have established, that of near-term jobs and wages, even though these criteria are a very poor fit for the goals these institutions aspire to.

A final point of comparison is this. As Bill Sullivan and others in this volume point out, professionals and their associations are properly expected to think of their work in more encompassing terms than simply that of treating their immediate clients well. Their relative freedom from the profit motive gives them a unique opportunity (and therefore, some argue, a responsibility) to frame the goals of their profession in larger social, cultural, and civic terms than a direct focus on "consumer protection" would entail. Following the same logic, leaders in nonprofit universities are asked to attend to their larger social mission, being concerned not only to treat well the students who happen to enroll but to help them to become more socially and civically valuable people both for themselves and for the sake of the civic culture, and to strive to provide educational services to a broadly diverse set of students, especially those from traditionally marginalized or disadvantaged groups.

I urge therefore that we view this stimulating volume as valuable not only for addressing many fascinating issues regarding the professions, but also as a contribution to the too-little-populated shelf of books about those "semiautonomous bodies" whose existence may well be vital to the success of modern democratic societies.

Spencer Foundation
Chicago, IL, USA

Michael McPherson

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perspective on the significance of this volume. Thanks also to our editor Ms. Melissa James and her assistant Miriam Kamil whose guidance in the preparation of the manuscript kept us on track and encouraged us to keep pursuing this work to conclusion.

Finally, as coeditors, we must thank our wives, Tedi and Patricia, and our families for their continuing patience, support, and opportunities for insightful conversations throughout this venture.

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chair of the Sociology of Education section of the American Sociological Association and on the Program Advisory Board of the Spencer Foundation. He was elected a Fellow of the American Association for the Advancement of Science in 2008. He is currently at work on a new book, *The Ends of Knowledge: Organizational and Cultural Change in U.S. Colleges and Universities, 1980–2012*. A native of Albuquerque, NM, Steven Brint received his B.A. with highest honors in Sociology from the University of California, Berkeley, and his Ph.D. in Sociology from Harvard University. He joined the faculty in Sociology at the University of California, Riverside, in 1993, after teaching at Yale University from 1985 to 1992. At UCR, he received the Chancellor's Award for Fostering Undergraduate Research in 2006.

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Michael Wilkes, MD, MPH, PhD is widely known for his creative efforts to introduce medical students to the humanistic side of being a physician, and for working tirelessly to include the public health and social sciences as part of training physicians. Wilkes introduced the UC's award winning "Doctoring" curriculum, a longitudinal curriculum spanning all four years of medical school that includes such topics as doctor-patient communication, clinical reasoning and end-of-life care, to name but a few. During his tenure as Vice Dean of the UC Davis Medical School he led the way toward enormous changes in medical education including developing the rural prime program, an innovative approach to mentoring, a mission directed/community focused curriculum, a host of student-run community clinics, a new education building, wide-ranging interprofessional educational programs, and a dramatic shift away from lectures toward small group and interactive learning. Wilkes is a pioneer in eLearning having received large grants from CDC, NIH, and private foundations. He has also led an international team of health science schools focused on developing eLearning tools and software for shared use. In his current capacity as Director of Global Health he works across the UC system medical and health sciences schools and around the world training the most capable health providers to address local health needs. He also directs the UC Davis Adolescent Clinic. Wilkes is currently a *Visiting Professor of Medicine* at Harvard Medical School and is stationed in Kigali, Rwanda, developing a new Health Sciences School at the University of Rwanda.

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Chapter 1
A Brief Introduction to the Problem of Professional Responsibility

Douglas E. Mitchell and Robert K. Ream

When agricultural extension agents began introducing hybrid seeds and other farming innovations, they reportedly ran all too frequently into farmers who said, in effect, "I don't farm half as good as I could now – what do I need with your new-fangled seeds?" While few may be willing to say so, a similar attitude is found today in America's schools and health clinics. Professionals in both these fields feel hemmed in by regulations, complex technologies, political pressures, perverse incentives, budgetary restrictions, and emotional exhaustion. These constraints translate into knowing that current practice is much less effective and less equitable than our current knowledge and fiscal investments should reasonably be expected to produce.

What exactly is the problem here, and how might it be addressed? America's schools have been the target of an avalanche of reform efforts for more than half a century, yet disappointment with their performance with regard to both education quality and equality of educational opportunity has grown more, not less, widely recognized. For decades, health services reform in the United States also has been the focus of highly charged political debates; large disparities in health care access, poor community outcomes, and exorbitant costs have been broadly acknowledged.

This book is based on the premise that we need to change the way we characterize and think about problems of professional service delivery in education, medicine, and other social welfare services. For most of the last half-century, the problems

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in education have been addressed by increasingly demanding efforts to: improve the knowledge base regarding how children learn, train teachers to use that knowledge, and develop an accountability system that enforces the use of research-based knowledge about learning and the management of educational processes. The problems in medicine and public health have been seen as less about knowledge development or application, and more about how to provide universal access to health care, improve the delivery of quality care, and lower the cost of care by reorienting the health care delivery system so that it takes greater account of the social, cultural, and community factors adversely affecting health outcomes.

Although reforms in education and medicine are typically considered separately, there are good reasons to consider them simultaneously. Education and medicine are unique among the professions in the degree to which they touch our entire citizenry; they are also naturally supportive of common goals. Healthy citizens are academically advantaged learners and educated citizens can better utilize today's sophisticated health services (Cutler and Lleras-Muney 2006). The nation's energetic and expensive efforts to improve health and education are much more likely to be successful if they are tackled together so as to generate integrated policies, structures, and practices.

The chapters in this book share in common a recognition of the need to focus on the development and maintenance of *professionalism* in education, medicine, and other social welfare services. That is, these authors see the nexus of the reform problem as establishing a more robust and effective working relationship between teachers and their students, between health care professionals and their patients, and between educators and health professionals. We take professionalism to mean acceptance of professional responsibility for student and patient outcomes—not just acceptance of responsibility for technical expertise, but commitment to the social norms of the profession, including trustworthiness and responsibility for client well-being. In the past, it may have been sufficient to assume that adequate knowledge can be shaped into standards of professional practice. Today, it is clear that we must take careful account of the ways in which practicing professionals develop, internalize, and sustain professionalism during their training, along with the ways in which this commitment to socially responsible professionalism may be undermined by the regulatory, fiscal, technological, political, and emotional incentive systems that impinge on professional workplaces and professional employment systems. Thus, at the center of this book is the complex and perplexing question of how to design professional preparation programs, organizational management practices, public policy systems, and robust professional associations committed to, and capable of, maintaining confidence, trust, and the other hallmarks of socially responsible professionalism. To do this, we need to rebuild our understanding of professional responsibility from the ground up. Then we will describe how individuals might be prepared to engage in responsible professional service delivery, examine promising options for the reform of professional service systems, and finally, outline a reform strategy for advancing the practice of human improvement in primary care medicine, public health, social welfare, and education.

The ideas articulated in this work were developed for, and honed during, an invitational conference sponsored jointly by three of the University of California,

Riverside's (UCR) academic units: the Graduate School of Education, the newly accredited UCR School of Medicine, and the UC One Health Initiative. The central theme of that conference, *Evolving Professional Responsibility for Diverse Communities,* emerged from a series of interdisciplinary discussions between faculty in the UCR Graduate School of Education and the UCR School of Medicine. These faculties were joined by the dean of the newly created University of California, Riverside Public Policy School, along with representatives from campus departments of sociology, economics, and management in order to generate a broad multidisciplinary look at responsible professional work and the training, support, and policy frameworks needed to support it.

As a result of this developmental process, the chapters in this volume emphasize the community and mission oriented commitments characteristic of America's land grant universities and of this university campus. UCR is situated at the population center of the nation's twelfth most populous metropolitan region (Riverside and San Bernardino counties in California). This metro region presents, in clear and challenging ways, all of the central issues of education and health care service delivery. The region provides a sobering cross section of national social, cultural, economic, and political characteristics, displaying the troubling inequalities in health and educational attainment that have stimulated national reform debates.

In both education and medicine, we find a rich history of deliberations over professional responsibility and professionalism, more broadly. In education, a series of largely unsuccessful efforts to declare teaching a professionalized occupation took place during the first half of the twentieth century. By 1960, however, classroom teachers largely abandoned the claim to professional status and shifted attention toward unionization. This move was quite successful, and teaching became one of the nation's most highly organized occupations. The professionalism debate was rekindled by two documents published in 1986: the Carnegie Forum on Education and the Economy report, *A nation prepared: Teachers for the twenty-first century* and the Holmes Group report, *Tomorrow's teachers: A report of the Holmes Group.* Both reports call for substantially raising the skill, autonomy, and prestige of teaching—in essence, finally realizing the century-long aim of recognizing teaching to be a fully professional occupation, rather than its more frequent characterization as a "semi-profession" (Burbules and Densmore 1991; Case 1986). In both these documents, professionalism is set in tension with democratic political control over teaching by civic governments, including local school boards. Democratic control is seen as preventing acquisition of the autonomy and compensation needed to secure a professionalized workforce. The call in the Carnegie Forum report was to create a more rigorous system for credentialing teachers managed by professional educators. For the Holmes Group, the reform of schools of education was seen as the preferable route to full professionalization.

The emergence of professionalism in medicine arose in conjunction with Comtean positivism, which became medicine's dominant philosophy by the late nineteenth century (Hilton and Southgate 2007). This philosophy underscored medicine's scientific base and framed its conception of professional responsibility. By the late twentieth century, however, the medical profession began to lose its patina of unchallengeable professionalism. As Le Fanu (1999) notes, the profession began

to encounter: (a) disillusioned doctors; (b) dissatisfied, though healthy, patients; (c) highly popular, but not highly reliable, "alternative" medical practices; and (d) soaring costs, foreclosing access to health care for many people. This last point is highlighted in a recent RAND (2012) study reporting that 32 % of the nearly $23,000 gain in annual household income generated between 1999 and 2009 was redirected to increases in health care insurance premiums (not including the increases in deductibles and co-payments). As a result of these recent challenges to medical practice, Hilton and Southgate (2007) argue, there has been an erosion of the trust essential to the professional practice of medicine.

Although the literature on professionalism in both education and medicine is voluminous and complex, several points of convergence, and a few fundamental points of divergence can be seen. Thus, for example, nearly all observers agree that professional work is skilled, complex, requires extensive preparation, and is grounded in the establishment of a trusting relationship between the professionals and their clients. Nearly all also agree that professional work has a moral or ethical imperative at its core, calling on professional workers to commit themselves to a "Hippocratic Oath" that requires sacrificing self-interest and accepting responsibility for protecting and supporting the interests of their clients (Gardner 2007; Sullivan 2005).

Most observers also agree that professional work was born in the occupations of medicine, law, and the clergy—occupations that serve as the archetypes of professionalism and from which many of the presumptive characteristics of professional work are derived. Importantly, these occupations emphasize the trust and interpersonal relationship dimensions of the professional-client contract. It has been observed by Steven Brint (1994), however, that most professional work is now embedded in and managed by large complex organizations with very different social relationship norms—norms emphasizing worker technical responsibilities and managerial control while undermining professional responsibility for client well-being.

There are also important points of divergence in the literature on professionalism. First, observers often do not agree as to whether the label "professional" characterizes the occupation as a whole or is a characteristic of individual workers within the occupational group. In most discussions of professionalism, specific occupations (like medicine, architecture, law, etc.) are considered professions—meaning that one is, or at least needs to be, a professional worker in order to participate in that occupation. By contrast, analysts like those writing the aforementioned Carnegie report propose that professionals in an occupation like teaching constitute a subgroup of the workforce whose superior skill and more serious commitment to their work would justify their being considered professionals working within an occupation that simultaneously has opportunities for employment of a substantial number of nonprofessional workers.

A second point of divergence in the literature concerns whether professionals can be organizational employees or whether they must be autonomous providers who may be *in* but not fully *of* the organizational structures within which they work. That is, the norms of practice and expected forms of responsibility for the professional workers may be drawn from their training in universities and their membership in professional associations, or their work may be defined and

operationally controlled by organizations that pay their salaries (like school districts or health maintenance organizations), or a complex hybrid of both.

A third point of divergence is found in differing conceptions of whether organizational and public policy regulations are necessarily enemies of a needed trusting relationship between professionals and their clients or whether such regulations can be important mechanisms for protecting and supporting professional work.

One important line of scholarship has hinted at a framework for analyzing work structures in a way that could serve to resolve elements in this divergence and disagreement. Three authors illustrating this line of scholarship are Mitchell and Kerchner (1983), Huberman (1993), and Rowan (1994). These scholars all begin by differentiating types of work tasks rather than types of workers. They generally agree that there are four fundamentally different types of work: (1) labor which relies on unskilled effort; (2) craft which relies on technical skill; (3) art which embodies sensitivity; and (4) creativity and professional work which involve acceptance of client trust and taking responsibility for client outcomes. The advantage of this approach is that it allows us to see that occupational jobs can be, and generally are, composed of a mixture of these task types. Some occupations are predominantly composed of laboring tasks (classically illustrated by the pig iron hauler "Schmidt" described in Frederick Taylor's 1911 volume *Scientific Management*). Other occupations are dominated by craft type tasks (computer programming is a good example of such an occupation). Others may be primarily artistic (e.g., plastic and performing artists) and finally some may be predominantly professional in task structure. Presentation of the task types in this order is not accidental as it conveys the fact that the task structures are layered in the sense that craft workers have to have laboring diligence in order to get their work done, artistic workers require performance craft skills and laboring commitments as well as utilizing their artistic sensitivities. Professional work cannot be undertaken without also discharging the labor, craft, and artistic components that are the prerequisites to high performance. Professional work, in short, adds interpersonal, social, and fiduciary responsibility to the diligence, skill, and sensitivity required of the other types of work.

As the unique, but limited, domain of professional responsibility, and professionalism more broadly, is brought into focus, authors in this volume address in fresh and productive ways how educators and physicians maintain appropriate levels of sensitivity, skill, and diligence to support their professional responsibilities. Taken together, the chapters in this work provide fresh perspectives on how organizational structures and public policies used to organize, authorize, and finance these occupations facilitate or interfere with each type of task performance—where, for example, diligence is being eroded by the imposition of anxiety or distracting tasks. Where supervision and accountability are arbitrary, diligent effort in the execution of laboring tasks will be undermined. Where training is inadequate, skill will be lacking; where political orthodoxies are required, artistic sensitivity will be weakened. Where regulations are intrusive, the trust needed for professional work will be undermined.

The Plan of This Book

The body of the work presented in this volume is divided into five parts. Following this brief introductory chapter, which serves as an overview of the conceptual dilemmas needing clarification in analyzing professional work, Part I delineates the challenges facing education (Chap. 2 by Mitchell and Romero) and medicine (Chap. 3 by Allen et al.). Part II frames the conceptual foundations of professional responsibility and examines what it means to assert that educators and physicians can and should exercise professional responsibility in the conduct of their work. The three chapters in this part dissect professional work to clarify key concepts and core issues. Chapters. 4, 5, and 6 examine professional responsibility historically, contextually, and organizationally. Chapter 4 (Sullivan) unpacks key concepts undergirding the professional responsibility needed to secure equity and quality in the fields of education and medicine. Chapter 5 (Montgomery) explores the institutional structures and social forces impinging on professional workers. From this institutional perspective, it clarifies the ways which professional responsibility is shaped by stakeholder groups that impose moral and fiduciary responsibilities on practicing professionals. Chapter 6 lays out the argument that over the last five decades professional work has been transformed from an individualized fee-for-service contract system to become embedded in large-scale complex organizations that have taken over responsibility for defining the purposes and parameters of the work.

Part III examines issues related to the recruitment, selection, training, induction, supervision, and incentivizing of professional work. Chapter 7 looks at recruitment, selection, and training from a medical perspective. Chapter 8 looks at the training context for education scholars, emphasizing the importance of hands on engagement in the work of practicing educators. Chapter 9 looks at the complicated processes of workplace induction for novice professionals, revealing the stresses young physicians confront as they move from medical instruction into hospital patient services. Chapter 10 provides an in-depth look at the incentive systems influencing workplace professionals—distinguishing supportive incentives from those dysfunctional incentive systems that deflect effort and undermine responsible professionalism. Chapter 11 elaborates a conception of professional work and highlights the role of robust professional associations in negotiating the regulatory demands of political regimes and the professional service expectations of the civic culture in order to promote and preserve responsible professionalism.

Part IV presents a series of seven chapters identifying four distinct options for developing and sustaining professionalism in educational and medical contexts. Building on the analyses of recruitment, selection, training, induction, and incentivizing processes supporting the development of professional workers these chapters probe alternative ways of organizing professional work to help overcome workplace challenges. The organizational alternatives identified by these authors include the following: (a) creating “institutional niches” where professionals are protected from bureaucratic and political pressures, (b) using the university as a “base of

operations" to guide and support professional work, (c) preparing "inter-occupational agents of change" to provide links and integrate services, and/or (d) facilitating professional worker community efforts to develop "collaborative routines" that assure professional standards are adhered to within complex organizations.

Part V draws together cross-cutting insights from the first three parts to develop a blueprint for building and sustaining responsible professionalism in education and health care organizations.

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Part I
Why Education and Health Reforms Are Needed

Introduction

The two chapters in this part document current challenges to the delivery of services in education and medicine. In Chap. 2, Ross Mitchell and Lisa Romero zero in on the core elements of public education – curricula, teachers, and students – and examine how these elements interact to produce (and all too often fail to produce) quality education. They paint a picture highlighting the various ways in which professionally responsible and capable teachers are distracted and disabled by the social, organizational, and political forces that determine how these core elements are resourced and regulated. Their analysis recasts the issues of educator accountability, student achievement gaps, and persistent low performance as problems repeatedly addressed by aggressive reform efforts but that still remain resistant to effective policy and practice changes. They note that the current generation of students is the most thoroughly schooled in the nation's history but remains troublesomely short on quality and equality in the teaching and curricular resources provided to them. They also recognize that the current generation of teachers has more training and more fully specified instructional responsibilities than any of their predecessors. Yet, while specialized expertise is the practitioner's main qualification to work with students, technical capacity is never enough. Even the most skilled teachers cannot work without the engagement of their students. Working with students who are less skilled or less healthy necessitates intelligent management of classroom complexity and a capacity to secure the trust and confidence of students and their families. Moreover, the system linking teachers, students, and curricula is not well coordinated with the result that all of the key stakeholders – families, school children, teachers, administrators, and education policy makers – are feeling frustration, alienation, and emotional exhaustion. At the core, these authors argue, it is important to create a fuller sense of buy-in and collaborative engagement to allow teachers to feel and express a deeper sense of professional responsibility for the well-being of students and communities.

In Chap. 3, Allen, Olds, and Schiller take up the question of medical professionalism. As in the case of public education, these authors find health services in the United States to be characterized by high cost, unequal and unreliable outcomes, and the target of intense political pressure for reform and improvement. They address directly the meaning of professional responsibility and highlight the moral and social commitments that are entailed in an authentic commitment to medical practice. These professional commitments are severely challenged, the authors of this chapter report, by "the market" and "the state." The market commoditization of medicine challenges professionalism in large part because the traditional fee-for-service compensation for physicians encourages attention to the services to which fees are linked, rather than the health and well-being of the patient whose maladies are being treated. Such a system easily leads to reliance on more expensive and less essential services. The market is also deflected from the most efficient and efficacious treatment plans by the fact that pharmacological and medical treatment services are provided by large, for-profit, corporations with strong marketing organizations that seek to purvey more profitable products and services.

The state challenges medical professionalism through its efforts to regulate the character and cost of medical services. Since the government is a major purchaser of medical services, it is also the primary watchdog to control inefficiency, fraud, and corruption. But to perform this market control function, the government must set prices and allocate services based on political values and using regulations that assume standardized rather than individualized medical treatments are the most efficient. These authors provide a cautionary note when they conclude that,

> While the renewed interest in medical professionalism by organized medicine and institutions of medical education is encouraging, simply teaching professionalism without addressing the firmly entrenched institutional structures that produce market and state stresses on professionalism would be pointless.

Taken together, these two chapters set up a fundamental challenge to human improvement that echoes throughout the remainder of this volume: How can we build upon a renewed interest in helping educators and physicians to understand the nature of the social contract that grants them (1) the license to practice skillfully, (2) the power to resist distracting market and state influences, and (3) the professional responsibility to deliver both quality and equality of access to well-educated and healthy lives.

Chapter 2
Responsibility at the Core of Public Education: Students, Teachers, and the Curriculum

Ross E. Mitchell and Lisa S. Romero

Education is the story that society tells about itself. What we teach our children is who we are, or who we want to be.

(Murray 2008, p. 39)

Education in the United States is at yet another crossroad in its history as an institution of American democracy (Fuhrman and Lazerson 2006; also see, e.g., Gándara and Contreras 2009; Mitchell et al. 2011; Timar and Maxwell-Jolly 2012; Valencia 2002). As "a nation accountable" (U.S. Department of Education 2008), we must confront unmet demands for the equalization of opportunity (U.S. Department of Education 2013) and make good on an "education debt" (Ladson-Billings 2006) owed to generations of underserved families. Educational quality, made available equitably, is an unfulfilled promise of the mass compulsory education advocated by Horace Mann in the early nineteenth century (Vallance 1973–1974). Throughout the nation and especially in the education system, this generation faces large gaps between who we are and who we want to be.

So, it is not surprising that our nation's political and economic elites contend that, "We remain a nation at risk" (U.S. Department of Education 2008, p. 1), or that our government follows a long history of making educational prescriptions to cure our social ills and fend off external threats to our political or economic security (Tyack 1991). As most recently articulated by the Co-Chairs of The Equity and Excellence Commission:

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> Our leaders decry but tolerate disparities in student outcomes that are not only unfair, but socially and economically dangerous…. The data the commission reviewed make clear that officials, administrators and constituents at all levels of government must attack our education failings as a moral and economic imperative. (U.S. Department of Education 2013, p. 9)

With each generation, practically since the nation was founded, schools have been the target of reform (e.g., Kaestle 1983; Tyack and Cuban 1995; U.S. Department of Education 2013). Rather than emphasize reform, however, we want to inform—redirecting attention to the problems of education on principles of duty and responsibility at education's core, where teaching and learning engage the curriculum. We agree that disparities have existed and continue to characterize the condition of education. Indeed, there are failings with serious social, political, and economic consequences. But we wish to focus on the practice of education rather than its management and governance arrangements. Practice is the living construction of educational reality, and this occurs where teachers and students enact their roles in the curriculum.

Root of Responsibility

Public education bears a substantial responsibility for America's children and youth. This societal institution makes the single greatest claim on children's time and attention during waking hours, sometimes more than their families (Christensen et al. 2011). And families reinforce school effects through their role in early literacy development, homework support, and other educational interactions and activities outside of school hours. Public education is the largest segment of state and local government expenditure and employment (Raffel 2007). This vast system has sprung from state constitutional mandates and is exemplified by such constitutional clauses as: "promotion of intellectual, scientific, moral, and agricultural improvement" (Constitution of the State of California, Article IX, Section 1) and

> to countenance and inculcate the principles of humanity and general benevolence, public and private charity, industry and frugality, honesty and punctuality in their dealings; sincerity, good humor, and all social affections, and generous sentiments among the people. (Constitution of the Commonwealth of Massachusetts, Chapter V, Section II)

Also, we are to recognize that "religion, morality, and knowledge [are] necessary to good government and the happiness of mankind" (North Carolina State Constitution, Article IX, Section 1), requiring "suitable provision for the support and maintenance of an efficient system of public free schools" (Constitution of the State of Texas, Article VII, Section 1).

Since public schools have their origins in the service of both society and the state, they are ready target institutions called upon to respond to new and emerging societal needs and concerns (Graham 2005). School reforms are popular solutions to societal problems: "Americans have thought [and continue to think] it easier to instruct the young than to coerce the adult" (Tyack and Cuban 1995, p. 2). A course

for the future is set with new prescriptions for the schools hoping to awaken a new national character by providing the needed training for our nation's youth (see Mitchell and Mitchell 2003). However, schools are both shaped by, and give form to, local communities on a daily basis, intending to contribute to future adult political, economic, and social participation and well-being. This makes successful education a nested challenge. The nation's young people are to emerge from schools designed to be insulated and nurturing so that a new social, political, and economic order can be created (e.g., Walzer 1983). At the same time, children and youth are surrounded by and must grow and develop in a world of active people outside of the school (sometimes involving their own families) who are coping with dissatisfaction, stress, threat, or other trouble (e.g., Grubb and Lazerson 1988). The practice of education is situated in a place that is part sanctuary from the day-to-day world and part crucible for tempering new community ideals and relationships. This is where competent and responsible practitioners strive to establish and maintain relationships of mutual trust and enthusiasm in schools and classrooms, on the one hand, and sustainable engagement with the strains of new and changing learning demands for and aspirations of the children and youth who come to them each day, on the other.

Education's Core

Behind the churn of policy talk, and central to the constitutional mandates creating mass compulsory schooling, lies the fundamental core of education: teachers, students, and the curriculum (see Turner 1997, p. 234). To understand educators' professional responsibilities we must focus on these three core elements and their interrelationships. Figure 2.1 depicts four aspects of these core elements: (a) it illustrates the conceptual elements of this fundamental core (the three labeled circles), (b) it indicates that they are interrelated and mutually constructed through practice, activity, and agency (the double-headed arrows between each pair of circles), and (c) depicts their placement in the institution of formal schooling (the labeled funnel containing the circles and double-headed arrows), and (d) it notes that schooling is a significant but limited period in the life of the students (single-headed arrow pointing to the "End of Student Passage") (Turner 1997; also see Ball and Forzani 2011; Laden 2013; Walzer 1983). It is this more or less societally insulated funnel through which our children and youth are compelled to pass as they grow and develop into adult members of their communities. And, this is where the personal and collective responsibility for and of public education is taken up, where practice is enacted.

The enactment of educational practice creates routines of action forming the sensible organization of schooling. Established practice, though not easily changed, is always subject to reconsideration. At every crossroad intersecting the demands (or impending demise) of the family, the political community, or the economy, there is an impulse to continue our "tinkering toward utopia" (Tyack and Cuban 1995), a willingness to penetrate the insulation between schools and the rest of society, a

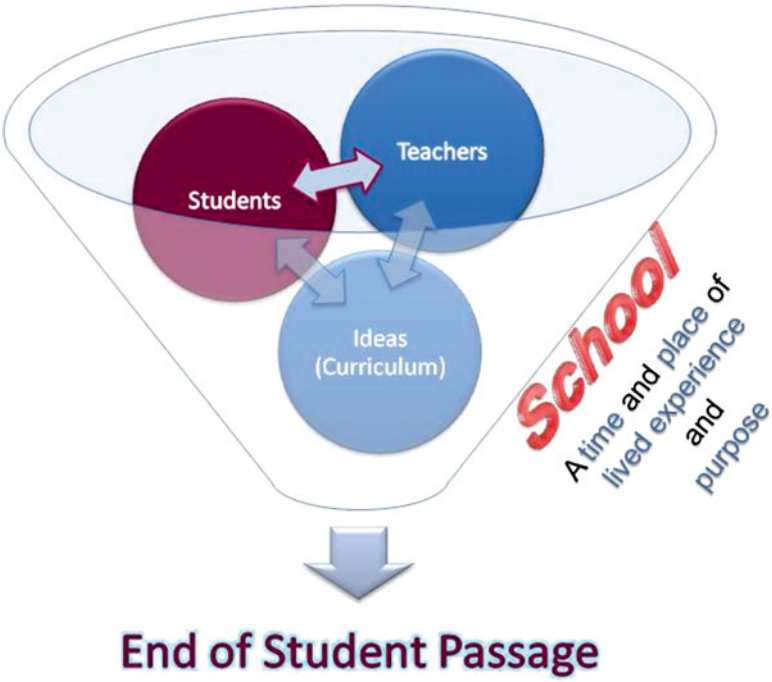

Fig. 2.1 Conceptual diagram of the elements and construction of educational practice through formal schooling

desire to intervene in the relationships among teachers, students, and the curriculum for the betterment of society. Time and again, we must ask: Do we have the right people doing the right things with the right curriculum, so our children are trained and nurtured in the right ways to keep themselves and our nation on the right or best course?

This last compound question needs to be looked at carefully, however, before its answers can be provided because its contents are contested, unstable, and abstract. It goes without saying that "the right or best course" is a point of contention that, if ever truly agreed upon, may nonetheless shift from time to time and appear differently from one place to the next. Moreover, whether viewed at a national distance or at the locally enacted level, schools are never exactly the same place, doing the same thing in the same way with the same people, as they were the last time we looked to them for assistance. The funnel metaphor reminds us that schools attempt to direct a fluid and dynamic social system. They are responsible for and must be responsive to generational, personnel, and ideological changes when and where they occur. Beyond the school, populations, economies, technologies, and other circumstances change—changes to which schools are called upon to respond.

Even when done by "the right people" in "the right ways," those who are responsible for the work of schooling are not able to uniformly produce ideal national

citizens able to fit into any part of the engine of society anywhere in the country.[1] In the remainder of this chapter, we seek not to arrive at answers to questions of educational reform and improvement, but to continue looking carefully at the component parts of the schools' institutional core. We do so by reviewing the character of various problems plaguing the core and the ongoing challenges demanding the schools' considered attention. We employ the conceptual framing provided in Fig. 2.1, an architecture that reflects the nested nature of working toward success with the complicated mission assignments to the public schools.

Mission and Responsibilities of Mass Compulsory Education

Before addressing the details pertaining to responsibility for and of students, teachers, and curriculum, and the interactions among them, let us review what brings all of America's young people to school—the purposes for which public education was established and which animate its practice. The United States developed a system of mass compulsory education for the purpose of training up future generations of responsible citizens who are equally capable of meaningful participation in the democratic and civic life of their communities, able to contribute to society, and enabled to pursue economic self-sufficiency and meaningful work in the current economy (e.g., Hochschild and Scovronick 2003). This is to be done by attending to both training in and development of specific skills, habits, and knowledge systems, as well as an awakening or inculcating elements of character and value systems consistent with the political, economic, and social life of the communities, states, and nation in which we live (e.g., Brown v. Board of Education of Topeka 1954; Tyack and Cuban 1995). Moreover, this compulsory education should help children adjust to their environment in anticipation of assuming their full responsibilities as loyal citizens (also see Grubb and Lazerson 1988; Kaestle 1983; Mitchell 2000; Plyler v. Doe 1982).

Following the *Brown* (1954) decision, federal involvement in shaping public school policy has steadily and dramatically increased, which has resulted in a revision of the constitutional purposes of mass compulsory education (e.g., see Mitchell 2011). National security threats, typically expressed as matters of defense or commerce, have animated both the substance and rhetoric of federal legislation intended to affect the content and conduct of public education (also see Cross 2004). At present, and with an unprecedented reach and focus, the national government demands that America's schools provide an education that would have its students lead in the

[1] If we were to stay with this mechanical production metaphor, we would also question whether reform demands come faster than the timescale on which educational production takes place. That is, if reforms come more frequently than every 12 years, especially if they are to affect the entire system, then reform will create damaging rather rectifying disruption and make for incoherency and instability instead of laying a foundation for the students, teachers, and curriculum. Reform will be at odds with rather than a spur for responsible educational practice.

global competition for the highest test scores (e.g., Meyer and Benavot 2013; Schmidt 2012; U.S. Department of Education 2013) and, more urgently, greater economic vitality in a global marketplace (e.g., Shipps 2000; U.S. Department of Education 2013).

Regardless of the specific emphases among the purposes of schooling, the central design of public education has not shifted. The state has assumed the responsibility for the training, development, and character of the next generation of citizens. It does so by compelling families to send their children to school and engage a curriculum with a certificated teacher to carry out this responsibility. And here is where we explore the successes, failures, and continuing challenges of practice in mass compulsory public education.

The Field of Education

As with any assessment of performance and possibility, the sense of success and failure, as well as the challenges ahead, is best gotten by understanding the contexts faced. The educational enterprise in America is an enormous system of social, political, and economic institutions. There are more than "ten thousand democracies" embodied in governing K-12 education in the United States (see Berkman and Plutzer 2005). There are thousands more governing agencies in private, religious, and charter schools. All of the country's multiple millions of school-age children and youth are compelled to attend and their families are directly affected by this compulsion. The care and training of these young people is concentrated in the hands of millions of schoolteachers, support staff, and administrators employed by 16,990 school districts among the fifty-plus states and territories (Gray et al. 2013). Nearly all of the certificated employees (i.e., the state credentialed or licensed teachers, administrators, counselors, psychologists, social workers, nurses, librarians, etc.) received some or all of their certification training in state and regionally accredited professional schools among the nation's colleges and universities.

In addition to all of the people involved in the day-to-day activity of education, facilities and materiel are required and provided. Though invisible to many and taken for granted by most Americans, except when something goes wrong, these are interests and influences on education beyond its core, and we cannot neglect to identify them. Each school and classroom is built, maintained, and provided for by a host of businesses that contract with states and their school districts.[2] These businesses include building contractors, computer manufacturers, food and dining supply vendors, office and school supply distributors, sports and playground equipment manu-

[2] We note here, but do not cover in detail, that too often, especially in urban school districts, facilities are often run down and lacking vital materials, textbooks, and technology (e.g., see Oakes 2003). Moreover, new schools built to serve low-income families, which tend be overrepresented by students of color, may be sited in comparatively (or absolutely) unhealthful locations (e.g., see Cohen 2010).

facturers, standardized test and textbook publishers, and uniform suppliers, and other vendors too numerous to list. Moreover, many of the involved and interested parties are represented by unions, professional associations, trade associations, or other organizations that promote the welfare of their membership (individual or corporate) and advocate for their interests and benefit in dealings with both public and private entities (e.g., governments, insurers, service providers, etc.).[3] All of this complexity remains, however, an elaboration on the primary structure and responsibility of the educational enterprise. The core of educational practice remains a matter of bringing students together with teachers in order to take on a curriculum.

The Actors and Activities of Schooling

We start with the students circle within the funnel. We then work our way around to teachers and the curriculum, stopping to address the dyadic interactions along the way. Finally, we address the fully interdependent triad. Learning is mutually constructed through teacher practice, enacted curriculum, and student agency. This is where the aims of education are realized.

Students

The students for whom this enterprise is responsible are a diverse and numerous lot. As of 2010–2011, nearly 50 million students attend public elementary and secondary schools in the United States (see Snyder and Dillow 2013, Tables 44–47, 51, 53, pp. 85–88, 92, 94): just over half (52.4 %) were White, and about a quarter were Hispanic/Latino (23.1 %). About one in every six students was African American (16.0 %) and one in 20 were Asian/Pacific Islander, with just over 1 in a hundred (1.1 %) American Indian/Native Alaskan. About one of every eight students (13.0 %) had an identified disability and Individualized Education Program (IEP).[4]

[3] We must note that some states are not unionized, many paraprofessionals are not represented (i.e., they neither have their own unions nor are part of larger classified employees unions), and many small vendors are not organized.

[4] Though the additional number of students is comparatively small, this percentage excludes students with disabilities who have specific accommodations that do not require IEPs but, instead, are provided for through "Section 504 Plans" (in reference to provisions of the Vocational Rehabilitation Act of 1973, P.L. 93–112) or "ADA Plans" (in reference to provisions of the Americans with Disabilities Act of 1990, P.L. 101–336). Of course, there are some students for whom no accommodation plans of any sort exist, the reasons for this are quite variable and the number is unknown. Further, we note that, currently, the following disability categories are employed to characterize the one or more conditions or impairments that have lead to students having IEPs: Autism, Deaf-blindness, Deafness, Developmental delay, Emotional disturbance, Hearing impairment, Intellectual disability, Multiple disabilities, Orthopedic impairment, Other health impairment, Specific learning disability, Speech or language impairment, Traumatic brain injury, Visual impairment, including blindness.

Just over one in twelve students (6.7 %) were identified for Gifted and Talented Education (GATE).[5] Nearly half the student population (48.1 %) were from poor households and identified as eligible for the National School Lunch Program (NSLP, the program that provides free or reduced price school meals to children from low-income households).[6] Nearly one in every ten students (9.8 %) was an English learner (the children of immigrants or immigrants themselves). These national figures mask very large regional variations. For example, in the most populous state, California, the majority are Hispanic/Latino (51.4 %), only about a quarter are White (26.6 %), followed by Asians/Pacific Islander (11.7 %), African American (6.7 %), and 0.7 % American Indian/Native Alaskan. This state has fewer students with disabilities (10.7 %) and more identified for GATE (8.3 %). California's NSLP participation is a bit higher than the national average, but their population of English learners is nearly three times the national average (28.9 %).[7]

Among local districts, diversity profiles are often even more dramatically different. Students in some districts are virtually all of one ethnic group while in others they may have a mix of students closely matching the national profile. At individual school sites students tend to come from households that are living close to the school, and these neighborhoods tend to be far more homogeneous than the larger geographic regions in which they are located. Hence, in the day-to-day practice of education students are geographically "funneled" together in widely varying mixes of economic, ethnoracial, linguistic, legal, and capability distinctions.

Capability Differences and Achievement Gaps

Student capability or disability is a professionally important attribute of students. Public school educators are responsible for providing a free and appropriate education for students across their entire range of social, emotional, cognitive, and psychomotor functioning.[8] As noted earlier, students identified for an IEP have impairments that interact with the school environment in a way that handicaps

[5] The GATE statistics are for the year 2006–2007, not 2010–2011. And, as is true with all of the other statistics, there is substantial state-to-state variation in the proportion of students identified for GATE.

[6] To be eligible, students must come from households that are at 185 % of the poverty level or lower. Free lunch qualification is at 130 % of the poverty level or lower.

[7] For further comparison (drawing from the same data sources), the state with the lowest enrollment, Wyoming, is predominantly White (81.0 %), followed by Hispanic/Latino (12.3 %), American Indian/Native Alaskan (3.3 %), African American (1.1 %), and Asian/Pacific Islander (0.9 %)—remaining 1.4 % "two or more races"; 17.1 % were students with disabilities; 2.2 % were identified for GATE; 37.1 % were NSLP participants; and 2.9 % were English learners.

[8] As mentioned in note 4, an enforceable responsibility to accommodate students with disabilities was first codified in the Vocational Rehabilitation Act of 1973, but the statutory right guaranteeing a free and appropriate public education (FAPE) followed in 1975 with the Education for All Handicapped Children Act (P.L. 94–142), which is now better known as the Individuals with Disabilities Education Act (IDEA, P.L. 108–446; 20 USC §1400 et seq., 2004).

(unnecessarily disadvantages) them without specific forms of individualized attention or responsive adjustment to the school and classroom environments.[9] The variation in students' cognitive functioning gets most of special education attention and resources. In addition to students with IEPs, Gifted and Talented Education (GATE) students qualify for special services. These programmatic categories capture a small part, the extremes, of the substantial variation in capabilities among students (e.g., Potter et al. 2013; Waldfogel 2012).[10] Even after the extremes are removed, however, children enter school with important achievement-relevant differences in functioning that do not qualify as impairments or developmental delays and thus need substantial variation in access to teachers and curricula. Sadly, as is well documented, all too frequently and quickly these differences manifest themselves in the well-known "achievement gaps" between children from families of different socioeconomic classes (advantage to the wealthy), ethnoracial groups (advantage to Asian and White children), countries of origin (advantage to those from English-speaking countries), and so on (e.g., Farkas 2003; Reardon et al. 2012; Timar and Maxwell-Jolly 2012).[11] Some students are better fit to the school before instruction begins; their advantages are large; and these advantages rarely diminish throughout their schooling. Much of recent policy and program reform efforts have been aimed at overcoming inequalities in achievement—too often, however, by emphasizing accountability for test score attainment without adequate differentiation in student instruction.

Nearly Universal Access to Schooling

The students enrolled in today's schools are a population of unprecedented diversity and inclusion. This is due as much to the long, slow march of educational reform as it is to shifting demographics. Beginning with federal Reconstruction following the Civil War, which was supposed to tear down the barriers of race and class to create a newfound equality of persons as citizens nearly 150 years ago, glacially slow progress toward full access to public schooling was made up to and through World War II (Reese 2000; Tyack and Cuban 1995; Snyder 1993). Dramatic change began with the *Brown* (1954) decision. During the three decades of federal lawsuits following and building upon its declaration of the end of state-sanctioned school

[9] To be clear, it is the responsibility of the school to adjust its environment and practices in light of the child, not the responsibility of the child to adjust to an insensitively constructed environment or rigid educational practice.

[10] Under IDEA, districts have an affirmative "child find" duty to identify and provide services to infants, toddlers, and preschoolers who have an educationally relevant disability. So, on the first day of school, some students already have been identified for special educational programming.

[11] Merry (2013) documented between-country differences in child capabilities at school entry for the United States and Canada, and these contrasting country-to-country intake characteristics were able to account for all of the much ballyhooed differences in international test performance between the two countries' 15-year-olds as measured by PISA.

segregation, new classes of plaintiffs successfully demanded an end to nearly all bases for exclusion,[12] though subsequent federal legislation and executive enforcement were required to codify and secure these legal victories (e.g., see Mitchell and Mitchell 2011, 2012). America's schools now provide effectively universal access to K-12 public education to all children regardless of race, sex, creed, color, language, national origin, alienage, or disability, free of charge. For specific student groups, by policy but certainly not always or uniformly in practice, this access should be accompanied by an appropriate (for English language learners and students with disabilities) or compensatory (for economically disadvantaged students) education.

Access Does Not Mean Success

With access successfully granted, there is currently very little disparity in K-12 enrollment for children and youth 5–17 years of age (see Snyder and Dillow 2013, Table 6, p. 24; also, Snyder 1993, Table 2, p. 14); in 1960, 82.6 % of all 16–17-year-olds were enrolled in school; by 2010 this number had risen to 96.1 % (see National Center for Education Statistics n.d.a). However, dropping out of high school continues and is sharply different among ethnoracial groups (e.g., Ream et al. 2012; but see Oropesa and Landale 2009). Differences in education among adults remain appreciable despite graduation rate improvements since *Brown*. In 1960, 43.2 % of white Americans, age 25 or older, had graduated from high school; by 2010, this percentage more than doubled, to 92.1 %. During the same period of time, the percentage of African Americans, aged 25 years or older, who graduated increased fourfold from 21.7 % in 1960 to 84.6 % in 2010. In 1970, 32.1 % of Hispanic Americans, 25 years or older had graduated from high school whereas by 2010 this had grown to 62.9 % (see Snyder and Dillow 2013, Table 8, p. 27; U.S. Census Bureau 2012, Table 229, p.151). Not surprisingly, the groups of students at the bottom of the achievement gaps are also the ones more likely to dropout.

Segregation and Discrimination Persist

Outcomes are a function of opportunity, not just ability, but increased access has not been accompanied by equal opportunity across student groups. Largely due to differences across school district boundary lines, America's schools are more segregated than they have been in close to 50 years (e.g., see Bishoff 2008; Fiel 2013;

[12] We mark the end of this period with the *Plyler v. Doe* (1982) decision requiring that public schools enroll and provide an identically free education to children of undocumented immigrants. That is, there is no reason, not even citizenship status, for denying children residing in the United States a free public education. (Residency is key, however, because children sent to the United States for an education may be charged tuition and, without renewed visa status, denied re-enrollment after 1 year).

Mitchell et al. 2010). And, when compounded by within-school segregation (e.g., Conger 2005; Mitchell and Mitchell 2005), students often find themselves sorted into very different opportunity structures for reasons unrelated to their educational needs or demonstrated competencies (Boger and Orfield 2005). Schools are sufficiently segregated and unequal in their capacity to serve student needs that one nationally prominent educator asks: "If we are unwilling to fully implement *Brown* [desegregate the schools], can we at least have *Plessy* [separate but equal schools]?" (Ladson-Billings 2007, p. 1279). Persistently and in violation of the principles of simple justice, the students for whom schools are responsible are neither provided for nor treated equally, and students are certainly not served equitably (i.e., in proportion to need). Students ready and willing to take responsibility for their own learning continue to be presented with less than adequate opportunities to learn on bases unrelated to their motivations or capabilities.

Teachers

The participants in the educational enterprise who have the greatest responsibility for and with students are teachers. They are with students every day for nearly all of the school day. Teachers are "the key arbiters of instructional content and practice" (Ogawa et al. 2003, p. 173). In addition to the instructor role, teachers serve as classroom managers, disciplinary interventionists, and student socialization agents (Brophy 1996; also see Phillippo and Stone 2013). Consequently, and appropriately, teachers are the most influential people students encounter in school (e.g., Clotfelter et al. 2006; Little and Bartlett 2010).[13]

The teaching workforce in the United States is composed of 3,385,200 public school teachers. In contrast with the students they teach, the vast majority of teachers are White (81.9 %); only 7.8 % are Hispanic/Latino, 6.8 % are African American, and 1.8 % are Asian/Pacific Islander. Even in California, where the student body is nearly three fourths non-White, teachers are overwhelmingly White (70.5 %), with only 17.3 % Hispanic/Latino, 3.2 % African American, and 6.1 % Asian/Pacific Islander (National Center for Education Statistics n.d.b; also see Little and Bartlett 2010; Villegas et al. 2012). Largely, this is because the demographic characteristics of the teacher population are not uniform across birth cohorts (just as with student populations younger generations have lower proportions identified as White than older generations) and because education and licensure qualifications for the office of teacher, which are not evenly distributed across ethnoracial groups, serve as barriers to occupational entry.

Due to long established ideas about who should occupy the office of classroom teacher (e.g., see Grubb and Lazerson 1988; Little and Bartlett 2010), as well as the

[13] Peer influences are not to be ignored, of course, but the school legitimately controls which teachers are present to influence student outcomes, while it is quite limited as to how far it can go to control which students are present.

voluntary nature of the occupation, gender selection effects follow. Unlike the students, who have a nearly balanced male-female gender ratio, teachers are far more likely to be women (76.3 %), especially at the elementary level (89.3 %) (Goldring et al. 2013, Table 2, p. 8). There is no systematic data collection on teachers with disabilities and, with the possible exception of deaf and hard of hearing teachers working in Deaf Education, there is good reason to believe that persons with disabilities are dramatically underrepresented in the occupation of teaching (Hauk 2009). There has been research on the family backgrounds of teachers before going to college, which indicates that many teachers grew up in low-income households during their school years—not all teachers were well off as children—and many spoke a language other than English growing up (Zumwalt and Craig 2008). In socioeconomic terms, current teachers are well above the poverty line (their salaries are solidly at the middle-income level) and few can identify with the dilemmas of English learners (both educational requirements and teacher certification examinations screen out adults who have not attained the occupational standard for English fluency).

Occupational selection standards for teaching encourage similarities among teachers on relevant qualifications (Little and Bartlett 2010). Nearly all teachers have at least a bachelor's degree (96.2 %),[14] and almost half have a master's degree as well (47.7 %), but only about one in nine have education beyond the master's degree (8.7 %) (National Center for Education Statistics n.d.c). Just over 3 %, either on their own initiative or encouraged by state or district incentives, have attained National Board Certification (National Board for Professional Teaching Standards n.d.). Following the mandate for a "highly qualified teacher" in every classroom under the No Child Left Behind Act of 2001 (2002), roughly 13 % of public school teachers still did not hold regular certification from the state in which they taught, though less than 4 % had either no certification or certification that required completion of a credential program (see Keigher 2010, Table 2, pp. 7–8).

Upgraded Personnel Qualifications

The present teaching population has been subject to the highest demand on preservice qualification in the nation's history. They are also subjected to more in-service training activities (though many of these are seen by teachers as not very helpful). It is increasingly clear that alternative routes to certification risk subverting some of the monitoring and supervision assurances provided by university-based programs (Little and Bartlett 2010). In large part, contemporary training procedures evolved following the release of *A Nation at Risk* (National Commission on Excellence in Education 1983), which lamented a "rising tide of mediocrity" and spurred teacher education programs to raise their admissions standards, particularly where they created postbaccalaureate credential programs (Zumwalt and Craig 2008). Selectivity

[14] Today, only career and technical education (CTE) teachers have clear pathways to certificated teaching without a bachelor's degree.

for preservice teacher candidates has become sufficiently tight that earlier disparaging claims about prospective teachers are no longer accurate (Zumwalt and Craig 2008). In fact, by 2005, teachers pursuing single-subject (secondary-level) credentials had higher GPAs than fellow students in the same majors who did not go into teaching (Zumwalt and Craig 2008).

As it has become more widely used, teacher testing for certification provides another screening device that, in principle, is another quality check on teacher qualifications (Little and Bartlett 2010).[15] The first written examinations covered basic skills, content area, and "professional knowledge" (Haertel 1991, p. 3). Subsequent testing has focused on demonstrations of knowledge, skills, and abilities through written reflections referencing artifacts of practice (e.g., Pecheone and Chung 2006). In addition to preservice screening, beginning teachers are frequently given early induction (in-service) training and support through more or less structured mentoring and assessment programs (e.g., Ingersoll and Strong 2011). These programs can help ensure a successful start to new teaching careers.

Though far too many teachers have been in assignments that take them out of their field of training and certification (e.g., Hill 2011; Ingersoll 2013) or are not fully certificated (also see Boyd et al. 2008; LoGerfo et al. 2011), and while the connections between various qualifications and teacher effectiveness continue to be questioned (see Clotfelter et al. 2006), today's selection, screening, and certification standards have attended to various measures of teacher qualifications and raised the quality expected on them.

Connecting Students and Teachers

Learning in the classroom is socially mediated and occurs through complex, didactic interactions between students, their teachers and peers and, as such, is dependent on the social environment and the quality of relationships that exist (Romero in press). As Pianta et al. (2012) argue, "Relationships are a mechanism or medium through which settings engage developmental processes…, perhaps the key mechanism through which classroom experiences add value" (p. 366). As teachers and students interact, interpersonal, not just cognitive, connections are fundamental to the realization of responsible and effective educational practice.

[15] The expansion of teacher testing has a rather ignominious history, however, as one of many devices deployed by Southern states to resist court-mandated desegregation in all its forms. As detailed by Baker (2001), the National Teachers Exam (NTE) was known to have highly differential pass rates for White and Black examinees, and Southern legislators passed laws mandating the NTE in order to keep Black teachers from retaining their employment (i.e., must pass the exam to remain credentialed) and thereby keep from having Black teachers in formerly all-white schools. Angrist and Guryan (2008) document ethnoracial selection effects in more contemporary teacher testing regimes.

Cultural Incongruity and Deficit Thinking

Since classrooms are highly diverse and substantially segregated while teachers are far more homogeneous, opportunities for incongruent culture clashes are manifold. Hence, students and teachers can neither safely assume a common basis for trust nor be certain that they can interpret each other's actions or intentions accurately. Without this common understanding, students are more likely to perceive their teachers as authoritarian, rather than authoritative, when teachers perform their roles as instructors, classroom managers, disciplinary interventionists, and student socialization agents (see Brophy 1996). Similarly, teachers can misinterpret their students' actions and responses as unintelligent, misbehaving, or otherwise without merit and, possibly, deserving of sanction.

Relationship building is more difficult when screening and selection biases result in teachers who have little knowledge about, understanding of, or experience with the circumstances and perspectives of the school community in which they work. In fact, some new teachers find themselves negotiating a seemingly alien culture (Howard 2010). Also, some of these teachers may espouse or unwittingly fall into a mode of "deficit thinking" (Valencia 2010)[16] by which they deflect responsibility from themselves for the outcomes of their inadequate teacher-student relationships and shift blame to the students, their families, their economic and neighborhood circumstances, etc. The challenges of relationship problems and cultural incongruity are most apparent in schools that serve high poverty, high minority communities. In these settings, we find noticeably fewer experienced teachers (Lankford et al. 2002), higher rates of teacher exit and principal turnover (Loeb et al. 2010; Ingersoll 2001), and higher suspension and expulsion rates (Losen and Gillespie 2012). Any serious effort to strengthen professional responsibility in the nation's schools must take these culture clashes seriously.

(Dis)orderly Settings

Teachers take day-to-day responsibility for maintaining order in schools via rules, regulations, and other unwritten norms and behavioral expectations (Jackson 1968). Classroom management, disciplinary intervention, and student socialization together constitute one of the greatest ongoing challenges reported by urban teachers (Milner 2011); instruction is more often on hold, or unduly interrupted, as a consequence. The majority of disciplinary issues start in the classroom (Skiba et al. 2002). These and other struggles to manage the classroom are significant factors in

[16] Kirkland (2010) characterizes the *achievement gap* discourse as functioning in very similar terms: "It seems to blame oppressed groups for their oppression as well as their identities, for suffering and for not being white.… However good- or ill-intentioned the construct of the achievement gap may be, its supposed claims to urgency and its fierce repetition in the national discourse reinforce a particular kind of performance—one tied to promoting Whiteness, one that mischaracterizes the true differential between white and nonwhite students".

teacher success, burnout, and job satisfaction (Emmer et al. 2011). To anticipate a topic discussed below, establishing classroom order through student engagement rather than the manipulation of rewards and incentives is one mark of successful professionalism in the classroom.

Students suffer when classes are disrupted, particularly when this arises out of conflict between a student and teacher, especially when student suspension from the classroom (or school) typically follows.[17] Culture clash disruptions lead to serious inequalities in educational opportunity as shown by the fact that African American students are more likely to be referred to the office for minor and "subjective" offenses such as "disrespect, excessive noise, threat, and loitering" (Skiba et al. 2002, p. 334). Disproportionality is most acute for males, African Americans, and Latinos, who are referred to the office for discipline, and suspended and expelled at much greater rates than their classmates (Skiba et al. 2002; Losen and Gillespie 2012; Wildhagen 2012). This disproportionality, termed the "discipline gap" (Gregory et al. 2010), persists net of such considerations as socioeconomic status, higher rates of misbehavior, disruption, or more serious conduct (Skiba et al. 2002). As a result, some scholars are asking if the discipline gap and achievement gap are "two sides of the same coin" (Gregory et al. 2010).

Curriculum

Every state has some constitutional provision for education (sampled above), but none articulates a comprehensive framework at this level of policy making. A full conception of curriculum articulates the "aims, view of children, perspective on learning, concept of teaching, conception of knowledge, and beliefs about assessment" that organize and direct the educational enterprise (Schiro 2013, p. xv). Though broad aims and a conception of knowledge relevant to public schooling may appear in state constitutions, these rudiments do not form the ideologies subscribed to by educators or their communities. When it comes to curriculum format and content, educational ideologies are multiple and conflicting. The practice of education taking place in schools relies on curriculum legacies that are the fruits of compromises and shifts in curriculum definition that have occurred over decades (e.g., Kliebard 2004; Schiro 2013; Tyack and Cuban 1995).

Similar to our discussion of students and teachers, we discuss the curriculum around which the educational enterprise is organized in terms of the tension between diversity and standardization. The established "grammar of schooling" is an age-graded curriculum (Tyack and Cuban 1995). What students are asked to learn and do, what teachers are to understand and instruct, is sequenced and advances on an annual basis (i.e., for each year the children age, there is a new grade level for their

[17] A relatively small percentage of teachers are responsible for the bulk of referrals. Students often perceive these teachers as being untrustworthy and do not recognize them as having legitimate authority, which may foster the development of student disaffection, disengagement, and alienation (Gregory and Ripski 2008; Gregory et al. 2010; Emmer et al. 2011).

cohort). Typically, the curriculum begins with basic knowledge, skills, dispositions and deportments, habits, routines and rituals to be learned, and reinforced across a limited range of variously defined subjects (Kliebard 2004). Consistently, the required subjects have included the English language arts (i.e., speaking, reading, and writing, often with spelling emphasized separately), mathematics, social studies (history, government, and so on), and science—schools have always taught more than the 3 R's (reading, writing, and arithmetic). Physical education and activity, computers and technology, foreign (non-English) languages, sex education and family life, art, music, and vocational arts (career and technical education) have a place in the curriculum. Schools also create and organize opportunities to engage in competitive sports, debate, spelling bees, college bowls, music and arts festivals, agricultural fairs, and other extra-curricula, as well as host student-run community service organizations and interest or hobby clubs. The boundaries of the curriculum readily expand, particularly for adolescent students, to include new ideas and activities for the education of our children and youth. And, though school is typically thought of as a singular location (a particular funnel), its boundaries, too, may be expanded to include museums, symphony halls, seascapes, farms, factories, and other sites for engaging the curriculum.

The Tested Versus the Untested Curriculum

Amid all the expansion, there have been only narrow and inconsistent efforts to create standardized assessment instruments for the contemporary school curriculum. Routinely, progress through the reading and mathematics curricula is assessed, but other subjects remain either untested for long periods of time or completely ignored outside of assessments by individual classroom teachers. This creates a disjuncture between individual classroom and collective school (or larger) educational practices and provides justification for the perception that test-based accountability for achieving curricular ends is a source of educational dysfunction (e.g., see Ravitch 2010). Further, large-scale testing programs typically employ instruments that emphasize basic skills. As Hochschild and Scovronick (2003) observed,

> The most thoughtful reformers insist that curricula be not merely systemic but also substantively rich and focused on learning beyond the basics. They want schools to be responsible for ensuring that students achieve at a high level, with depth of understanding, analytic skill, and the capacity to integrate knowledge…. (p. 92)

And, though the new Common Core State Standards and their assessment systems are supposed to address some of these concerns, they remain limited to English language arts and mathematics (National Governors Association Center for Best Practices, and Council of Chief State School Officers 2010a, b).[18]

[18] At the same time, the curriculum implied by these standards is one that appears to be diminishing the notion of democratic citizenship present in many state constitutions; the NGA and CCSSO state, "a particular standard was included in the document only when the best available evidence indicated that its mastery was essential for college and career readiness in a twenty-first-century, globally competitive society" (2010a, p. 3).

Connecting Teachers and Curriculum

There are at least four kinds of differentiation that depend on the relationship between teachers and the curriculum, and which significantly challenge educational practice. First, and most fundamental, is the distinction between curriculum and instruction. Teachers are responsible for instruction, but they are rarely and only partially responsible for curriculum, even though responsible teaching practice is not independent of curriculum. Not only the "What," but the "How," "When," "Why," and "For Whom" of teaching are idealized in the curriculum, making practice subject to reinterpretation and reevaluation with each reform. Teachers may find themselves taking up sides or otherwise caught in contentious "curriculum wars" (see, e.g., Evans 2004; Loveless 2001; Stotsky 2000). The relationship between the office of teacher and the curriculum can be quite turbulent.

Generalists Versus Specialists

Second, there is the routine differentiation between teachers as curriculum generalists—primary school or multiple-subject credential teachers—versus curriculum specialists—single-subject credential, typically, secondary school teachers. Though this division importantly includes consideration of the developmental needs of the students with whom the teacher works, there are assumptions about the relationship between the teacher and the curriculum that are problematic. The scope, sequence, and coordination of the curriculum affects whether teachers have the necessary content and pedagogical knowledge for the subjects they teach. For example, both domestic and international comparative studies indicate that the middle grades mathematics curriculum of today, one for which both multiple- and single-subject teachers have license to teach, demands levels of subject-specific content and pedagogical knowledge beyond the scope of certification training required of the multiple-subject generalist (Blömeke et al. 2011; Hill and Charalambous 2012; Schmidt 2012). Responsible day-to-day practice under these circumstances is quite challenging.

Curriculum Tracking

Third, there is frequently differential programming or tracking in the curriculum (Oakes 2005). The distinguishing features may be sensitive to student needs, at least initially, but tracking inevitably produces status hierarchies. Sometimes, the distinctive status is apparent to all, for example, the "honors" track; other times, the distinctions are submerged by special services labels, for example the GATE class or the self-contained classroom (also see Mitchell and Mitchell 2005; Oakes 2003). Either way, curriculum differentiation not only raises questions of appropriate teaching assignment—fit between practitioner and practice—but attractiveness of the assignment as well. Responsible practice, administrative as well as teaching, is

confronted with challenges arising from threats to teacher status, as well as political or performance rewards, through assignment by curriculum track. And since teacher collaboration and teacher-to-teacher consultation can be powerful means to promote improved practice (e.g., Roehrig et al. 2007), great care must be taken to avoid invidious distinctions or curricular isolation.

Assessment Versus Testing

Fourth, there is the difference between classroom assessment and standardized testing as the bases for informing instructional practice. As previously noted, the full aims and knowledge systems of the curriculum cannot be fulfilled by "teaching to the [standardized] test," but this behavior is displacing responsible classroom assessment practice in the early grades (e.g., Ogawa et al. 2003). Curriculum standards are studied, locally interpreted, and translated into benchmark assessments intended to predict performance on statewide standardized (accountability) tests. But this exercise is not necessarily articulated with instructional planning and rarely integrated with the untested curriculum. Instead, other subjects receive little or no attention despite their relevance to the grade-to-grade progression of the curriculum or the larger purposes of educating informed, capable, self-sufficient, and loyal citizens.

Moreover, it is too easy to aim low, at the basic content defining minimal proficiency or minimally acceptable growth, even though the greatest learning occurs where advanced concepts remain a regular part of the instructional program (e.g., Bodovski and Farkas 2007). That is, when the assessment element of the curriculum is allowed to dominate the other elements, it not only disrupts the balance of teaching practice, it too readily reorients practice in ways that abdicate responsibility for the full curriculum and its highest aims.

Connecting Students and Curriculum

Finally, coming full circle to the students, we look at their relationship to curriculum. Student learning, motivation, and engagement with the curriculum are a function of interest, perceived value, and relevance (Brophy 2013). For example,

> when students believe that the topics they are dealing with in science have personal relevance and meaning for their lives they are more likely to experience enjoyment and interest from engaging with science content.… Personal meaning and relevance is an important factor in students' enjoying science and focusing their attention to expand their knowledge and understanding. (Ainley and Ainley 2011, p. 11)

This does not mean that the curriculum is best tailored to students' current activities and routine encounters in their daily lives. Students express interest and actively engage in projects that authentically represent contemporary practices and that apply what they are learning in their local settings (Tytler et al. 2011).

Activity Versus Recitation

However, students' experiences with the curriculum are too often irrelevant, uninteresting, or have little meaning to their daily lives. These reasons for disengagement frequently follow from the character of knowledge that defines the curriculum experience. Though students take great pleasure in understanding, they strongly prefer that learning comes through doing or activity rather than recitation or memorization (e.g., Swarat et al. 2012). Unfortunately, the wherewithal to present and sustain meaningful curricular activities is not equal across schools and classrooms. Students in high poverty schools and lower status curricular tracks tend to have fewer books, laboratory equipment, and other materials and facilities for authentic and engaging activities (e.g., Oakes 2003, 2005).

Pacing Versus Learning

In the current standards-based accountability era, school curricula are very tightly specified, including the time and timing appropriate to each topic or standard. This creates tension with student learning because the pace at which the curricula are to be covered, as though they were a series of packages to be delivered, can exceed the rate at which students learn what is being covered. Though uniformity of time and timing is helpful for ensuring that the scope, sequence, and coordination of the curricula are preserved, especially for mobile students who may transfer from class to class or from one school to another, the pace must be appropriate if no child is to be left behind. This is especially important since there is a strong tendency for curricula in the United States to superficially cover an extensive range rather than promote the development of deep understanding of complex subjects (e.g., Schmidt 2012). That is, if staying on pace comes at the cost of depth and complexity then little of value is learned.

Rigorous Versus Tested

Another reason that student engagement may suffer comes from the conception of rigor. If rigor means knowing sophisticated and meaningful content well then students are likely to benefit. But if rigor means knowing well only what is tested by the standards-based accountability system then interesting, relevant, and exciting curricular opportunities are sure to be lost (e.g., Roehrig et al. 2007).

Students-Teachers-Curriculum Triumvirate

As alluded to in the last paragraph, the analytical distinction of each dyadic interaction among students, teachers, and curriculum fails to emphasize that the triad is jointly determined. Teaching and learning occur in a highly contextualized and

localized social environment of schools and classrooms within neighborhoods and communities. Students' success is a function of their individual cognitions and agency, the curriculum as interpreted and enacted by the teacher with those students and the available materials and facilities, and social context of the classroom. The idea of success or failure depends on the conjoint interactions of students, teachers, and curriculum.

Let us return to the topic of tracking, for example. Low-track classes foreclose access to high-value curriculum not only in the actual classes, such as calculus or physics, but often within like-named courses. Lower track classes are characterized by less challenging curriculum and, very often, by rote instruction (Oakes 2005). Perhaps not surprisingly, discipline is also often an issue in lower track classes, and tolerable behavior is sometimes exchanged for low expectations and demands from teachers (Oakes 2005). In contrast, students in high-track classes are exposed to a higher value curriculum, engage in critical thinking, and experience more choice, higher quality instruction and more positive, trusting relationships with teachers (Oakes 2005). Unfortunately, the students on these tracks are distinguishable. Latino and African American (and especially male) students, English learners, and students from impoverished homes are significantly overrepresented in special education and underrepresented in GATE and Advanced Placement (AP) classes (also see Gándara and Contreras 2009; Losen and Orfield 2002; Skiba et al. 2006; U.S. Department of Education n.d.). Thus, all three elements converge, or conspire, to create teaching and learning conditions that reinforce the status differentiation and separateness that goes with the less than fully responsible educational practice of tracking.

Now, let us provide an example of the "hidden curriculum" and its conjoint interaction with students and teachers. In the case of many urban, low-income schools, there has been a proliferation of zero-tolerance policies, another term for the social and behavioral or citizenship (nonacademic) curriculum. These policies have created an environment that emphasizes security and order over learning and liberty.[19] The presence of police and security officers is common at these schools, and student behavior that in the past may have been handled privately, between educational practitioners and students' families, has become criminalized. The net result is that "children in urban public schools … routinely encounter surveillance and policing more than a rigorous [academic] curriculum and safety net of caring adults" (Winn and Behizadeh 2011, p. 148). Through severe discipline and criminalization, schools have profoundly reinforced "hidden curriculum" tracking, where the actions and expectations of teachers and students differ in ways that lead to inferior educational experiences for the lower track students. The hallmarks of responsible educational practice are almost entirely absent.

[19] In the mid-1980s during the Reagan-Bush presidencies concerns about drugs, violence, and school safety led to calls for zero tolerance policies. During the Clinton administration, these policies became ubiquitous in schools across the nation following the signing of the 1994 Gun Free School Act. Although zero tolerance policies varied by state and locality, mandatory suspensions and expulsions, even for first offenses, grew to cover guns, knives, other real or even look-like weapons, marijuana, alcohol and other drugs, fights, violence, and threats of violence (Skiba and Knesting 2001). As a result, suspensions and expulsion rates have soared.

Summation

The following passage from Suzi Sluyter's letter of resignation—she was a Cambridge, Massachusetts, 25+ years veteran kindergarten teacher—captures the sense of responsible and competent practice we have articulated. This teacher, her students, and the curriculum come together in a tightly interdependent system to pursue the education of schoolchildren. This excerpt from her letter also highlights some of the problems and challenges afflicting the education's core triumvirate today. We let this practitioner have the last words about what it means to have and enact a vision of responsible practice.

> In this disturbing era of testing and data collection in the public schools, I have seen my career transformed into a job that no longer fits my understanding of how children learn and what a teacher ought to do in the classroom to build a healthy, safe, developmentally appropriate environment for learning for each of our children.… I have watched as my job requirements swung away from a focus on the children, their individual learning styles, emotional needs, and their individual families, interests and strengths to a focus on testing, assessing, and scoring young children, thereby ramping up the academic demands and pressures on them.… I have needed to schedule and attend more and more meetings about increasingly extreme behaviors and emotional needs of children in my classroom; I recognize many of these behaviors as children shouting out to the adults in their world, "I can't do this! Look at me! Know me! Help me! See me!"… Each year I have had less and less time to teach the children I love in the way I know best—and in the way child development experts recommend. I reached the place last year where I began to feel I was part of a broken system that was causing damage to those very children I was there to serve. (see Strauss 2014)

This letter captures in poignant detail the contemporary clash between education reform efforts and the professional responsibility of teachers to create relationships, excite student engagement, and tailor their instructional efforts to the social, cultural, and intellectual needs of their students. As readers of this chapter critically appraise the analyses and recommendations found in the chapters that follow, we hope they will keep in mind the complexity of schooling and the fundamental importance of trusting and adaptive relationships for insuring success.

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Chapter 3
Medical Professionalism and the Relevance and Impact of the Profession on Society

Scott A. Allen, G. Richard Olds, and Neal L. Schiller

Introduction

In the first decades of the twenty-first century, the practice of medicine is evolving at a dizzying pace. The rapid advances made in the fields of pharmacology, biochemistry, genetics, and medical technology have resulted in constantly changing and improved diagnostic and therapeutic options. At no time in human history has the profession of medicine had as full of an understanding of the causes of disease or possessed such a potent arsenal of tools and interventions to diagnose and treat the maladies that affect humanity. And in the areas of medical knowledge and resources, the Unite States is a world leader.

At the same time, the United States is not the leader in health delivery or outcomes. In 2000, the World Health Organization made an effort to rank the health systems of the world's nations using criteria such as health access, preventive services, and infant mortality statistics. In that report, the United States ranked 37th (World Health Organization 2000). While that report generated both praise and criticism for its methodology, subsequent analysis support the basic finding: despite the highest per capita spending on health care arguably the finest and best equipped hospitals and clinics in the world, the United States does not come close to delivering the best outcomes for the population as a whole. According to a recent report by the Organization for Economic Co-operation and Development, the United States spent $8,508 USD on health per person in 2011, two-and-a-half times greater than the OECD average of $3,339 USD. While life expectancy in the United States used to be 1-½ years above the OECD average in 1960, it is now, at 78.7 years, below the average of 80.1 years (OECD 2013).

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Within this context, we consider the issue of medical professionalism. The medical profession, like other professions, has evolved to occupy a special position in society due to key attributes that define a profession. The practitioners of the profession possess specialized knowledge. They hew to an ethical framework. Practitioners police their own profession and they practice their profession to the benefit of society.

Or, at least, that's how it is supposed to be. While it can easily be argued that the medical profession largely lives up to these ideals of a profession, one cannot easily dismiss the fact that the profession is regularly challenged by conflicting influences and agendas. External influences on the profession and individual practitioners include both market forces and the role of government. Market forces can result in conflicts of interest for physicians, a phenomenon that has been referred to as the commercialization and commoditization of medicine (Brennan 2010). The influences of government, which range from issues relating to national security and human rights to the effects of government health program regulations on physician autonomy, create a different set of conflicts for physicians. In both areas, the conflicts are real and compelling and they create challenges to the integrity, autonomy, and legitimacy of the medical profession.

Medical research, particularly research in pharmaceuticals and medical devices, operates within the context of powerful market forces and is driven by profit motive. Government-sponsored medical research is influenced by lobbying and disparate political influences and agendas. Individual practitioners make clinical decisions in a world where the decision has direct and immediate impact not only on the patient but also on the physician's financial compensation. Responding to real or perceived threats to autonomy and power, medical professional organizations sometimes act more like trade guilds than as keepers of the flame of professionalism. All of these conflicts may contribute to a loss of focus of the profession on serving the best interests of the patient and society.

The practice of medicine requires that the physician be granted special privileges including the administration of powerful drugs or the practice of surgical procedures. Society grants those privileges but in return expects certain behaviors including confidentiality, respect for the patient's autonomy, and the expectation that the physician will act in the patient's interest and hold those interests above their own. The physician, as a professional, must successfully negotiate the competing forces of self-interest and social obligation, and social obligation (and specifically the obligation to honor the will and interests of the patient) must prevail.

Much of the failure of modern medicine to deliver better outcomes is due to fundamental flaws in the healthcare delivery system. In fact, it can certainly be argued that the problems in the delivery system are the central problem, and hence the ongoing focus in the United States on health care system reform is justified.

However, medicine as a profession should be providing insight, guidance, and leadership in developing and deploying solutions to the many obstacles to improved health outcomes both in the United States and abroad. It is in this context that medical professionalism becomes central and relevant. If the profession of medicine

exists as a profession, if it possesses specialized knowledge and has been granted special and extraordinary status and privileges, how is medicine as a profession responding to the real and present challenges to individual health and the health needs of society?

The State of Healthcare in the United States

From the perspective of skill, knowledge, and innovation, the record of the medical profession in the United States is generally quite good. Yet when the focus is health outcomes, the record is mixed. There are failures and missed opportunities alongside great accomplishments.

If viewed through a lens of availability of the most advanced technologies, specialists and care options for those with resources, the United States is the envy of the world. Without a doubt, the dramatic increases in life expectancy over the last century are attributable to medicine and public health improvements, many developed and refined in U.S. clinics and hospitals. According to the American Cancer Society, "between 1990/1991 and 2008 overall death rates decreased by about 23 % in men and 15 % in women. This translates to more than one million deaths from cancers that were avoided" (Simon 2012). Great strides have been made in HIV/AIDS treatment leading to increased survival. (Centers for Disease Control and Prevention 2011) Improvements in military medicine have dramatically improved battlefield injury survival (Gerhardt 2011). These are but a handful of examples of the success of modern medicine. From a historical perspective, the profession of medicine has much to be proud of.

Yet when viewed from a broad community or public health perspective, the performance of healthcare in the United States is not the best there is. In assessing the performance of the system as a whole, the quality of care and individual health outcomes are important, but so too are the fairness and equity of the system. A system that provides excellent care to only a fraction of society is deficient, and inequity in health care produces poor health outcomes.

As mentioned above, one of the most quoted rankings of the quality of nations' health care, the 2000 World Health Organization ranked the United States 37th (World Health Organization 2000). The report was a quantitative effort to rank 191 national healthcare systems by measuring, quantifying, and ranking critical objectives of medicine and health systems: improving health, reducing health disparities, protecting households from impoverishment due to medical expenses, and providing responsive services that respect the dignity of the patients. That report, and subsequent reports by the WHO, point out that in spite of spending more on health care per capita than any other country, the United States lags in performance measures including infant and adult mortality (Murray and Frenk 2010).

More recently, the Commonwealth Fund has published national scorecards on the performance of the health system in the United States. In the most recent edition (2011), the report found that from 2007 to 2009 the United States actually lost

ground in ensuring affordable access to health care. In 2010, 81 million adults (44 % of all working age adults) were uninsured or underinsured for some part of the year. Forty-four percent of nonelderly adults lacked a regular primary care physician. One-quarter of all children were not fully vaccinated against communicable disease. Despite recent improvements, the U.S. infant mortality rate as a whole is still 35 % higher than rates achieved in the best individual states and is twice as high as those achieved in certain industrialized countries. The United States ranks last out of 16 industrialized countries on a measure of mortality amenable to medical care (deaths that might have been prevented with timely and effective care), with premature death rates that are 68 % higher than in the best-performing countries. In 2008, only 43 % of U.S. adults with health problems were able to rapidly secure an appointment with a physician when they were sick—about half the rate of the best performing industrialized countries. Finally, while there were wide disparities in health care and quality geographically, minorities and low-income uninsured adults and children were more likely than whites or insured counterparts to wait to see a doctor when sick, to experience poorly coordinated care, and to have poorer outcomes (The Commonwealth Fund Commission on a High Performance Health System 2011).

National health outcomes, of course, reflect more than medical and public health efficacy. Social, economic, and political factors impact health outcomes in meaningful ways (Navarro 2001). But while responsibility for these failures extends beyond the profession of medicine—government in particular plays a meaningful role and bears responsibility as does the private health insurance industry—the lackluster performance of U.S. healthcare in significant areas including outcomes, accessibility, and equity does not bring credit to the profession of medicine.

When viewed through the lens of professionalism, the American medical profession has had success in the areas of technical competence, but has struggled in the area of self-regulation, civic engagement, and promotion of patient welfare and social justice.

Medicine and the Social Contract

There are many definitions of professionalism in general and medical professionalism in particular. Both the American Board of Internal Medicine (ABIM) and Royal College of Physicians and Surgeons of Canada (RCPSC) define medical professionalism within the frame of the "social contract" (Reid 2011).

In this model, "medicine functions within a social context" and "the practice of medicine is underwritten by trust" (Reid 2011, p 456). Lynette Reid has pointed out some limitations to this metaphor. A literal contract is explicit and legally enforceable and the obligations of each party have strict boundaries and explicit and clear remedies for violation. In the concept of the social contract of medicine, however, there was no formal or explicit negotiation of the parties (i.e., society and the profession).

In spite of its limitations, the concept has proven useful in providing a framework in which physicians, both as individual practitioners and as members of a profession can consider the balance of their privileges with their responsibilities and their accountability to their patients and society at large. In return for the privileges bestowed on the profession and the professional, society expects, among other things, "competence, care and trustworthiness" (Reid 2011, p 458).

The concept of the "social contract" was advanced by French, English, and Scottish Enlightenment thinkers but found fertile ground in the American republic as a useful framework for the new egalitarian social order (Wynia 2008). The theory provided an alternative to the traditions of conduct based on hierarchical social codes.

In 2001, the House of Delegates to the AMA adopted the Declaration of Professional Responsibility: Medicine's Social Contract with Humanity. The declaration recognized the profession's commitment to the welfare of society at large in addition to individual patients and declared "humanity is our patient." In addition to pledging as a "community of physicians" to respect human life and dignity, to apply medical knowledge when needed even in the face of risk to the physician, to protect patient confidentiality, and to educate fellow physicians and the public, the declaration also included commitments to civic engagement. The community of physicians, it declares, commits to advocate for "social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" (American Medical Association 2001).

Simply put, the idea of the social contract says that for the medical profession to remain relevant and valid, individuals and society must realize real and meaningful benefits to health attributable to the profession of medicine and the profession and individual professionals must not act against those interests. When they do, the trust on which the implied contract is founded is undermined. When the trust is undermined, the ability of the physician and the patient to enter into a therapeutic relationship is undermined. When that happens, the profession loses its legitimacy and its ability to advance the health of individuals and society.

Naturally, the world is not simple, and real and common scenarios can create complex and nuanced conflicts even within this framework (such as in the issue of quarantine where the physician and profession may act against the interests and autonomy of an individual patient in the service of society at large). Nevertheless, it is fair to say that in the present day practice of medicine, members of the public intuitively understand and assume the existence of a social contract. They are comfortable with physicians having status, generous compensation, and the power to practice their craft so long as the public, as a whole and as individuals, derive real and objective health benefits from the relationship. For the time being, the public appears to have faith that the medical profession will honor its obligations under the contract. But that was not always true, and it may not continue to be true without renewed commitment by the profession.

The Evolution of Medical Professionalism

The history of medical professionalism is actually quite recent. Although the roots of professionalism lie in the traditions of Hippocrates, in his day his code of ethics was a minority view (Wynia 2008). Similarly, the work of Dr. Thomas Percival (who authored the 1,803 book entitled *Medical Ethics*) inspired later efforts at the establishment of medicine as a profession, but they were never widely adopted in his time. In the mid-nineteenth century, responding to the lack of uniform standards in the medical field, the American Medical Association (AMA) produced a set of ethical and educational standards to define the profession. The 1847 AMA Code of Medical Ethics was the first national code of ethics for a profession (Wynia 2008).

As society has changed, so too has the concept of medical professionalism. So-called paternalistic traditions, where the doctor was presumed to "know best," have been replaced by relationships between practitioners and patients that balance the physician's knowledge, skill, and professional autonomy with the patient's right to informed consent for any treatment and individual autonomy.

Despite the ever-evolving code of professionalism, the codification of professional obligations and responsibilities, the profession has strived to make "uniform claims about the quality of its practitioners, which would be the basis of public trust and improved public health (and – not coincidentally – the foundation for the establishment of self-regulation and monopoly power)" (Wynia 2008).

Defining Medical Professionalism

Perhaps in response to erosions in the social contract, but in any event, in response to apparent drift and corruptions of professional conduct, there has been a renewed interest in medical professionalism. Public concern about the relationship between physicians and industry along with questionable business practices of some physicians has prodded the medical field to reflect on the meaning and relevance of professionalism.

There are many definitions for professionalism in general and medical professionalism in particular. However, many agree on some fundamental areas. First, a profession must add value to society by acting in the interest of society and its members. The profession must monitor and police itself to maintain ethical behavior and practice standards. A profession must have specialized and standardized knowledge and skills and the members of the professions must be competent in their field. Finally, a profession must have a code of conduct or ethical framework for its practitioners.

The Institute of Medicine as a Profession at Columbia University provides the following criteria for the medical profession:

- *Altruism and Commitment to Patients' Interests*. As changing market forces continue to confront the medical profession, physicians are increasingly challenged to maintain an unwavering commitment to their patients.

- *Physician Self-Regulation*. Group pressures not to report a colleague or indifference to the performance of others might lead doctors to ignore a colleague's ineptitude or malfeasance, compromising patients' health and safety.
- *Maintenance of Technical Competence*. The pace of innovation in medicine is unprecedented. Absent a commitment to life-long learning, the knowledge base of the best trained physician will soon be outmoded and fall short of best medical practice.
- *Civic Engagement*. Physicians should enlarge the scope of their concerns from the well-being of the individual patient to a concern for the welfare of all patients. They must make their voices heard by communicating their knowledge to the public (Institute for Medicine as a Profession).

In 2002, the American Board of Internal Medicine (ABIM) Foundation in collaboration with the American College of Physicians—American Society of Internal Medicine (ACP-ASIM) and the European Federation of Internal Medicine (EFIM) developed a Physician Charter. The charter described three fundamentals of the medical profession. These principles included:

- Primacy of patient welfare—a dedication to serve the interests of the patient. Trust is essential, and "market forces, societal pressures and administrative exigencies must not compromise this principle."
- Patient autonomy—physicians must be honest with their patients and empower them to make informed decisions about their treatment.
- Social Justice—the medical profession must promote justice in the health care system including the fair distribution of healthcare resources. Physicians should "work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion or other social category" (The ABIM Foundation et al. 2002)

The charter further delineated a set of professional responsibilities. These included commitments to competence, honesty with patients, patient confidentiality, appropriate relations with patients (no exploitation for sexual or financial advantage), improvement of quality care, improvement of access to care, just distribution of finite resources, scientific knowledge, management of conflicts of interest, self-regulation, and education. In 2011, the AAMC published a report delineating "core competencies" of practice that include many of the elements of professionalism including the requirements for ethical behavior, clinical competency, and service orientation.

Finally, the concept of professionalism includes the requirement for a code of ethics. Here again, ethical guidelines for physicians have had many articulations. However, all are based on some basic fundamentals, including:

1. Beneficence—the physician must act in the patient's interest.
2. Nonmaleficense—the physician must not act against the patient's interest (*primum no nocere*—first, do no harm).
3. Autonomy—the physician will respect the patient's right of autonomy in medical decision making.

4. Informed consent—the physician will provide full, accurate, and unbiased information in seeking the patient's consent for recommended treatment.
5. Dignity—the dignity of the patient will be respected.

Challenges to Professionalism: The Market and the State

There are two influences that challenge medical professionalism: the free market and the state or the government. In fact, it has been argued that medical professionalism arose in direct response to the incompatibility of those influences with a robust and socially worthy medical field (Relman 2007).

Market Influences

Arnold Relman has written that medical professionalism in the United States "is facing a crisis, just as serious as the crisis facing the healthcare system, and the two crises are interrelated" (Relman 2007). The fee-for-service model that serves as the model for most physician compensation provides a strong financial incentive to maximize elective service and attracts more and more young physicians into procedure-based subspecialties and away from primary care (Relman 2009). Through these financial incentives, subspecialty medicine looks more like a business than a profession. Professions distinguish themselves from other areas of the labor market by, among other things, placing greater value on doing useful and needed work than on economic rewards. Consequently, these strong economic incentives to order more expensive and elective care treatments to undermine professionalism (Friedson 2001).

Part of the problem with the built-in bias for procedures and visits in the fee for service compensation of physicians is the fact that reimbursement for physician services focuses and rewards activities that have poor correlation to health outcomes. Physicians are compensated for procedures and encounters but there is no adjustment for actual outcomes. Given that compensation models have a profound influence on professional behavior, the traditional fee for service model is overdue for revision. This need is now widely recognized and has been partially addressed with the expansion of the managed care model, but improved models for compensation are still early in their development and deployment and have focused more on primary care interventions than on reigning in subspecialty procedure-based compensation.

More broadly stated, "pressure on health care institutions to make medicine more of a business than a profession, more a commodity than a service" undermines respect and efficacy the medical profession (Pizzo 2001).

In recent times, perhaps the most glaring example of market influence on the profession is the role and influence of the pharmaceutical industry on physician

behavior. In addition to highly funded direct marketing efforts targeting physicians, the pharmaceutical industry has integrated itself into the fabric of both the peer-reviewed medical press by way of advertising support and has developed a prominent role in the arena of continued medical education of physicians in a manner that is primarily driven by commercial interests. Individual physicians, academic institutions, and peer-reviewed journals not only willingly accept financial support from the pharmaceutical industry but they often solicit such support (Relman 2001). In the process, the physicians and their institutions compromise their standing as autonomous and unbiased authorities of medical information. While many physicians strongly believe that they are not influenced by the pervasive hand of the pharmaceutical industry (Chimonas et al. 2007), the seven billion dollar a year physician-directed marketing effort by the industry evidence says otherwise.

The challenge of the influence of industry on the profession has been widely noted. Medical professional societies, including both the AMA and the AAMC have tackled the issues and produced recommendations to limit the influence of marketing efforts on medical education. Yet, both professional organizations stopped short of banning industry support of continuing medical education because no other funding source is currently available (Relman 2008). The central role of the pharmaceutical industry in supporting continuing education of physicians begs the question: who sets the agenda in medical education—academia or industry? Such questions can only undermine public confidence in the medical profession.

State Influences

In addition to pressures on professionalism derived from market forces, professionalism faces pressures and influences from the state or government as well. Despite the medical professions assertion of autonomy in medical decision-making, the government wields great power in determining therapeutic options by exercising its power as payer for health services. In addition, the power to grant or revoke a license rests not with the professional associations, but with the states. While state licensure boards often use the ethical guidelines of the professional organizations such as the AMA, the actual investigations and sanctions are determined autonomously by the state.

Government influence on medical practice may be seen in government-run health services such as the Veterans Administration where government exercises influence as the employer and policy maker with authority over clinicians. The most dramatic example of government power over physicians occurs in “chain of command” institutions such as prisons and the military.

When the Bush administration assigned doctors to support interrogation teams, a role that conflicts the physicians’ obligation to the patient, the administration attempted to justify the practice by saying that the monitoring role was not a clinical role, and therefore medical ethics did not apply. Then Deputy Assistant Secretary of Defense for Health Affairs, Dr. David Tornberg, argued that physicians assigned to

military intelligence have no doctor–patient relationship with detainees and therefore are not bound by medical ethics. A medical degree, he said, is not a sacramental vow—it is a certificate of skill (Bloche and Marks 2005).

In Tornberg's view, medicine becomes simply a trade or a collection of basic knowledge and skills. Note that subspecialists do act like technicians (Relman 2007) and businesses, so his confusion has some foundation. Still, as the AMA asserted when it issued its opinion banning physician participation in interrogations, whenever professional skills are applied, medical ethics apply (AMA Code of Medical Ethics).

The use of physicians to support forced feedings of hunger strikers at Guantanamo Bay and the participation of physicians in the design, development, deployment, and legal rationalization of the U.S. torture program underscore the threats to professionalism when physicians work in compelling security environments with chain of command structures.

But state or government influence on health professionals is not limited to chain of command settings. Government's role in health care financing and licensure ensures a powerful influence on the practice of medicine. Policy and reimbursement practices of Medicaid and Medicare have profound influence on physician behavior.

Even research priorities in medicine are greatly influenced by the government-run funding mechanisms (such as NIH and CDC). In 2007, the federal government funded 33 % of all biomedical research (industry funded 58 %) (Dorsey et al. 2010). As major funders of research, government wields tremendous power to set the agenda for areas of health research and consequently can influence the direction of health care and health care delivery. Physicians involved in research must operate within a world where government and industry dictate research priorities. Historically, new drugs, medical procedures, and technologies have been given priority, while research promoting equity in delivery, efficacy of delivery systems, and research to improve population health outcomes have been neglected, although this is beginning to change.

The substantial portion of the funding for medical education comes directly and indirectly from the federal government, particularly in the area of graduate medical education (GME). Medicare currently underwrites GME at a cost of $9.5 billion annually, making it the largest supporter of GME (Iglehart 2012). Again, the role of government in influencing the direction of medical education cannot be overstated.

Failure of Self-Regulation

One of the key elements of a profession is the ability to self-regulate. Here, the medical profession has a mixed record. In a 2011 survey, only 63.5 % of physicians surveyed ($n = 1{,}891$) agreed that significant medical errors should always be disclosed to the affected patient (Roland et al. 2011).

In the same survey, roughly the same number said they had reported a colleague who was impaired or incompetent in the practice of medicine. Physicians fail to report impaired colleagues. In addition to lapses in reporting and disclosure, physicians have a weak record of investigating and disciplining physicians when lapses are reported. In recent years, licensing bodies and professional societies have entirely failed to address violations of medical ethics of their members that have occurred in national security settings, an example of the influence of the state on professional autonomy.

Economics and Real and Enduring Change

While the renewed interest in medical professionalism by organized medicine and institutions of medical education is encouraging, simply teaching professionalism without addressing the firmly entrenched institutional structures that produce market and state stresses on professionalism would be pointless. A firm foundation in the principles of medical professionalism is a necessary starting point. But so long as market and state forces compete with ideals and good will, professionalism is in jeopardy. For this reason, medicine as a profession must work with government and the marketplace to reform excessive influences on medical autonomy and promote efficient and effective physician activities.

Despite the goals of population health, reducing disparities, and real health outcomes, the economics promote expensive subspecialty services and demote primary care. It is unrealistic to expect a real shift in the profession as a whole until this is corrected. This is not an issue of not enough money in the system, and in some ways, it might be a problem of too much in the wrong places. Arnold Relman has observed that the "…vast amount of money in the US medical care system and the manifold opportunities for physicians to earn high incomes have made it almost impossible for many to function as fiduciaries for patients" (Relman 2007). This is exacerbated by the fact that reimbursement rewards procedures and encounters but is not tied to successful outcomes, thereby creating perverse incentives. Moving forward, financial compensation must be redirected to support those functions and interventions that have demonstrated efficacy and efficiency in improving health care outcomes in an equitable way. At a minimum, reimbursements should use economic clout to promote primary care and public health services. Adjustments to reimbursements will need to be sufficient to counter the current incentives driving medical students into subspecialties and away from primary care.

In addition to reimbursement reforms to guide physician career choice away from subspecialties toward primary care, changes to reimbursement for physician services to reflect positive health outcomes over visits and procedures could positively influence the practice of medicine. Those activities that demonstrate the most efficient and greatest positive impact on individual and public health should receive meaningful support through reimbursement incentives, while more tenuous activities and treatments should be discouraged. Physician compensation needs to place less emphasis on activity or procedures and greater emphasis on outcomes.

Beyond reimbursement, there is the influence of health industries with key interest in influencing physician behavior. As has been discussed here, the most influential of these is the pharmaceutical industry. While pharmaceutical industry has a legitimate interest in marketing and promotion of its products, there is no reason that the industry should be the main source of funding for medical journals and continuing medical education—but in the current system, they are. Alternative sources of funding, whether from foundations or from public funding, would help to remove commercial bias from the dissemination of medical information. While increased government funding would only introduce a potential state bias, a hybrid system balancing public and private funding might be an improvement.

In governmental institutional settings, institutional commitment to the principles of medical autonomy and respect for medical codes of ethics are essential. Such commitments need to be enshrined in policy or even law, and there must be mechanisms for reporting conflicts and violations in a way that protects the medical professionals and their patients.

In addition, as modern medicine is evolved into a team model, compensation that rewards effective health teams and health delivery systems are likely to be more helpful than those that just focus on individual physician activity. For their part, physicians need to be able to demonstrate their efficacy in team-based health care delivery, and health reimbursement could be leveraged to promote team-based care.

Maintaining and Leveraging Professional Prestige

Despite the erosions to medical professionalism, public respect for the profession remains high. Physicians remain among the most respected professions, and following a period of relative decline, applications to medical school are again trending up (though they are still below the high water mark). Still there are warnings of some erosion in the public trust. While still highly respected, physicians have fallen behind nurses and pharmacists in terms of how the public perceives the honesty and ethics of their respective professions (Jones 2011). Roughly one in four individuals who are chronically ill feel their conditions are not well managed, and a similar number felt that their doctor or provider failed to provide all of the needed information about their treatment or medications. Nearly three-quarters of sick Americans want their doctor to spend time with them discussing other, broader health issues that might affect their long-term health (72 %), as opposed to just talking about their specific medical problem (21 %) (NPR et al. 2012).

We have argued that one of the key objective measures of the relevance and efficacy of a profession is the observable positive impact it has on the society that has granted it special status and privilege. While failures of the U.S. healthcare system are the primary cause of many failures of achievement in population health measures, the leadership—or abdication of leadership—of physicians in the debate about health care policy and practice is an important barometer of the profession's

relevance and integrity. To the extent that diminishing physician autonomy may be contributory to health system failures, physicians as a profession need to better demonstrate to the public and policy makers why physician leadership in health care remains essential and of value to society.

Recommendations

Promoting and preserving medical professionalism is essential not only to the integrity and sustainability of the profession but to the health of society at large. In the ideal, the medical profession's commitment to the well-being of the individual patient as well as the public health should be unassailable. In reality, this ideal will prove elusive. However, there are a number of ways that the profession and society can work to strengthen medical professionalism in a way that preserves and honors both the public trust and the best traditions of the profession.

In broad terms, in order to reinvigorate the relevance, effectiveness, and legitimacy to the profession of medicine, the following steps within the framework of professionalism must be undertaken:

1. *Altruism and commitment to the patient's interests*: Medical professionalism is intimately related to health outcomes. There is a pressing need for the profession to renew its commitment to altruism and patient well-being in a manner that measurably improves the health of both individual patients and society at large. These elements of professionalism are essential in order to counterbalance the profound influence of the marketplace and the state.
2. *Self-regulation*: In order for the profession to maintain its standing, there needs to be more meaningful accountability within the profession for unprofessional behavior deriving from market and state influences.
3. *Civic engagement*: The profession must actively participate in the public discourse regarding health policy in a manner that goes beyond simple trade guild level interest to a level of serving the public interest on health issues. Profession also needs to reassert its autonomy in government settings. Medicine as a profession must address health inequities and promote policies that successfully address social determinants of health.
4. *Technical competence*: Economic incentives and disincentives to support the framework of professionalism (including alternative sources of funding for CME). Change education to better reflect the values of professionals (basis of next paper):

    (a) Improve candidate selection and promotion, pedagogy.
    (b) Shift from simply individual care paradigm to a balanced approach that considers population-based health outcomes and health equity
    (c) Development of collaborative care models under physician leadership

In order for these goals to be achieved, comprehensive reforms are needed at all levels. Recruitment of medical school applicants must place greater emphasis on demonstrated altruism and ethical conduct. Medical education must incorporate elements of professionalism in a meaningful way such that they are taught, graded, and rewarded or sanctioned as appropriate. Practicing physicians need to be financially rewarded for conduct that produces positive health outcomes in individual patients and the public health. Professional licensure boards and professional societies must employ broader and more effective regulation strategies for professional behavior.

There is clearly work to do at multiple levels, and some goals are more easily achieved than others. Some, like recruitment and training of students, are well within the control of the profession, particularly the academic arm. Others, such as health care reimbursement reforms will require civic engagement on the part of the profession with industry and government.

As difficult as the tasks outlined in this paper are, much is at stake: first and foremost the health of the community and individual patients, and second, the legitimacy and integrity of the medical profession. If the profession can't deliver on the former, there is little justification for the latter.

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Part II
Framing the Problem of Professional Responsibility

Introduction

This part consists of three chapters devoted to interpreting the nature of professional responsibility and articulating how quality and equity of services in education and health care depend on the development of responsible professionalism among practitioners of social services supporting human improvement by transforming minds and enriching human capabilities. In Chap. 4, William Sullivan tackles the conceptualization of professional responsibility by addressing the question, "what is needed to develop and sustain the practice of professional responsibility… and the enduring purposes of the professions as institutions of public purpose?" In exploring this question he notes that "contemporary economic and political trends pose a serious threat to high quality professional work" in these occupations. Sullivan's analysis begins by endorsing the idea introduced by Mitchell and Ream in Chap. 1 of this volume that professional work arises in a "layered task structure" in which the requirements of diligent labor, skilled craft, and sensitive artistry are all subsumed as prerequisites to the special kind of moral and fiduciary responsibilities that characterize professional task performance. Responsibility, he notes, is a modern ethical idea that applies to all types of work. For professional tasks, however, the ethic of responsibility springs from the presumption that human improvement professionals have accepted a "social contract" to serve the interests of their clients. In this sense, professional ethical responsibility is intrinsic to the work itself – good work is ethical work because it supports individual flourishing and social well-being. Sullivan is concerned that this emphasis on the civic morality of professionalism has been eroded by a contemporary emphasis on the professional as a technical "expert" with responsibility for technical craft work but not for civic beneficence. He worries that the "social contract" binding professionals to their responsibilities, clients, and communities has become "frayed" and that this threatens to undermine humanization and democratization of modern societies. Organizational management and the marketization of professional services are real, of course, so Sullivan concerns himself with how to keep these contextual forces from destroying

the ability of professionals to accept and discharge their responsibilities for their clients and for larger social purposes. He turns attention to the ways in which misalignment between market forces, organizational management directives, and professional norms of practice undermines the willingness and capacity of professional workers to accept and discharge their responsibilities. To combat the degenerative organizational and market forces, Sullivan prescribes three kinds of "apprenticeship" training for professionals. Professionals need to be apprenticed to: (a) the core theoretical knowledge, (b) the applied practice, and (c) the professional culture, ethics, and fiduciary responsibilities of the occupation. Organizations can routinize technical practices, but in Sullivan's view professionals must be prepared to assert their ethical responsibilities and to champion organizational redesigns that make execution of these responsibilities possible. Citing work on the Chicago public schools, Sullivan argues for the centrality of "organic trust" in the creation of viable and flexible professional service institutions.

In Chap. 5, Kathleen Montgomery enriches the discussion of what it means to be professionally responsible by focusing on the ways in which professional work is institutionally embedded, not just in the complex social organizations that employ professional workers, but also in the institutional environments of stakeholders with substantial resources to influence professional work and important interests in how that work is performed. She begins by noting that professional responsibilities include not only the moral and ethical norms centrally addressed in Sullivan's work, but also involve substantial coercive forces arrayed to sanction workers who do not respond appropriately to stakeholder expectations. Montgomery calls attention to recent advances in what has come to be known as "institutional theory" – a theoretical framework whose central premise is that "the norms, beliefs, and rules" found in relevant social environments "play a key role in shaping behaviors" within complex social organizations. This leads directly to the proposition that professional autonomy and authority rest substantially on whether professional behaviors conform to environmental expectations and are perceived as legitimate by key stakeholders. This leads, in turn, to an interest in mapping the terrain of relevant stakeholder groups and beginning the process of analyzing their expectations and their capacity to morally or coercively challenge questionable professional behavior. Paradoxically, she notes, stakeholder power tends to increase the further one moves away from the center of the stakeholder map, making it possible for distant actors with less intimate knowledge of the professional–client relationship to have disproportionate influence. From this perspective, Montgomery explores some of the challenges facing professionals working in complex institutional settings. Among the challenges discussed are: (a) the nature of responsibility for vulnerable stakeholders, (b) the tension between requirements for confidentiality and pressures for transparency of actions, and (c) the role of professional schools in preparing these professionals.

In Chap. 6, Steven Brint launches a discussion of professional responsibility by reminding his readers that our traditional views of professionalism arose in a historical context characterized by independent, fee-for-service, contracts between individual professionals and their personal clients. Brint notes that the idea, derived from this historical set of relationships, that professionals have a moral

and fiduciary responsibility for the well-being of their clients and society has not only been "in tatters" for many years, but that it is not likely to be even rhetorically embraced by more technologically oriented salaried professions like accountants, engineers, and corporate lawyers. The big historical shift, Brint notes, is the eclipsing of personal, fee-for-service, contracting by the employment of most professionals in complex social organizations – efficiency-oriented organizations that establish contractual relationships with the clients and seek to manage professional workers to deliver the contractually specified services. Brint calls the earlier form of professionalism "social trustee professionalism" to ground the kind of professional responsibility which he sees in William Sullivan's work in the realm of social morals in the service of recognized social purposes. He contrasts this kind of professionalism with what he calls "expert professionalism" to highlight his conviction that the central moral responsibility of the professionals employed in modern social organizations is responsibility for "doing a good job" in executing their technical craft skills with care and diligence in the service of organizational objectives. He finds the notion of expert professionalism to be especially relevant in the contemporary era of a "knowledge economy." Knowledge is the coin of the realm in a knowledge economy, and being a technical expert in a knowledge domain is what entitles a worker to independence of action and to the status of professional. Moreover, Brint observes, in the large complex social organizations that now employ most of the professional class of workers, virtually all of the professional workers must defer at important moments to the professional expertise of ancillary workers in the same organizations and thus cannot single-handedly shoulder responsibility for client well-being. In the end, Brint emphasizes that professional responsibility exists within organizational settings, and therefore technical and managerial skill in service to organizational goals is just as much a professional responsibility as the broader social and fiduciary responsibility highlighted in discussions of social trustee professionalism. Brint also wants us to distinguish the "for what" aspect of professional responsibility from the "to whom" aspect so as to keep analysts aware that loss of *expert capacity* is just as morally suspect as loss of *social morality*.

Chapter 4
Professional Responsibility: Its Nature and New Demands

William M. Sullivan

In the introductory chapter to this volume, its editors Douglas Mitchell and Robert Ream have usefully defined professionalism as the enactment of professional responsibility, including not only competent practice but "behaviors that align with the social norms associated with the profession." Second, they have proposed comparison between medicine and teaching as a prism for inquiry into how professional responsibility functions in both case-structured fields focused on individual clients and in program-structured professions such as education in which common structures prevail. Third, they have given us the concept of a "layered task structure" as a way to focus on what is distinctive about work organized on professional basis.

In what follows, I want to build on these ideas. My focus, however, will be on the question of what is needed to develop and sustain the practice of professional responsibility. I want to call attention to the ways in which I believe contemporary economic and political trends pose a serious threat to high quality professional work in both medicine and teaching by undermining some of the institutional supports needed for such work. I will ask how professional education might respond to these developments, drawing on research in a number of fields of professional preparation. Finally, several contributors to this volume have put forward notions of an emerging convergence around a new model of professional practice, including Douglas Mitchell and Robert Ream but also Paul S. Adler, Charles Hecksher, and Saul A. Rubinstein with their notion of "collaborative community" in Chap. 18. In Chap. 6, Steven Brint has raised some important objections to the line of argument taken. In my last section, I want to respond to these perspectives by placing them within the context I have sketched. I will conclude with an illustration from the education sector of the crucial role that an explicit ethic of responsible professional participation places in making collaborative communities effective.

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The Ethical Meaning of Professional Work Considered as Layered Task Structure

The notion of a layered task structure is a valuable device for clarifying the discussion. In their introductory chapter, Douglas Mitchell and Robert Ream summarize the literature which distinguishes the specific features which make work professional, and therefore requiring the exercise of professional responsibility. Drawing upon Mitchell's work, they propose a fourfold division of kinds of performance among the activities typically called "work": labor, craft, artistic, and professional. At whatever level of performance, labor demands diligence. Craft work similarly requires diligent attention to task but adds the demand for the application of a high level of specialized skill. Artistic performance adds the component of aesthetic sensitivity, but these artistic capacities cannot be actualized without also employing the dispositions characteristic of diligent labor and craft skill. For its part, professional work has components of labor, craft, and artistic activity but adds the dimension of interpersonal, social, and fiduciary responsibility.

The virtue of this schema is that it makes explicit professionals' involvement in all four components of their work. It makes possible a more probing analysis of the conditions which support or undermine high performance in tasks such as teaching or medicine. All these components must work together, and be supported by the way in which professional work is institutionalized, in order for the members of professions to retain their integrity as parts of the social division of labor. This provides an analytical taxonomy which enabled the diverse papers presented at a 2012 University of California, Riverside conference on *Professional Responsibility for Diverse Societies* to speak to each other and to the problems surrounding the work of physicians and teachers in the context of calls for change and reform.

At the same time, the schema usefully highlights the social and ethical dimensions of professional work—as distinguished from its artistic, craft, and laboring dimensions—as the components that give a distinct, and socially important, quality to the diligent, skillful, and sensitive work of teachers and physicians. In this perspective it is features of the kind of work they do that demand of teachers and physicians, as well as other professionals, a high degree of responsibility. The very idea of responsibility implies that teachers and medical personnel are already embedded in a set of social relationships which make ethical demands of them.

Responsibility is an important, modern ethical idea. In the early twentieth century American pragmatist thinkers such as John Dewey, Josiah Royce, and George Herbert Mead pioneered development of a conception of the ethics of responsibility that built upon their developing theory of the social self (Dewey 1930; Mead 1943). A social view of the self such as the pragmatist thinkers advanced conceives personal development taking place primarily within patterned, that is institutionalized, social relationships. Examples include family and school settings, the workplace, and religious and community organizations. The relationships these institutional settings support and structure shape individual needs and impulses into socially recognized intentional dispositions. Since intention is always socially formed

through participation in common practices, it reaches its proper development in the stance of intelligent responsiveness on the part of the individuals to the expectations of their social relationships.

That is, individual meaning and purpose arise not simply out of activity, but out of relationship with human others who already embody in their lives the pattern of a meaningful life built up in community. This is the meaning of education. On this view, interdependence turns out to be basic to the human situation, even affecting the most intimate features of individual psychology. Character is therefore essentially a disposition to respond to the world in appropriate ways, determined by how the agent interprets the situations of life. That interpretation always develops through an ongoing "conversation" with those George Herbert Mead famously called significant others.

In Mead's view, the formation of personality and personal decisions has strongly conversational features. This allows for individual creativity and freedom without denying that individuals are at the same time deeply embedded in relations with others. A person acts within a stream of interaction. That person's own actions are thus always responses to the actions of others. Because those actions are interpreted by both self and others as meaningful, as parts of a significant pattern in which the agent is engaged, even self-initiated actions are shaped in anticipation of how others will respond.

It seemed obvious to the pragmatist thinkers that all parties to such interactions benefit in the long run from a willingness to cooperate on the basis of mutual respect. This observation provided them with a kind of basic rationale for an ethic of cooperation and mutual trust as the moral basis for democracy. However, whether this ethos can be sustained by any given group of individuals, or among groups, is heavily dependent upon the actual social "conversation" of which they have become part. So, if the experiential context of life rewards cooperation and trust, the individual will come to accept these attitudes as normal and rational responses to reality. If, on the other hand, experience validates a social context of distrust and threat, defensive self-interest will come to seem to such persons the obviously reasonable stance toward life. Such cycles of trust or distrust, rooted as they are in social relations and not just individual psyches, tend to develop powerful momentum, making the development of a social ethic of mutual trust and reciprocal aid, the key ingredient in a successful and just society, always a precarious project.

The ethical dimension of professional work is not separable, then, from the other components of such work. Professional ethics includes the dispositions or virtues necessary for high performance at laboring, developing craft skills, and artistic sensitivities. But the fiduciary aspect of professional work does add a distinct dimension, a particular kind of responsiveness to others to whom the professional has special commitments because of the nature of the work undertaken, tasks consciously carried out to enhance the well-being of the other.

Professional ethics thus falls within the subject matter of a "politics" in the classical sense of an inquiry into the just and worthy forms of the common life. An adequate conception of professional ethics must therefore move from the questions of individual meaning and responsibility to include consideration of social and

institutional contexts within which these arise. It must encompass the actual functioning of those contexts, seeking to make sense of the dynamics of these social situations so as to deliberate about how to respond to them in ways that are consistent with the profession's declared ethical purposes.

Professional Responsibility and the Frayed Professional "Social Contract"

There was considerable overlap between the ethical and social theorizing of early twentieth-century American pragmatism and the contemporaneous formulations of professionalism as an ideology of civic reform. Nor was this only a North American phenomenon. The early twentieth century saw not just the rise of medicine and other aspiring professional groups but also efforts of professionals to draw a contract with the public in which professional social responsibility played a featured role. It was the economic historian and theorist of the British Labor Party, R. H. Tawney, who went furthest in linking the moral ethos of professionalized occupations with a reorganization of work in society to serve social justice and communal solidarity.

Tawney urged a generalizing of the features of professionalism to other occupations in order to humanize and democratize the twentieth-century society of large-scale industry. Tawney defined a profession as "a trade which is organized, incompletely, no doubt, but genuinely, for the performance of function. an activity which embodies and expresses the idea of social purpose." Not abstract credentials, then, but demonstrated expertise and effective collective responsibility were his criteria for a profession. But these hung on the practical embodiment of recognized social purposes. Tawney acknowledged that the idea sounded strange but insisted that was because of the distorting effects of the era of laissez-faire capitalism, which had contracted the notions of social purpose and collective responsibility to a vestigial existence in only the enterprises of state and church (Tawney 1920, pp. 92 and 98).

Tawney argued that a more interdependent and complex society cannot do without the recognition of common purposes and the professional solidarities which derive from that recognition. "A wise system of administration," he wrote in implicit refutation of the disciples of the then-popular scientific management promoted by Frederick Taylor, "would recognize that professional solidarity can do much of its work for it more effectively than it can do for itself, because the spirit of his profession is part of the individual and not a force outside him." Indeed, continued Tawney, it is only by fully developing professionalism in all occupations that "what is mechanical and obstructive in bureaucracy can be averted" (p. 150). If Tawney's observation proved prescient for industrial bureaucracies, though largely unheeded, might it also provide useful insight for building flexible, service-intensive, and publicly responsive organizations to meet present needs for health care and education?

The subsequent eclipse of that earlier civically oriented notion of professionalism by a conception of the professional as simply a technical expert has threatened the previous notion of a fiduciary "social contract" between professional groups and the publics they professed to serve. The very success of the professions turned later twentieth-century professional leadership inward toward building their own organizations and prestige. As Steven Brint and others have described developments through the twentieth century, claims to professional expertise displaced community trusteeship as the coin of legitimacy for most professional groups. This long-term development pushed toward "the transformation of professionalism from an ideology linking community and authority into an ideology linking markets and skills" so that "the cultural connection of professionals to public life" grew weaker even as the strength and reach of professional organizations expanded (Brint and Levy 1999, p. 200).

An unintended result of that shift has been to diminish the importance of the professional voice in public debate (Brint 1994). Another consequence has been the increasing difficulty professional groups seem to have in persuading their publics of why the nature of their mission may require a different kind of work organization than is typical in much of contemporary American business. Devising a way beyond the present situation will require fields such as medicine and teaching to engage with its publics in new ways. Such a new start, indeed, would require a less exclusive reliance upon the technical model of the professional as expert in favor of a conception framed in part in moral terms. For example, a reformed model of the physician would fuse something of the old ideal of the professional as active trustee for the patient's and the community's health with a more cooperative relationship to allied health fields and the public at large. The new type of professional leadership must be able to persuade the medical field to assume new responsibilities for and with the public.

There have been recent movements within medicine toward what has been called a "new professionalism" embodying this spirit. Some of these have begun in academic medicine and medical education, where the focus has been on cultivating a physician identity over time that will be responsive to the concerns of more patient-focused and socially orienting kind of practice. Other movements have begun to address the large issue of corporate leadership in the field and its relationship to both practitioners and the public. In the United Kingdom, for example, a strong movement for a new professionalism has emerged within the National Health Service, spurred by serious malpractice scandals of the mid-1990s.

Subsequently, in the United States several foundations associated with internal medicine, the largest of the specialist bodies, issued a "Charter on Medical Professionalism" (2002). The British understanding of the "new professionalism," as described by Sir Donald Irvine, recent president of the General Medical Council, has three features. These concern: first, maintaining knowledge and skills needed for good patient care; second, fostering respect, communication, and patient-guided care, including the promotion of access to quality health care for all; third, accountability, both personally on the part of individual physicians and collectively through professional self-monitoring in cooperation with public regulation (Irvine 1999).

On the other hand, as students of the professions have shown, less noble ambition and self-interest have always played large roles in the rise of the professions conceived as "collective mobility projects." University training was sought not only because it was believed to improve standards of practice but because it boosted any aspiring field's aura of prestige through association with the ideal aims at knowledge and science espoused by the academy (Bledstein 1976; Larson 1977). The contexts as well as the content of the work of professions differ widely. As disastrous failures of professional judgment during recent years make clear, service to society according to a profession's best standards can be reliably expected only so long as the practices and institutional settings of work, as well as the aspirations of practitioners, align with the larger goals of aiding clients and benefiting society.

Authentic professional values are still vital, serving for many of the most respected members of their professional communities as sources of moral identity and motivation. But the misalignment between professional ideals and the concrete goals of actual settings of professional work, widespread in many fields today including prominent areas such as health care, business, and financial services, place these purposes under real threat (Gardner 2001). In order to revitalize a coherent professional identity, while acting responsibly under pressures to the contrary, it is essential to articulate a full, civic meaning of professionalism.

In today's fluid occupational context, professional morale depends heavily on how strongly professional purposes can be embedded in patterns of work that connect the professions to their larger public purposes. But this is not likely to be easy. The shifts over past decades away from the politically managed economies of the postwar era toward so-called neoliberal, market-based policies have put heavy pressure on the professional organization of work in all sectors. Within this context, the role of the emerging information technologies remains a point of debate. It is certainly no longer possible to take for granted alignment between the imperatives enforced by the current organization of work and the fiduciary purposes of professional work in either medicine or teaching.

The question about professional responsibility today is how to realign conditions of professional work so that they not only protect the interests of practitioners but also promote the enduring purposes of the professions as institutions of public purpose. A second question follows: How to develop and nurture, among both practitioners and aspirants, the skills and commitment to making this realignment effective? How, in other words, to align the preparation of professionals with the project of reforming professional work itself?

Realignment: Organizational and Market Pressures vs. Professional Responsibility

In a study of high performing and ethically exemplary professionals in a wide range of fields, psychologists Howard Gardner, Mihaly Csikszentmihalyi, and William Damon found recurrent structural problems that they described as a misalignment

between what they called the professional "domain," meaning the key purposes and ideas espoused by a body of practitioners, and their "field" of practice, including the demands of practice organization and the expectations of stakeholders. (p. 90)

In their 2001 book *Good Work*, Gardner et al. use genetics to illustrate a field that, at least at the time of their data collection, appeared well aligned. Although they note that the field's alignment was threatened by gathering "storm clouds":

> Genetics emerges at the turn of the millennium as a profession in remarkably good shape. Leaders and midlevel practitioners concur about the primary missions, the most important standards, and the principal personal goals and profiles of responsibilities. They look comfortably into their mirrors and are reassured by the identity they behold. To an extent that can only generate envy among professionals in less favorable environments, genetics appears to be a beautifully aligned enterprise: the aspirations of the practitioners, the values of the domain, the practices of the field, and the desires of the shareholders and stakeholders blend together harmoniously. (p. 128)

Gardner, Csikszentmihalyi, and Damon contrast genetics with news journalism, which they describe as a misaligned field. In their view, many factors, including an increased push for market share and larger profits, a perception that the public is not demanding serious news coverage, a technology-driven increase in the pace of journalistic work, and the degradation of newsroom culture through budget cuts and corporate rather than family ownership, have led many journalists to feel that forces of the field have "intruded on their domain's integrity, obstructing their capacity to pursue the mission of good reporting" (p. 27). The authors summarize their conclusion by noting that,

> A professional realm [the persons who actually practice a particular profession] is healthiest when the values of the culture are in line with those of the domain [the key ideas informing the profession and its ethical code], when the expectations of stakeholders match those of the field, and when domain and field are themselves in sync. When these conditions exist, individual practitioners are free to operate at their best, morale is high, and the professional realm flourishes. We term this *authentic* alignment. (p. 27)

News journalism is not alone in its misalignment of culture, domain, and field. Its state of weakening morale and direction is shared by other professions. As former executive director of the Accreditation Council for Graduate Medical Education, David Leach (2008), has pointed out,

> [T]he current context in which resident formation occurs does not make the task of fostering medical professionalism easy. Relentless pressures of time and economics, fragmentation of care and the relationships supporting care, increasing external regulation, exciting but disruptive new knowledge and technologies, and above all the broken systems of health care … characterize the external environmental context. (pp. 515–516)

A recent empirical study of undergraduate medical students' responses to ethically compromising situations sheds light on the specifics of this misalignment. In a Canadian study, fourth year medical students in clerkship were provided with a set of videos depicting situations that raised significant, though not necessarily extreme, challenges to the avowed values they had learned and professed as aspiring physicians.

It turned out that for most students, the most common response to these situations was to reason from motives quite different from their avowed values. For example, it turned out that the most important source of decision-making were concerns about the students' own standing, especially the way they might be viewed by supervisors (and the recommendations that might be received or denied) and their peers—rather than concern with patient well-being or the effects of their decisions on the outcomes of the cases (Ginsberg et al. 2003).

The un-avowed and sometimes even explicitly *dis*-avowed motives the students would reject in principle thus turned out to be the most effective determinants of their *actual* decision-making and subsequent reasoning. However, instead of simply condemning the students or recommending remediation that would inculcate the correct—that is, avowed—values, the authors propose that medical educators use their findings as an important learning device. The first big finding, after all, is that through confrontation with their own internal contradictions, the students had become significantly self-reflective about their own decision-making as aspiring professionals. They were becoming more aware and less naïve about not only themselves but also about the pressures operating in both their education and the settings of practice in which that education was taking place. What this makes possible, the study's authors conclude, is movement on the students' part toward a more "balanced professional stance," one that does not seek to eradicate or deny all self-concern but rather seeks to temper and direct it within the larger purposes of professional mission (p. 1021). We might want to add that this pedagogy of self-reflection needs to be extended beyond the goal of nurturing individual maturity of judgment to include leaning how and why to practice advocacy for institutional reform so as to better align self-concern with the needs of patients.

The Priority of Professional Responsibility in Effective Professional Education

This example points to the fact that educators who want to ensure ethical professional practice in their graduates have to prepare them not only for ethically supportive contexts, but also for contexts that undermine the profession's fundamental purposes and standards. Indeed, the biggest challenge for educators trying to prepare their students for high quality professional practice—work that embodies both deep expertise and sound ethical standards—arises from the fact that, in many professions today, graduates will be entering fields in which the contexts of work actually undermine the profession's fundamental purposes and its standards of quality and ethical practice.

Based on research on professional education that was conducted over the past decade at the Carnegie Foundation for the Advancement of Teaching in a number of professional fields, it seems clear that educators can do a great deal more to prepare students to work effectively and ethically in this broad sense, even in misaligned fields. If the status quo continues unchanged, however, professional schools will not

only fail to realize their positive potential but may even contribute to professional work that is compromised.

The first finding of these studies was the broadly comparative nature of professional education itself. All professional schools face the challenge of shaping their students' modes of thinking in ways that will enable them to become contributing members of their professional context and, ultimately, the larger society. Chartered for their public mission to train professionals, these schools institutionalize a culture which is built up through pedagogical practices plus academic activities such as scholarship and research. As organizations, they aim at a goal which is in a profound sense holistic. Their mission is to educate for professional judgment and performance. They are charged to enable students to learn how to integrate specialized knowledge with a specific matrix of skills and know-how, within the professional community's characteristic disposition toward clients and society.

Effective professional education means laying the foundations for a life-long process of mastering these complex tasks. Yet, the university, the site at which this process has to be organized and begun, is built around a curricular structure, as well as research and pedagogical traditions, which are specialized, independent, and often intentionally competitive with each other. While this competition drives research forward, its educational effects are less uniformly positive. The challenge of professional education is to square this circle by bringing the disparate pieces of the student's educational experience into coherent alignment. This alignment involves apprenticeship of three distinct types, each based on different facets of professional expertise, and guided by a variety of distinct pedagogical intentions (Sullivan 2005, pp. 207–210).

The first "apprenticeship" could be called an *apprenticeship to the theoretical knowledge base* of the profession. Of the three, it is most at home in the university context since it embodies that institution's great investment in quality of analytical reasoning, argument, and research. In professional schools, the intellectual training is focused upon the academic knowledge base of the domain, including the habits of mind which the faculty judge most important to the profession. The students' second apprenticeship is *apprenticeship to applied practice* of the occupation. Students encounter this skills-based kind of learning through quite different pedagogies, and often from different faculty members, than those through which they are introduced to the knowledge base apprenticeship. In this second apprenticeship, students learn to take part in guided, imagined, or simulated, practice situations, as in case studies, or actual "clinical" experience with real clients.

The third apprenticeship—*apprenticeship to the professional culture, ethical, and fiduciary responsibilities* of the occupation—is taught through dramatic pedagogies of participation. In some fields, such efforts are primarily didactic, while in others more participatory. The essential goal, however, is to teach the skills and traits, along with the ethical standards, social roles, and responsibilities which mark the authentic professional. Through learning about these, and beginning to practice them, the novice is introduced to the meaning of an integrated practice of all dimensions of the profession, grounded in the profession's fundamental purposes.

If professional education is to introduce students to the full range of professional demands, it has to initiate learners into all three apprenticeships. But it is the third apprenticeship through which the student's professional self can be most broadly explored and developed in the context of understanding the practices, institutions, and history of the field.

These three types of apprenticeship are metaphors or analytical lenses through which to see more clearly how the business of professional training gets carried out in different fields and schools. They represent more than three elements in the curriculum served by different kinds of pedagogy. These dimensions of apprenticeship also reflect contending emphases within all professional education, a conflict of values which has deep roots in the history and organization of professional training in the university. To see this more clearly, consider today's education for the law. That is, imagine how law school is experienced by aspirants to that profession. Law schools have long been an object of study and criticism. Approaching legal education as a threefold apprenticeship, however, reveals ambiguities in the current organization of legal education. At times it enlists the three kinds of apprenticeship in support of the larger goal of training competent and committed practitioners, while in other ways the current system undermines that aim by failing to do justice to the full range of apprenticeship.

In the end, students apprentice to a variety of teachers but they also apprentice to the aggregate educative effects of attending a particular professional school and program. That is, they are formed in part by the formal curriculum but also by the informal or "hidden" curriculum of taken-for-granted practices of interaction among faculty and students and student life itself. The profound, and sometimes self-undermining implications of this has been explored in medicine more than elsewhere, though the problem seems endemic to the academic institutionalization of professional training (Hafferty and Franks 1994).

Much of this socialization is tacit and operates below the level of clear awareness but abundant studies have confirmed its great importance in the third apprenticeship students' experience: the process of learning what it is to be a professional. Many schools and many faculty will say that all their forms of teaching and learning are oriented toward the single end of preparing practitioners to enter on the work of the profession. However, a look at an actual case of professional education, such as law school, reveals that the relation between the academic life and the demands of practice is often not nearly as straightforward and logical in reality as it is imagined to be in the minds of faculty. This is especially true in the area of the third or professional apprenticeship.

How, Then, Might Professional Education Help?

The research literature is clear that the key to resilience in the face of difficulty and obstacle is the cultivation of larger purpose (Damon 2008). The formation of purpose is precisely the key aim of the third apprenticeship of professional education.

But given these endemic weaknesses, one might say misalignments, between the structure of professional schools and needs of professional formation, is it reasonable to hope that professional education can make a positive contribution to strengthening professional responsibility today? In several ways, it clearly can. First, professional education can enable students to see the mission or purpose of the profession as the foundation of their work's significance, the source of its intrinsic value, and the ultimate rationale for its standards. Second, professional education can help students understand the ways in which the field's standards are intrinsic to high quality work. Third, educators can intentionally aim to provide experiences that enable their students to experience some of the intrinsic motivations of their fields, the pleasure, excitement, even enchantment in connection with their work.

Of course, daily practice of any profession consistently evokes these emotions. The point here, however, is that through inspiring models, respected colleagues, *esprit de corps*, and various reminders of the work's purposes, it is possible to maintain connection with these intrinsic satisfactions even when the conditions of work—or academic preparation—make them feel distant from daily life. All these aims fall within the third apprenticeship of professional preparation. Their importance in developing strong professionals illustrates both the foundational quality of that apprenticeship and also its integrative character, the ways that it serves as organizer, inspiration, and benchmark for the other two.

In order to have a good chance of sustaining growth in professionalism across the arc of professional development, professional education needs to be aligned with other institutions, such as accrediting and licensing bodies, professional associations, and national academies. To start the process, however, professional education needs to provide a strong and effective third apprenticeship. That means two things: giving importance to the third apprenticeship in actions as well as words, and weaving the third apprenticeship together with the other two.

One of the most important formative opportunities available to professional schools is the chance to immerse students for a period of several years in a living tradition of standards and practices. To achieve this goal, the field's standards must not only be addressed directly through exposure to codes of ethics and the like, but the standards must also be pervasive in both the classroom, clinics and field placements, and the broader culture of the institution. Students are inevitably undergoing socialization into the profession throughout the years of their education, for better or worse. In order to ensure that these experiences will support high-quality, ethically grounded work, professional schools need to look critically and systematically at the many experiences that contribute to students' moral learning and at the values these experiences convey.

Unfortunately, on the basis of the Carnegie studies, it is clear that this kind of intentionality with regard to campus culture as a formative mechanism is still comparatively rare in most professional schools.

The Promise—and the Challenge—of Flexible Structures

A major challenge to this project of reshaping professionalism for a new organizational age, as Steven Brint has forcefully argued in Chap. 6, "Professional Responsibility in Complex Organizations," is posed by the growing complexity and differentiation of modern institutional development. And, as Brint has pointed out, the emphasis in professional work is typically on the "technical core" of that work, though this is more specifically focused on mathematically programmed procedures and quantitative outcomes in business and technological fields than in human service professionals in fields such as education, medicine, and the public sector. In previous work, Brint has usefully shown that while sharing a commitment to meritocratic values, professionals in the private sector typically diverge significantly in social and political values from those in the public, human services areas such as the fields represented in this volume (Brint 1994). This limits the immediate appeal of ideals of service to society outside the human service professions.

As the scale of social organization in both private and public sectors has grown over the past century, mounting public expectations and demands for accountability have produced regulatory intervention. Brint points out that this in turn has spurred the development of forms of organizational specialization, such as offices to monitor compliance with various imperatives. Examples abound in universities, schools, and hospitals. Brint argues that these organizational innovations mark a necessary evolution in the translation of social responsibility from the level of the individual professional to the operation of the system in which the professional is a participant.

There is, then, an important parallelism between the way in which rule-governed organizations are able to routinize craft knowledge and skill through incorporating them into standard operating procedures and what Brint calls a "partial outsourcing of conscience." We might say that one aim of modern formal organizations has been to routinize responsibility along with craft and judgment. On the other hand, theorists of professions have noted the differences between the craft orientation of much professional work and the rule-governed nature of formal organizations, on the one hand, and market incentives, on the other (Freidson 2001). Management of organizations that employ professionals who must exercise considerable discretion in the application of their knowledge and skills, such as schools and health maintenance organizations, is therefore particularly complex and difficult to fully routinize.

These considerations suggest that there are probably limits to the extent to which it may be possible to "outsource" professional judgment so as to render redundant the training and nurture of socially responsive expertise. The possibility and even the desirability of a full implementation of the bureaucratic model has remained a major point of disagreement across modern societies throughout the period in which the professions have developed and proliferated. For a century, a variety of thinkers ranging from John Dewey and George Herbert Mead among the American pragmatists to Max Weber and Georg Lukacs in Europe have worried both about the viability of rationalizing projects to encode moral responsibility into procedures as well

as about the dehumanizing potentials of alienation and the Iron Cage. For the present discussion two other reasons might be adduced to question whether the routinization of responsibility into organizational procedure, valuable and even necessary as it is in complex organizations, can be enough.

In common with many institutional sectors of contemporary society, primary and secondary education have been the scene of struggles over organizational re-design that proponents see as making for greater collective responsibility than an emphasis upon the professional commitment of teachers. Reengineering schools around testing and accountability systems of the kind the No Child Left Behind law mandated have strengthened bureaucratic, top-down hierarchical structures in the educational workplace while undercutting older forms of organizational loyalty. At the same time, efforts to undo unionization among teachers are often coupled with the introduction of more market-responsive forms of organization, such as the drive for "flexible" and contingent patterns of teacher employment and school staffing. These programs to re-align organizational structures in the educational sector have given rise to intense controversy, with critics such as Diane Ravitch charging that the systems, by undermining professional autonomy, weaken the schools' ability to discharge a collective responsibility to society (Ravitch 2013). Proponents of the reforms argue forcefully to the contrary (Lee 2013).

A second reason to think that the cultivation of responsibility needs to be considered integral to professional competence stems from different developments. In some modern work settings alternative forms of organization have developed which co-exist with both bureaucratic and market-like structures. These are workplaces whose functioning depends upon the cultivation of strong norms of communal commitment and trust within the work team. Some school organizations embody these features, as the following section of the chapter will show. In the present volume, these developments are emphasized in Chap. 18 by Paul Adler, Charles Hecksher, and Saul Rubinstein. Adler and his co-authors highlight the increasing importance of what they call, in contrast to the formally structured organization, forms of "collaborative community." These new forms of work especially involve professional and, more generally, so-called knowledge workers. Their emergence seems clearly another aspect of the great technological and economic changes of recent decades.

As more production, service, and administrative functions become routinized, literally turned into algorithms by "smart systems," the emphasis in managerial as well as professional roles has been shifting toward something recognizable as practical, that is, requiring a considerable degree of discretionary rather than purely technical judgment. In such forms of management and professional work it is difficult to disaggregate moral norms of responsibility from technical rules of efficiency and effectiveness. This kind of organization is today often found within larger, bureaucratic organizations but in spaces that are conspicuous for sparse formal hierarchy. They also lack the older moral relations of loyalty and security between subordinates and leaders, and workers and organizations. Compared to earlier organizational forms, then, the new work organizations depend upon

interdependent relationships rather than superior-subordinate forms of dependency. In contrast to earlier (and present) forms of professional practice, less importance is placed on individual autonomy and responsibility and more on that of teams and intimate-scale working groups.

In this new context, moral complexity expands. Project teams and flexible networks place new demands on workers not just for productivity but for commitment, trustworthiness, and the ability to think for the good of the team and the project, even as they must also reckon with their fellow team members as potential competitors. Under these conditions, it can be argued that technical problem-solving becomes less separable from the other dimensions of professional work since the organization's effectiveness relies on collaborative learning in which mutual trust and a commitment to the collective purpose become more important than in more traditional, role-structured organizations. Whether and to what degree this new orientation can extend to responsibility for the public impact of the work that a collaborative community makes possible remains an open question. It is not clear, in other words, whether this form of collaborative work organization can, as a result of its inherent logic, generate an understanding of the public, as well as privately appropriated, value created by the organization.

Given this ambiguity, it remains an important question whether new forms of public—regarding responsibility will become well institutionalized in the work practices of such organizations (Hecksher and Adler 2006). Such practices, I would argue, implicitly link the development individual expertise with a sense of participating in a collective process. That is, they already embody the nucleus of a collective sense of participating in a social enterprise of larger value. The moral understanding of trust and shared contribution implicit in such a view is rarely abstract and does not represent the "application" of moral principles to specific cases. Rather, it is embedded in practices which conjoin technical processes and collective learning within practices that provide the individual participants with a sense that they are recognized as significant for both what they can do and for the consequences of their work.

But if such collaborative communities are to influence and perhaps determine the future of knowledge work, their form and operative practices will have to become explicit aspects of the training as well as the operating rules of such work. And this means giving explicit concern to the fiduciary dimensions of professional work as an integral aspect of the expertise properly called professional.

The Challenge of Responsibility in Collaborative Communities: An Illustration

In their study of efforts at school improvement in Chicago during the 1990s, Anthony Bryk and Barbara Schneider identified what they called "organic trust" as a "core," perhaps *the* core resource for improvement. They contrasted this kind of trust with the sort of "instrumental" trust typical of short-term transactional

relationships such as those between buyers and sellers in a market. By contrast, organic trust is essential for effective education because, as they wrote,

> [T]he social relations of schooling are not just a mechanism of production but are a valued outcome in their own right. [These relations] shape participants' lives; they provide opportunities for self-identification and affiliation around an enterprise of much social value (Bryk and Schneider 2002, p. 19).

The authors could have been describing a professional enterprise of any type, but it is significant that they emphasized the communal nature of effective school organization. Because, they argue,

> "[T]he aims of schooling are multiple and interrelated, the social dynamics of such workplaces are much more important, from a productivity perspective than well-defined and routinized production." The basis for such cooperation in pursuit of shared, valued ends depends, then, on successfully institutionalizing particular kinds of social relationships. These are based on specific role relationships which are governed by conscious reciprocity, in which long-term partnership and shared responsibility are built up over time. (pp. 20–22)

Achieving this kind of workplace organization, in turn, depends upon "interpersonal discernment," local leadership that is sensitive to these aims and able to manage complex relationships among staff, pupils, parents, and the larger community. It also requires similar qualities of the staff, including the moral virtues of regard for others and keeping one's own promises. And it also required a larger system organized precisely to facilitate and reward the cultivation of this kind of workplace culture. The authors present such school workplaces, organized as "intentional communities" on the basis of strong organic trust among the participants, as models of high educational performance and as alternative strategies to both bureaucratic and market-based systems of control.

The great challenge that such examples present is twofold. First, how can they be sustained, given their complex and fragile nature—as all moral communities require constant care and renewal? Second, how might it be possible to develop and attract enough participants to enable the model to be extended on a large scale? The schools profiled in the Chicago study provide vivid "existence proofs" of the power and value of the "third logic" of the communal form of professional organization in the face of bureaucracy and markets in the world of education. Analogies exist in other fields as well. The question continues to be whether the chief obstacle to their triumph as pace setters of social reform lies in some intrinsic limitations of communal organization of professional work itself or rather within the politics and economics of our time.

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Chapter 5
How Institutional Contexts Shape Professional Responsibility

Kathleen Montgomery

In this book, scholars explore various approaches to understanding and implementing professional responsibility. In particular, several chapters explore the impact on professional responsibility of various professional development activities such as recruiting, training, inducting, and incentivizing professionals. My goal in this chapter is to delve more deeply into conceptualizations of professional responsibility from an institutional perspective that takes into account the relationships of professionals to salient stakeholders in their environment. This perspective also helps to clarify the types of pressures that stakeholders place on professionals, with a particular focus on those in the medical and educational fields.

Definitions of Professional Responsibility

To begin, it is important to recognize differences in how 'professional responsibility' is defined and interpreted. Multiple definitions have been proposed, including in this volume, demonstrating the complexity of the concept. For the purposes of this chapter, I offer two generic definitions, to illustrate the nature of institutional pressures confronting professionals. Using institutional theory terms, we can think of these as *normative* and *coercive*.

The normative approach: Professional responsibility is a moral obligation to behave correctly in accordance with normative expectations.

The coercive approach: Professional responsibility is a duty or obligation that is legally required as part of a role.

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Both types of responsibility carry negative sanctions for noncompliance. The normative approach draws from the normative expectations of a relevant community (which could range from a local community or broader society, as well as a professional community of peers). Violations of behavioral expectations can take the form of loss of face, respect, and esteem; loss of relationships; and loss of the ability to be part of the social life of the relevant community. Noncompliance with legal requirements as part of a role carries the force of law and has a coercive element, up to and including loss of licensure and the legal ability to practice the profession.

Avoiding negative sanctions for noncompliance with normative or coercive expectations may be a motivator for professionals to behave responsibly. However, an institutional theory perspective demonstrates that the benefits of conformity with expectations can be more far reaching than merely avoiding punitive sanctions. Yet, institutional theory also highlights the challenges in complying with expectations when they arise from multiple sources who may hold incompatible ideas about how professionals should behave. In what follows, I explore these complicated challenges in more depth.

Institutional Theory Principles

Over the past 30 years, scholars have increasingly drawn on institutional theory as a revealing lens for the study of social behavior, because of its potential to explain why individuals, organizations, and professions act as they do, even when the behavior may not appear to be the most technically rational or efficient course of action (Scott 2008; Tolbert and Zucker 1996).

A central premise in institutional theory is that the norms, beliefs, and rules in the relevant environment play a key role in shaping behaviors. The relevant environment, also referred to as the terrain or *field*, has been conceptualized as the community of actors (e.g., individuals, groups, and organizations) that partake of a *common meaning system* and whose participants interact more frequently and fatefully with one another than with actors outside the field (Scott et al. 2000, 13). A field's common meaning system is also referred to as its *institutional logic*, which provides the organizing principles and practice guidelines for field participants (Friedland and Alford 1991). This observation might suggest that uniformity exists within each field with respect to a field's common meaning system (Scott 2008). However, the institutional logic is both created [produced] and enacted [reproduced] by the actors themselves, who may bring different interests to a field and who thus may not agree on which norms and principles deserve priority.

To deal with the potential for competing interests within a field, actors in the environment draw on resources—typically resources reflecting their legitimacy and power—in order to navigate across the field and to engage effectively in their preferred behaviors. In particular, the concept of *legitimacy* underpins much of the dynamic of institutional theory. Definitions of legitimacy abound in the literature. Suchman's (1995, 574) definition is well suited to our purposes: legitimacy is a generalized perception or assumption that the actions of an entity [in this case, a

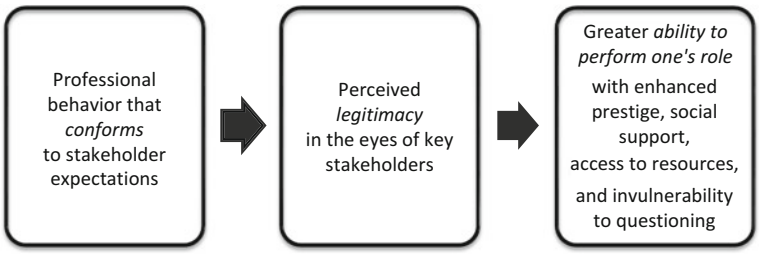

Fig. 5.1 The process and outcomes of legitimacy

profession and its members] are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and rules—that is, a field's institutional logic. As noted, the meaning system is socially constructed, rather than existing as objective truths or beliefs that are the same always and everywhere. Thus, the logic is developed and enforced by the community of actors in the field, with some actors having greater normative or coercive enforcement power than others.

As depicted in Fig. 5.1, the process of professional legitimacy begins when professional activities *conform* to expectations for, and requirements of, appropriate behavior (i.e., the norms and rules) that are held and enforced by important stakeholders in the relevant environment, including professional bodies and educational institutions. Such conformity generates perceptions of *legitimacy* in the eyes of key stakeholders, which in turn leads to tangible and intangible forms of *social support* for the profession, including access to resources, enhanced prestige, and invulnerability to questioning. Ultimately, these forms of social support serve as the basis for the profession's ability to perform, succeed, and survive.

For example, school superintendents and principals expect teachers to follow curricular guidelines and assure that students excel on standardized tests; when teachers conform to these expectations, they may be rewarded with teaching bonuses and opportunities for additional training; when teachers don't conform to these expectations, they may be subject to closer monitoring and denied requests for more favorable teaching assignments. In the medical field, hospital and physician leaders expect doctors to maintain low levels of readmission for complications following surgery; when surgeons conform to these expectations, they may be rewarded by referrals from colleagues for complicated cases and nominations for professional recognition; when surgeons don't conform to these expectations, they may lose hospital admitting privileges and be at risk of malpractice charges from dissatisfied patients.

Analyzing Stakeholders and Their Relationship to Professionals

Stakeholders constitute the essential actors in the profession's environment, whose perceptions of legitimacy are important because they have a *stake*—a potential or actual moral or legal interest—in how the profession operates. A stakeholder is

defined as any entity that *can affect* or *is affected by* achievement of the profession's objectives and/or who *may attempt to influence* the direction of the profession's activities so that they are consistent with the stakeholder's interests (Freeman 1984, 46).

The nature of a profession's relationship with its many stakeholders can vary substantially, which in turn affects the ability of a stakeholder to influence activities of others in the environment and the ability of the professional to behave responsibly. Several relational dimensions are noteworthy: the *closeness of the relationship* between the profession and the stakeholder, the *stability of that relationship* over time, and the r*elative power* between the stakeholders and the profession. Other dimensions characterizing stakeholders are the *legitimacy* and *urgency* of their demands on the professional.

In this section, I discuss two approaches to analyzing stakeholder relationships that have been employed in the literature. The first approach uses the lens of a stakeholder map (following Leahey and Montgomery 2011), which begins by focusing on the core work of the professional in order to identify key stakeholders, and assesses the closeness of the relationship (from a micro-level one-to-one relationship to a macro-level group-to-group relationship) between the professional and stakeholders in the relevant environment.

The second approach (introduced by Mitchell et al. 1997) builds on the first, but rather than examining the closeness of relationship, shifts the perspective to stakeholder saliency, by assessing the dimensions of a stakeholder's power, legitimacy, and urgency. Together, these two approaches can equip professionals with a deeper understanding of their organizational field and the sources of expectations, influences, and pressures they are likely to confront.

Mapping the Closeness of Stakeholder–Professional Relationships

Stakeholder maps can be developed based on different sets of variables, although a common method, and that used here, is to map the stakeholders according to the closeness of their relationship to a central entity—in this case, the education and medical professional. These relationships are shown in Fig. 5.2 and discussed next.

(a) *Personal Relationships.* The innermost circle represents the most central, micro-level relationship of a professional with an individual stakeholder: the teacher–student relationship and the physician–patient relationship. It is noteworthy that, while these micro-level relationships routinely take place within an organizational setting—the school and the hospital or medical clinic—they nevertheless occur in a way that transcends the organization by virtue of the personal interactions that typically are not observable to other organizational members.

This relationship is at the heart of what a medical or teaching professional does: "I provide medical care to you" or "I teach you." This relationship is

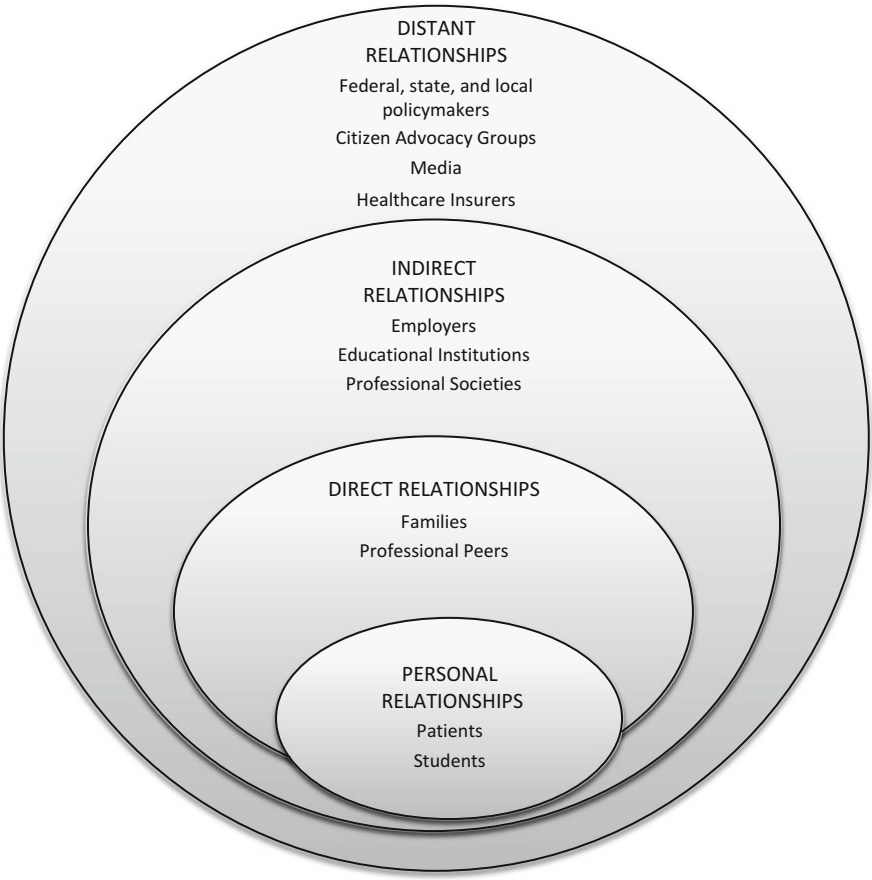

Fig. 5.2 System of stakeholder relationships in a professional environment

characterized by one-on-one, face-to-face interactions and is one where the greatest professional autonomy is exercised and where the greatest expectation for professional responsibility rests. This is because these relationships typically reflect substantially unequal power dynamics between the professional and the individual stakeholder who is dependent on the professional for services. At the same time, these interactions are commonly not observed by other stakeholders and thus demand the highest level of moral professional responsibility and trustworthiness[1] from the professional toward the individual student or patient.

[1] As elaborated by Hardin (1996), one's *trustworthiness* is demonstrated by engaging in behavior that reflects competence, benevolence, and integrity (i.e., honesty, fairness, and follow-through). The result is *trust*, defined as the willingness of an individual to be vulnerable to the actions of another, on a matter of importance to the individual, based on expectations that the other will not take advantage of the individual, even when the behavior cannot be monitored or controlled.

When professionals comply with expected norms of responsibility, perceptions of professional legitimacy will be strong, and the predicted outcome will be a higher degree of cooperation from stakeholders at this level (e.g., greater student effort in the classroom and greater patient adherence to recommended treatment regimes).

This personal relationship can be highly intense, although its duration can be variable. Some teacher–student relationships end when the school term ends; others may develop into a mentor–mentee relationship of long standing. Similarly, a physician–patient relationship may be intense during a period of treatment for acute illness, then diminish or end when the patient recovers. For others, particularly for patients with chronic conditions, the relationship may continue for the rest of the patient's life. When such relationships extend beyond the immediate period of interaction, the power dynamics may also adjust, with the student/patient moving from a vulnerable, dependent position to one of interdependency with the professional. In such circumstances, the stakeholder's expectations of professional behavior and responsibility may also adjust accordingly.

(b) *Direct Relationships.* The second ring contains stakeholders who may have a direct relationship with the medical or educational professional—e.g., families and professional peers—but who are not the actual recipients of the professional services. This remains a micro-level individual-to-individual relationship, and its duration typically parallels that between the individual service recipient and the professional. Stakeholders in this ring may act as surrogates for those in the center, interacting directly with the professional on behalf of the student or patient, in circumstances when a student or patient may not be able to articulate their expectations of professional responsibility, from either a moral or legal perspective. That is, students and patients may not always know what behavioral norms they should expect from the professional and may not know what is legally required. Family members of young students or disabled persons commonly play a large role as direct/surrogate stakeholders on behalf of a profession's especially vulnerable personal stakeholders.

Among the benefits to professionals for compliance with expectations from these stakeholders can be invulnerability to questioning; for example, a parent may be less likely to challenge the professional's behavior if it conforms with the parent's expectations about appropriate student-teaching or patient–doctor relationships. Professional peers also are less likely to question a colleague if the colleague's behavior appears consistent with expected norms of responsibility. At the same time, these direct stakeholders may provide some oversight of professional behavior, but may not always be able to enforce their expectations because they are not privy to all the interactions between the student/patient and the professional. Again, a profession's obligation to exhibit utmost adherence to professional responsibility when engaging with their most vulnerable stakeholders cannot be overstated.

(c) *Indirect Relationships.* This ring incorporates a broader set of stakeholders, most of which are groups and organizations, rather than individuals. It is at this

location that rules and guidelines become important, alongside moral norms that characterize the expectations in the first two positions. For example, this ring includes professional societies, whose members formulate guidelines for their professional peers, which typically are voluntarily imposed on members, with the (rarely imposed) sanction for noncompliance of expulsion from the society. Employers constitute another key stakeholder group, which can establish and enforce their own policies regarding responsible behavior for their professional employees. Similarly, educational institutions and universities can establish guidelines and rules of behavior for those studying to be professionals.

In each of these settings, sanctions for noncompliance can take the form of escalating disciplinary actions, with the ultimate sanction of dismissal from the organization or institution. The benefits for conformity are those associated with perceptions of legitimacy. That is, conformity with expectations of professional responsibility can yield access to additional resources and opportunities (such as promotions, bonuses, and raises), enhanced esteem (such as praise, awards, and recognition), and invulnerability to questioning (such as absence of monitoring).

The duration of indirect relationships typically lasts for the length of time that the professional is associated with the organization or institution. In the case of professional societies, the relationship may extend throughout the professional member's career; while for employing organizations, the relationship will no longer be relevant when the professional is no longer employed by the organization; and for universities, the relationship may end following completion of the degree. Alumni associations may continue the relationship, albeit with little ability to influence the behavior of the professional in a meaningful way.

(d) *Distant Relationships.* Stakeholders in this outer ring, farthest from the center of micro-level relationships, are agencies and other bodies that exert influence through macro-level connections to the collective profession. Most importantly, it is at this level that local, state, and federal policymakers affect professional behavior by means of laws and regulations with respect to licensing and rules of practice. Sanctions for noncompliance can be strict and include loss of licensure and the legal authority to practice one's profession. Because of the potential for coercive sanctions throughout one's career, the relationship of the professional to the licensing bodies is career-long.

Also at this level are actors reflecting market forces, especially in the healthcare field in the United States, such as health insurance companies, firms involved in pharmaceutical and medical technology development and sales, and competitors. In the education field, textbook publishers would represent this type of stakeholder. Often the interests of these actors are not well aligned with those of professions and the people they care for, yet their ability to influence professional behavior can be strong. For example, while health insurance firms legally cannot dictate how a physician treats a patient, the companies may exert indirect influence by placing reimbursement limits on the use of certain therapies and medications, perversely affecting professional decisions for reasons unrelated to a patient's health needs.

> The complexity of a stakeholder map becomes especially apparent at this level when we acknowledge that stakeholders have relationships with one another, as well as with the professional entity itself. For example, the biomedical research community indirectly influences how healthcare professionals behave when research results are incorporated into clinical practice guidelines and protocols adopted by employing organizations, with which practicing professionals are expected to conform. Education policymakers may interact with textbook publishers to assure that preferred theories are given priority in textbooks, which are then required for adoption, thereby affecting professional behavior in the classroom.

Another example of distant stakeholder interaction that ultimately exerts influence on professional behavior at the individual level is the relationship between citizen advocacy groups, the media, and policymakers. Citizen groups, often via the media, may place pressure on policymakers, who in turn may respond with new regulations, laws, and guidelines about professional behavior. One example would be changing guidelines about how teachers present sex education in schools, as a result of local community pressure on politicians. Another example would be requirements for second opinions prior to surgery, imposed by health insurance companies. In both these cases, professional responsibility is redefined by distant stakeholders who are neither members of the profession itself nor direct recipients of professional services, but who nonetheless can have a profound influence on expectations of professional responsibility, both morally and legally.

The duration of distant relationships with the professional entity is less time based than issue based. When a particular issue ceases to be salient to advocacy groups, the media, and policymakers, the influence of these stakeholders on professional behavior recedes, until a new issue appears to capture the attention of such stakeholders.

A paradoxical consequence of the ability of distant stakeholders to influence professional responsibility and behavior is that, the farther away from the center of the stakeholder map and the one-on-one relationship that professionals have with the people they teach and care for, the less knowledge of individual relationships the distant stakeholders have. That is, a teacher can work with an individual student to help the student learn in a way that will be most effective. Ideally, a teacher can tailor the lessons to the student's individual learning style. All too often, however, standardized curricula and teaching guidelines generated by distant stakeholder groups (i.e., policymakers) restrict the discretion needed for individual learning.

A similar issue arises for the medical profession, should physicians' decision-making on behalf of an individual patient be constrained by clinical protocols, health insurance requirements, and drug formularies. Standardized curricula and teaching methods assume homogeneity in a student population, and standardized treatment protocols and formularies share this limitation. In both situations, professional discretion and autonomy—the hallmark of professional responsibility—is undermined.

Dimensions of Stakeholder Salience

The stakeholder map helps to identify important stakeholders in a profession's environment, based on the closeness of relationships—from micro- to macro-level relationships—that a profession has with various stakeholders. The stakeholder map also helps to specify the nature of the relationship in terms of its duration. Also noted is that stakeholders hold different degrees of power *vis-à-vis* the professional, and that the closeness of the relationship may be inverse to the amount of power the stakeholder has to influence professional behavior.

To enrich the analysis of stakeholders' ability to influence professional behavior, we can add a second perspective that highlights a different set of dimensions. Mitchell et al. (1997) have proposed a useful typology that enables an assessment of the nature of stakeholder *salience*, which rests in part on the elements of power, legitimacy, and urgency held by the stakeholder.

According to Mitchell et al. (1997:865–867), *power* is the extent to which a party to a relationship can impose its will in that relationship through coercive or normative means. *Legitimacy* is defined similarly to the definition used above; namely, the generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and rules. *Urgency* exists when a relationship with the professional is important or critical to the stakeholder and is of a time-sensitive nature.

For our purposes, four types of stakeholders described by Mitchell et al. can illustrate these features. The first two types possess only one of the three attributes:

(a) *Discretionary stakeholders* are actors whose *legitimacy* renders them important to the profession, but whose demands on the professional are less urgent and who have little coercive power over the professional. Their ability to influence professional behavior rests in fostering normative conformity with behavioral expectations. Included in this group would be educational institutions and professional societies.
(b) *Demanding stakeholders* are actors with a perception of issue-based *urgency*, such as advocacy groups and the media, who often use voice to urge conformity and reveal noncompliance with their expectations about professional behavior on a pressing issue of importance to them. Although they have no direct ability or power to enforce professional responsibility, their voice can be strong and can indirectly affect professional behavior by placing pressure on other powerful stakeholders, as below.

The next two types of stakeholders possess two of the three attributes, and hence are of greater salience to the professional (regardless of where they may be placed on a stakeholder map):

(c) *Dominant stakeholders* are actors with *power* and *legitimacy,* as these two features combine to give the stakeholder recognized and accepted authority to impose expectations about professional responsibility. Included in this category would be government bodies and employing organizations, which are in a

position to coerce compliance with their interests (e.g., through threat of licensure removal or loss of employment), despite being somewhat removed from the professional's central relationships. It is through these stakeholders that discretionary stakeholders (e.g., consumer advocacy groups) may attempt to influence professional behavior.

(d) *Dependent stakeholders* are actors with *legitimacy* and *urgency*, but who generally must depend on others with power in order to coerce compliance with behavioral expectations, as they do not hold legal authority. Students and patients constitute the main stakeholders in this group. As noted, the imbalance of power between the professional and these stakeholders, who are located in the inner ring of the stakeholder map, places a higher moral expectation on professionals to honor their responsibility, both morally and legally, to these more vulnerable stakeholders.

Unlike the concentric rings depicted as a stakeholder map in Fig. 5.2, Mitchell et al. (1997) depict stakeholder salience using three intersecting circles, as on a Venn diagram, each representing one of the dimensions of salience (legitimacy, power, and urgency). The overlapping segments would reflect the areas where stakeholders may hold two dimensions (e.g., dominant stakeholders with legitimacy and power, and dependent stakeholders with legitimacy and urgency); and the center segment would reflect the intersection of all three dimensions (characterized as definitive stakeholders). It is interesting to note here that none of the stakeholders identified in the stakeholder map could be characterized as a definitive stakeholder, possessing all three dimensions of stakeholder salience.[2]

While the positions on the stakeholder map shown in Fig. 5.2 are relatively stable in terms of the closeness of the relationship between the professional and the stakeholders, the nature of stakeholder salience is more dynamic. In particular, the dimension of urgency is likely to fluctuate as the needs and demands of patients and students, parents and reformers may shift over time. Nevertheless, an appreciation of the dimensions of stakeholder salience is a valuable addition to understanding the system of stakeholders within a profession's relevant environment.

Challenges and Practical Implications for the Professions

The foregoing analysis of stakeholder–professional relationships and stakeholder salience helps to reveal several thorny challenges for professionals. Many of these challenges stem from the reality that different stakeholders in a professional's

[2] A rare exception might be if a physician were treating the leader of government that has a national health service, who thus technically holds coercive power over the physician, as well as having legitimacy and urgency because of a need for health care.

environment hold potentially conflicting interests and expectations, as well as differing degrees of power to enforce behavior consistent with their interests. Scholars have referred to this reality as an example of *multiple institutional logics*, and a growing number of studies demonstrate various approaches that actors may engage in when confronted with conflicting pressures within their environment (e.g., Dunn and Jones 2010; Greenwood et al. 2010; Montgomery and Oliver 1996, 2009; Reay and Hinings 2005, 2009; Shipilov et al. 2010; Suddaby and Greenwood 2005). Many of these studies grew from ideas first introduced by Oliver (1991), who proposed that strategic responses to institutional pressures and expectations would vary along a continuum—from acquiescence and compromise, to avoidance and defiance, to manipulation. Each strategic response carries its own risks and benefits, depending on the nature of the pressure, as well as the stakeholders' salience and closeness to the professional. Because of the many contingencies that can affect a professional's strategic response to a particular pressure or expectation, an extended discussion of this literature is beyond the scope of this chapter. But suffice to say, professionals are not without their own resources and strategies to affect the behavior of other stakeholders, as well as to resist their attempts to influence the professionals' behavior.

Below are examples of some stakeholder-related issues that professionals in education and medicine are advised to pay particular attention to.

Responsibility for Vulnerable Stakeholders

First, the stakeholders with whom medical and teaching professionals most closely interact (patients and students) are generally also those who have the least power and hence are the most vulnerable to the actions of other stakeholders in the relevant environment. Thus, an important, but potentially overlooked, element of professional responsibility is how to protect the interests of these stakeholders from being trampled by more powerful actors in the environment, who may have different interests and priorities. For example, healthcare organizations and health insurance companies may impose restrictions on a physician's treatment decisions (e.g., by levying financial penalties for prescribing off-formulary drugs). Such constraints may pressure physicians into choosing a treatment option that is not in the best interest, medically, for the patient, while it may make sense financially. Teachers may face a similar dilemma, when curricular guidelines and textbook choices are imposed by policymakers, which, to many teachers, may not be the most effective way to encourage learning.

Thus, professionals routinely face the frustration and challenge of dealing with potentially competing interests of various stakeholders in their environment, who wield different degrees of influence. In these circumstances, deciding what is the most professionally responsible behavior is not always clear-cut.

Pressures for Confidentiality Versus Transparency

As noted in the above discussion about distant stakeholders, these are often powerful actors in the relevant environment who are in a position to impose guidelines and regulations about professional practice and responsibility. Yet, they are removed from the day-to-day activities in delivering professional services to individuals. As a result, policies may be developed based on assumptions of homogeneity in student and patient populations, rather than taking into account the need for professional discretion and autonomy at the personal level in deciding about what is best for an individual student or patient.

Exacerbating this problem is the potential for misperceptions about professional behavior. As seen in Fig. 5.1, perceptions that professional behavior conforms to normative and legal expectations lead to assessments of professional legitimacy, which in turn lead to access to tangible and intangible resources necessary to perform one's role. Therefore, it is essential that powerful stakeholders who control resources accurately perceive what professionals do. Yet, the work of professionals in education and medicine takes place in a micro-level environment (the classroom, the doctor's office) where actual behavior is not easily observed by macro-level decision-makers. Indeed, strong normative and legal expectations exist regarding confidentiality in the doctor–patient relationship, as well as confidentiality restrictions about student performance. Professionals thus face a quandary about responsibly adhering to confidentiality norms for their students and patients, while needing to assure that their (unobserved) behavior is accurately perceived as legitimate.

The Role of Professional Schools

An important element in the preparation of future teachers and doctors is educating trainees about the realities of the environment in which they will practice. This includes assuring that new doctors and teachers recognize the set of stakeholders whose expectations will affect the practice of medicine and teaching. A stakeholder map is a useful tool for this purpose, followed by an analysis of each stakeholder's relative power to influence professional behavior, highlighting areas where stakeholder interests may generate conflicting pressures on the professional.

Often such conflicting pressures create ethical dilemmas for professionals. Although medical ethics and teaching ethics are customary components of professional education, the typical issues covered in ethics training programs may not extend to the dilemmas of dealing with various stakeholder demands. Expanding curricular design to incorporate stakeholder-related issues would be a valuable addition to education about professional responsibility.

Bringing the community of stakeholders into the process of professional education is another avenue for enriching stakeholder appreciation for how professionals do their jobs and the challenges they face. All too often, stakeholders are so focused

on their own interests that they may fail to recognize when they are placing unrealistic demands on teaching and medical professionals. Professional education programs, especially those geared toward community outreach, are in a position to facilitate dialogue among the stakeholders in a nonadversarial way.

Summary

Every medical and teaching professional knows that he or she does not perform in a vacuum in the classroom or examining room. Rather, there are multiple voices in the environment expressing expectations about professional responsibility and how it should be enacted. As presented here, an institutional perspective can reveal characteristics of these voices—stakeholders—that should enrich professionals' understanding of their environment, toward the goal of better serving their primary stakeholders, their students and patients.

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Chapter 6
Professional Responsibility in an Age of Experts and Large Organizations

Steven Brint

The Anglo-American professions originated as occupations that dealt with very sensitive and high-stakes matters: life and death in the case of the medical profession; the circumstances of one's liberty and fortune in the case of the legal profession; the salvation of the soul in the case of the ministry. In matters of such ontological significance, trust was naturally an important part of the relationship between professional and client. The truly high status professions of medicine and law were based on the economic relationship of fee-for-service. Of course, they required higher education, but, unlike today, higher education was intended for elites and practice in a profession was for the most part limited to the sons of the gentry and merchant classes. The idea of professions as built on a special relationship of trust between practitioners and clients grew out of this matrix of social status-based recruitment and fee-for-service practice (Elliot 1972, Introduction; Larson 1979: chap. 2; Reader 1966). The professional man was not only someone who had studied and practiced in a field that required a certain depth of specialized knowledge; he was, ideally, also an adviser and counselor and a person who could be depended upon to defend one's interests vigorously based on a personal commitment cemented, but cemented only, by a fee. Many professionals of the era did not fit the ideal-typical economic and social circumstances of the "trust" professions, but that did not matter. The notion of professional practice was narrower than it is today, and salaried men were not often accepted as "true" professionals (see Larson 1979: chap. 2).

The rise of large organizations in the nineteenth century created demand for cadres of new types of salaried experts – engineers, accountants, urban planners, social workers, and many others (see, e.g., Bledstein 1976; Wiebe 1967). Intellectuals like R.H. Tawney attempted to generalize the trust relationship to these new salaried

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professions by emphasizing the responsibilities of professionals as guardians of social values, or what I have termed "social trustees" (Brint 1994: chap. 1). Let me quote him here:

> [Professionals] may, as in the case of the successful doctor, grow rich; but the meaning of their profession, both for themselves and for the public, is not they they make money, but that they make health, or safety, or knowledge, or good government, or good law… [Professions uphold] as the criterion of success the end for which the profession, whatever it may be, is carried on, and [subordinate] the inclination, appetites, and ambition of individuals to the rules of an organization which has as its object to promote the performance of function (Tawney 1948, pp. 94–95).

These functions, for Tawney as for many others who sought special social status for the professions, were activities that embodied and expressed the idea of larger social purposes. This connection between advanced education and service to society elevated the social importance of the new salaried professionals, while providing them with an ideology around which to organize as a distinct, morally elevated stratum in society. Unlike business people, they were not simply interested in selling their services for a profit. They had larger civic and social responsibilities. The non-capitalist, even anti-capitalist elements in this ideology are worth emphasizing. As I wrote in *In an Age of Experts* (1994) in this respect, the idea of professions, so intertwined with the development of modern capitalism and the modern welfare state, nevertheless showed a remarkable resonance with much older pre-capitalist cultural and political formations: not only elevated social purposes, but the idea of work in a calling, collective self-governance, and high levels of self-direction in day-to-day activities.[1]

In its inclusiveness, the ideology of social trustee professionalism served many important functions for members of occupations that required higher-level degrees and aspired to a distinctive status in society. Occupations like school teaching and social work with dubious technical knowledge bases could nevertheless claim a kind of moral superiority, and they could at least look forward to further technical advancements as an important aspiration for the future. Occupations like engineering with their secure technical bases often found it convenient to identify themselves as serving larger social purposes.

The same sentiments expressed by Tawney, but framed in occupation-specific terms, were the conventional wisdom of the leaders of professional associations during the nineteenth and early twentieth centuries. We can begin to show this by examining the speeches of leaders of professional associations and the colleges and universities that produced professional men and women. Charles S. Levy and I studied the speeches of leaders of ten professional associations during the period 1875–1995. We also coded

[1] The origins of the sense of professionals as serving particularly elevated social purposes and the latent or explicit anti-capitalism of professional ideology differs somewhat in continental Europe with the higher status of the civil service there and the connection between professionals and labor unions in the building of social democratic movements in countries like Sweden.

the inaugural speeches of presidents of four prominent colleges and universities.[2] In each speech we coded the incidence of more than a dozen types of expressed concerns and commitments. These data showed that references to the civilizational purposes of professions were the most common rallying point of leaders of professional associations in the years prior to the Great Depression and much more common than references to civic life, community life or social reform. They were also much more common than references to the technical achievements or internal affairs of the professions (Brint and Levy 1999).

What did professional elites mean by serving civilization? This varied from profession to profession, but, in broad outline, the ideals followed the frame of social responsibility described by Tawney. College and university presidents emphasized the importance of the diffusion of knowledge, the creation and perfection of a "higher vision" of life, and the cultivation of desirable qualities of mind. Leaders of the bar emphasized the ideals of justice, the protection of individual freedoms, and the improvement of human abilities to meet social needs in an orderly and nonviolent fashion. James O. Broadhead, the first president of the American Bar Association, for example, evoked a common theme of lawyers and judges as the "wise guides" of society: "It is the business of those who have studied [the law]…to see that public sentiment springs from a pure fountain and flows in an unobstructed channel, and [that] pursuance of its mandates shall secure to each citizen the fullness of individual existence and impose so much restraint on each as is necessary for the good of all" (Broadhead 1879, 70). Presidents of the American Institute of Architects evoked the spiritual and social benefits of beauty in built environments. Although references to the civilizational purposes of medicine were less common, when they were made by leaders of the AMA they focused on the application of scientific intelligence to the humane project of curing disease. So, for example, the 1945 speaker of the AMA's House of Delegates, Dr. H.H. Shoulders challenged his colleagues: "Let us again concern ourselves with advancing the science of medicine, with meeting the standards of medical education and with delivering a higher quality of medical service, ever mindful that science without a soul may be cruel and inhumane, where science possessed of a soul is the very highest achievement, the apotheosis of humanity" (Shoulders, quoted in Fishbein 1947, 483).

Civilizational themes were, however, never dominant in the science-based professional associations: the American Chemical Society and the American Society of Mechanical Engineers. Instead they focused on the technical achievements of their

[2] The professional associations included the American Bar Association, the American Chemical Society, the American Institute of Architects, the American Medical Association, the American Society of Mechanical Engineers, and the National Education Association. Among the more or less strictly academic professional associations, we coded speeches of presidents of the American Historical Association, the American Political Science Association, and the Modern Language Association. The colleges and universities were the University of California, Berkeley, the University of Chicago, the University of Pennsylvania, and Pomona College.

fields.[3] During the early years the presidents of the American Psychological Association worked hard to establish the scientific *bona fides* of the new discipline, also focusing on technical achievements. Unlike in the other associations we studied, sociocultural themes grew in importance in the APA during the two later periods and discussions of the technical achievements of the discipline receded.

The Rise of "Expert Professionalism"

The years 1880–1930 were the heyday of social trustee professionalism, and by the 1960s this ideology was in decline. A big part of the difficulty professional elites found in sustaining it was that some of the most important and fastest-growing professions – including engineers, accountants, and management consultants – saw nothing particularly wrong with the pecuniary purposes and the utilitarian practices of business enterprises, and they did not feel the need for an ideology that helped to differentiate high-minded professionals from low-minded business people. This was evident in the speeches of leaders of scientific associations from the beginning of the period studied. A second difficulty is that the era of occupational self-regulation waned. The state and corporations took a larger and larger role in the regulation of the professions, often taking up the cause of consumers and criticizing the tendencies of professionals to feather their own nests. Thus, for example, health maintenance organizations developed in large part to control the exorbitant treatment costs of fee-for-service doctors (Starr 1982; Freidson 1993). This latter development was a particularly hard blow for the ideology of social trustee professionalism because now it was the state and other efficiency conscious organizations that appeared to be serving the interests of clients against the pecuniary interests of professionals. A third obstacle was that professional associations became large bureaucratic entities in their own right, and internal organizational life became a focus for leaders of the professional association rather than the larger purposes the professions served. By the last period Levy and I studied (1970–1995) sociocultural references constituted only about one-quarter of the themes in presidential speeches. Issues related to membership concerns and internal activities, such as task forces and committee recommendations, assumed a correspondingly larger share of attention. ABA President James D. Fellers used his speech in the mid-1970s, for example, to describe the formation of 15 commissions and projects to examine controversies in such areas as information technology and the law, accounting practices, media law, and medical malpractice (Fellers 1975).

I have argued that a narrower ideology of "expert professionalism" – the focus on the value of specialized skills requiring higher education – filled the ideological space conceded by the dwindling number of advocates of social trustee profession-

[3] Several presidents of ASME in the years between 1930 and 1970 did become interested in the intersection of technology and social life, leading to a temporary surge in themes concerning the civilizational and civic values of engineering.

alism (Brint 1994: chaps. 1–2). The archetypal "expert professional" saw him or herself as having acquired specialized skills through advanced training in a formal body of knowledge and working in areas requiring not only skill but judgment. The outlook was more technocratic than service-oriented. Expertise is used to aid organizational (and personal) advancement rather than any "aims" society might have for professional service. Formal rationality and utilitarianism were intrinsic to expert professionalism just as substantive rationality and service ideals were intrinsic to social trustee professionalism. The outlook of expert professionalism is captured well in David Halberstam's portrait of an archetypal figure of mid-twentieth century America, Robert McNamara, chief executive of the Ford Motor Company and later Secretary of Defense under Presidents Kennedy and Johnson. Halberstam wrote of McNamara:

> (McNamara) symbolized a new kind of executive in American business… (men) who were modern, well educated, technicians who prided themselves that they were not tied to the past but brought the most progressive analytical devices to modern business, who used computers to understand the customers and statistics to break down costs and productions. At Ford what distinguished McNamara was the capacity to bring a detailed financial system to (repair) the almost total disorganization of the company. He was brilliant at systematizing, telling Ford where it was going before it got there (Halberstam 1969, pp. 231–232).

Although he quickly rose to the rank of star executive, McNamara had formerly been a teacher at the Harvard Business School, one of the many places that brought efficiency-mindedness and problem-solving expertise into trained alignment. He symbolized the mind-set of the engineer in the service of organizational objectives that I see at the heart of expert professionalism. A representative paean to expert professionalism can be found in Daniel Bell's *The Coming of Post-Industrial Society* (1973), here in a section on the significance of new intellectual technologies for solving social problems:

> An intellectual technology is the substitution of algorithms…for intuitive judgments. These algorithms may be embodied in an automatic machine or a computer program or a set of instructions based on some statistical or mathematical formula; the statistical and logical techniques that are used in dealing with 'organized complexity' are efforts to formalize a set of decision rules…The chain of multiple calculations that can be readily made, the multivariate analyses that keep track of the detailed interactions of many variables, the simultaneous solution of several hundred equations – these feats which are the foundation of comprehensive numeracy – are possible only with (the primary) tool of intellectual technology, the computer (pp. 29–30).

Whether or not one agrees that "expert professionalism" describes the dominant professional ideology from the mid-twentieth century to today, it seems clear that, structurally, about all that remains in common across the professions is that: (1) they bring (some degree of) specialized skill and a (some level of a) formalized knowledge base into the labor market, (2) they have high levels of education and therefore higher than average standing in society, and (3) they do not have line authority in the management of organizations.[4] The ideology of social trustee professionalism per-

[4] Because they frequently interact and inter-marry, college graduate professionals and managers are probably better thought of as members of a common social class, in Max Weber's sense of the term, or, if one prefers, as members of a common social stratum (see Brint and Proctor 2011).

sists in many of the human services professions – in occupations like school teaching, public law, and parts of general care medicine – but it is rather uncommon in the professions whose work is primarily quantitative in nature, conducted in for-profit corporations, and well remunerated. The more specific concern for serving the underserved has become connected with bids for symbolic status (and additional resources) by members of a subordinate fraction of the professional-managerial stratum, typically those working in government and non-profit social welfare agencies and among those who are sensitive, for whatever reasons, to the injustices caused by poverty and disadvantage.

A Revival of Social Trustee Professionalism?

The social philosopher William M. Sullivan is perhaps the most prominent modern advocate for a revival of professional responsibility along the lines suggested by early twentieth century progressives. Sullivan's proposal focuses on creating a new generation of professionals who embrace a stronger sense of social purpose. They derive this orientation from educational training that includes a strong social and ethical component. Part of the reawakening Sullivan advocates requires a proper appreciation of the professional–client relationship. He defines this as "the stance of intelligent responsiveness on the part of individuals to expectations of their social relationships." I agree that shoring up what Sullivan calls the "third apprenticeship" – the apprenticeship into the values and social responsibilities of the profession – can be a helpful way to revive professionals' interests in their civilizational responsibilities, at least in limited ways. Others represented in this volume argue that the development of a sense of responsibility for reducing inequality and serving the underserved would be an appropriate and broadly appealing functional equivalent to the social trustee professionalism that united much of the professional stratum during and immediately after the Progressive Era.

For reasons that I will discuss in the remainder of this chapter I do not think that a coherent and broadly inclusive ideology of professional responsibility can be reconstructed in the twenty-first century. Any effort to do so would require realism about four decentering elements in the circumstances of professional life: (1) the limited appeal of contemporary versions of progressive idealism; (2) the continuing prominence of occupational skill and expertise in the definition of the professional stratum; (3) the decisive role of formal organizations in shaping and allocating professional responsibilities; and (4) the contested and unsettled nature of professional responsibilities in practice. I do not think that the issue of professional responsibility is unimportant or beyond discussion. Instead, I will argue that identifying its influence properly will require piecing together the net result of multiple strands of supportive ideology and supportive organizational arrangements, rather than focusing on the development of a single broadly appealing framework.

The Limited Appeal of Progressive Idealism

Let me examine first the limited appeal of contemporary versions of progressive idealism. We can gain a sense of the size of the group to which politically liberal ideals about professional responsibility might appeal by looking at the professionally dominated industries and then picking out those in which progressive ideals are most likely to resonate. An industry-based analysis is preferable, in my view, to an individual-level analysis because concentrations of sentiment are more important for effective political action than the sheer distribution of sentiments, and concentrations are better examined at the industry level.

To define the industries of interest, I will use a simple criterion: professionally dominated industries are those in which at least 5 % of employees hold graduate or professional degrees. Graduate degrees are concentrated in fewer than 70 of the many hundreds of industries the government identifies in its standard industrial classification. When I began to track these industries in the late 1990s, the list that resulted from using the 5 % criterion included all industries that previous writers had identified as falling within the sphere of the "knowledge-based" or "post-industrial" economy.[5]

Table 6.1 displays the list of "knowledge economy" industries from the 1990–2010, together with the proportion of employees with graduate degrees in these industries, according to an analysis of the General Social Survey (GSS). To qualify an industry must have had at least 25 respondents to the GSS during the period. This limits representation in the "knowledge sector" due to statistical fluctuation. The actual proportions will obviously vary by a margin of error which itself varies by the size of the industry population in the GSS. Here I include only the industries that remained on the list from the last quarter of the twentieth century through 2010 (see Brint 2001).[6] The knowledge sector, defined in this way, includes agricultural services, mass media industries, chemicals, plastics, pharmaceuticals, computers and electronic equipment, scientific instruments, banking, accounting, consulting and other business services, medical services and hospitals, educational services (obviously including colleges and universities), legal services, and nearly all of government.[7]

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[5] My approach was strictly empirical and consequently refused to take sides between the contending visions of post-industrial society – between Daniel Bell's (1973) emphasis on high-tech industries and "quality-of-life" services, Thomas M. Stanback's (1981) rise of business services, or Richard Florida's (2002) urban future of science-based industries joined to civic planning and the arts.

[6] Thanks to credential inflation, a few new industries joined the list for the first time in the 2000s, including some, like jewelry and sporting goods, no theorist of post-industrial society would wish to include in the "knowledge economy."

[7] I conducted a separate analysis to determine how much the knowledge sector was contributing to the gross domestic product over time. I found that the knowledge sector accounted for approximately 37 % of GDP in the last quarter of the twentieth century (Brint 2001), growing from just over one-quarter in 1959 to nearly two-fifths in 1997. With the help of graduate student Jacob Apkarian, I recently updated these estimates. Knowledge sector industries continued to be among the most dynamic in the economy in the early 2000s. Taken collectively, they still did not constitute the majority contribution to gross product, but by 2010, they were getting close – 43 % of GDP.

Table 6.1 U.S. "knowledge economy" industries, late twentieth and early twenty-first century

	1990–2010 cumulative percent w/graduate degree	1990–2010 *N*
Offices of health practitioners, not elsewhere classified (n.e.c.)	0.500	42
Colleges and universities	0.398	723
Legal services	0.350	297
Non-commercial educational and scientific research	0.311	61
Elementary and secondary schools	0.299	1,904
Commercial research, development, and testing labs	0.288	52
Museums, art galleries and zoos	0.235	34
Educational services, n.e.c.	0.230	74
Engineering, architectural, and surveying services	0.227	203
Miscellaneous professional and related services	0.221	95
Social services, n.e.c.	0.216	310
Offices of physicians	0.204	260
Religious organizations	0.202	183
Business management and consulting services	0.185	184
Computer and data processing services	0.183	268
Security, commodity brokerage, and investment companies	0.176	170
Pharmaceuticals	0.165	91
Libraries	0.153	59
Offices of dentists	0.151	126
Electronic computing equipment	0.149	141
Guided missiles, space vehicles, and parts	0.140	57
Administration of human resources programs	0.135	163
Agricultural services, except horticultural	0.126	87
General government, n.e.c.	0.124	347
Telegraph and miscellaneous communication service	0.122	82
Administration of economic programs	0.120	117
Scientific and controlling instruments	0.115	26
National security and international affairs	0.111	468
Administration of environmental quality and household programs	0.110	100
Radio and television broadcasting	0.108	74
Health services, n.e.c.	0.105	455
Job training and vocational rehabilitation services	0.103	29
Accounting, auditing, and bookkeeping services	0.101	138
Residential care facilities, without nursing	0.099	91
Electrical machinery, equipment, and supplies	0.098	51
Hospitals	0.095	1,226
Photographic equipment and supplies	0.094	32
Business, trade, and vocational schools	0.091	33
Membership organizations	0.088	102

(continued)

Table 6.1 (continued)

	1990–2010 cumulative percent w/graduate degree	1990–2010 *N*
Petroleum products	0.087	46
Public finance, taxation, and monetary policy	0.086	81
Justice, public order, and safety	0.079	519
Theaters and motion pictures	0.077	155
Banking	0.077	470
Petroleum and coal products	0.073	124
Optical and health services supplies	0.072	83
Aircraft and parts	0.072	125
Printing, publishing, and allied industries, except newspapers	0.066	272
Advertising	0.064	78
Book and stationery stores	0.064	47
Real estate, including real estate-insurance-law offices	0.063	509
Newspaper publishing and printing	0.060	116
Insurance	0.060	452
Air transportation	0.058	155
Credit agencies, n.e.c.	0.058	156
Total		13,019

Source: Cumulative General Social Survey, 1990–2010
Bold = Industries in which employees were significantly more liberal than the adult population during the period
Italicized Bold = Industries in which employees were more liberal than the adult population during the period, but not by a statistically significant margin

Politically liberal knowledge-economy industries are those showing a statistically significant difference in mean scores on a seven-point liberal-conservative scale between members of the industry and the American adult population. This seven-point scale is an imperfect but widely used measure that is fortunately highly correlated with more specific topic-based measures of political liberalism (see Gross 2013: chaps. 3–4). In Table 6.1 I have bolded the industries in which liberal political views tended to prevail. The level of liberalism in these industries was significantly higher than that found in the American population as a whole during the period studied, 1990–2010.[8] I have italicized those industries in which political views were more liberal than the mean but differences in means do not reach statistical significance at $p < .05$. These are industries in which future change could lead to stronger identifications with liberal political views.

[8] I would like to thank Jacob Apkarian for running these analyses of the political views of employees of "knowledge economy" industries.

The politically liberal industries in the "knowledge economy" include significant parts of government, human services, higher education, health services, and media. They do not, however, include elementary and secondary schools, offices of physicians, any of the business services industries, or government executive or security agencies. If we include only the bolded industries, those in which differences in political outlook were statistically significant from the American population at large, the politically liberal industries include only a minority of industries (14 of 57) and only a relatively small proportion of employees in the knowledge-economy sector (21 %). If we include the italicized near-liberal industries together with the bolded, clearly liberal industries, slightly more than half of the "knowledge economy" industries listed (28 of 57), but still fewer than half (43 %) of the total number of employees are in the liberal camp.

We cannot expect professionals in most of the industries listed above to embrace ideas about reducing inequality and serving the underserved. Professionals in general tend to be more liberal than business people on social issues, such as the role of religion in public life and the extension of opportunities for minorities and women. But when questions engage issues of economic distribution, equality of results, and taxation, most professionals shift back toward the more conservative positions typical of business people (see Brint 1994: chap. 5; Brooks and Manza 1999).

The Morality of Expertise

Although the two are often counterposed, it is unclear to me that expert professionalism necessarily implies a lower level of social responsibility than more explicitly value-based ideologies. An important caveat is that for skill and expertise to register an autonomous moral impact they must be rooted in the relevant occupational community, rather than embedded in the regulatory apparatus of the state or the market. Expert professionalism carries with it the spirit of a distinctive form of social responsibility and one that can be at least as potent as the high-minded, but vague idealism of a Tawney. Professional craft skill is training to make an improvement in the circumstances of clients. For the teacher it is an improvement in students' knowledge and motivation to learn. For the physician it is the treatment of a patient's ailment and motivation to maintain a healthy lifestyle. These craft skills are rooted in social relationships: teacher–student and doctor–patient. These relationships foster interpersonal responsibility and, cumulatively, also an incremental contribution to a broader social responsibility.

We can subject this idea to thought experiments that bring the point home. Imagine a doctor who fully commits, as a normative ideal, to the improvement of the health of the patients she encounters – or even, as Tawney proposed, to the health of the larger society. Let us say she feels responsible for enacting this normative ideal in all of her encounters with patients and other citizens. But let us also say that this physician is poorly trained and cannot diagnose or prescribe properly. From the perspective of interpersonal and social responsibility, how unimportant is the craft

aspect of professional knowledge as compared to the socially normative elements of Tawney's ideal? The opposite circumstance is equally illuminating: In what esteem should we hold the physician who is an exceptional diagnostician and communicates exceptionally well with patients, but has no sense of professional responsibility beyond the perfection of craft in patient care? Who can say that this physician lacks effective social responsibility? In teaching, we have the analogous examples of the high-minded idealist whose students learn little because he has not mastered the techniques of effective instruction, motivation, and assessment as compared to the master teacher whose sense of social responsibility extends no further than the evidence of learning and the motivation that he produces in his students.

Craft skill and social idealism are not mutually exclusive, of course, and the sense of social responsibility commended by Tawney can certainly elevate professional life. But the combination is rare, and the rhetoric of elevated morality is a poor substitute for the solidity of craft, if the latter is missing. If forced to choose one, which should we choose, given that the issue of responsibility is addressed, albeit in markedly different ways, by both? In Table 6.2 below, I provide an answer: The common factors among those who deserve our esteem, those on the left side of the diagram, are effective craft skills.

In any efforts at ideological reunification of the professional stratum, respect for technical and interpersonal skill in the provision of services will be essential for segments of the professional stratum that are closer to engineering than human services. The human services too have much to gain from a heightened respect for technical skill. In parts of Asia where students perform better than they currently do in the United States, the school teacher is thought of more as a virtuoso performer than as an empathic care-giver (Brint 2006). Of course, nothing is wrong with empathy as long as it is accompanied by techniques that lead to results. It follows that excellent training will be essential to all segments of the professional stratum so that craft skills can be realized consistently in practice.

Table 6.2 Distribution of professionals in relation to two forms of distinction

		Level of craft skills/expertise	
		High	*Low*
Moral aspirations to serve clients and/or society	*High*	Skilled, socially idealistic practitioner	Unskilled, socially idealistic practitioner
	Low	Skilled, socially disengaged practitioner	Unskilled, socially disengaged practitioner

The "Collective Organizational Worker"

The management scholar Paul Adler and his colleagues have argued that few professionals were ever solely responsible for the well-being of their clients or patients. Most always worked in teams. This situation is certainly the norm today. Few patients, and none with serious medical issues, are treated solely by a single M.D. A whole professional team – each with trained expertise – is involved. In surgical cases, this team would include nurses, general practitioners, medical specialists, anesthesiologists, surgeons, and physical therapists. One doctor may be primarily responsible, but the treatment cannot be a success without the joint labor of many professionals. For this reason, Adler and his colleagues focus not on the individual professional but on what those in the Marxist tradition would call the "collective worker," – that is, the ensemble of professionals who are jointly responsible for treating patients, educating students, and managing the needs of business clients (see also Adler et al. 2008; Heckscher and Adler 2006).[9]

In tandem with Adler's conception of the "collective professional worker," I would suggest the need for a complementary conception of the "collective organizational worker." Without the "collective organizational worker" neither the public's nor the government's expanding expectations of professionals' responsibilities could be met. To understand professional responsibility it is therefore necessary to examine organizational life and to analyze the differing expectations interest groups have of large and prominent organizations as compared to small and little-known organizations.

The smaller the organization, the less developed the relationships with the outside world and the fewer the expectations of clients and others who have an interest in the performance of the organization. At one end of the spectrum are legal and certified public accounting firms run by a small number of partners or even a solo practitioner. These firms can practice with little reference to expectations beyond serving the needs of clients and, when times are bad, the firm's need to recruit new clients. Even these firms must typically employ an office manager to bill clients and to monitor the firm's compliance with state and professional regulations. Clients and other stakeholders make more numerous and more complex claims on larger and more prominent organizations. Consequently, the capacity of individual professionals to engage with the responsibilities society places on them declines with every increase in the size and prominence of the organizations that employ them.

Let me illustrate with an example drawn from an organization with which most readers will be familiar: research universities. The leading professionals in these organizations are the members of the faculty. The institution identifies the main facets of their professional responsibility: research, teaching, and service. During

[9] New regulatory frameworks are building in interesting ways on the team model. In experimental sites doctors are no longer being reimbursed individually for the treatments they prescribe, but rather teams are reimbursed and deductions are made when avoidable faults are found in treatment. This puts a premium not only on collective responsibility, but on careful uses of checklists to manage patient care.

review cycles both campus colleagues and university administrators determine whether faculty members have achieved an acceptable level of accomplishment in each area. Those who are truly excellent in all three areas of evaluation are models, but their level is not reached by many.

The challenge of achieving recognition even in one's own narrow specialization area precludes attention to many facets of the professional role that could in theory be considered matters of professional responsibility. Where gaps develop, the university deploys specialized offices to handle this expanded set of professional responsibilities that professors are no longer able to address. A few examples: Advising students can be considered a sphere of professional responsibility related to teaching. Research university professors continue to advise graduate students, but they are only rarely involved in advising undergraduates. Instead, an entirely separate staff of professional advisers grows up to fill this all-but-abandoned responsibility. Similarly, professors may be conscious of the desirability of inclusiveness so that students from all backgrounds will feel comfortable in class and on campus, but most are not professional experts on inclusiveness and they have limited time to monitor the extent to which inclusiveness is being achieved. Universities consequently create offices of equity and diversity to monitor campus climate. Similarly, excellent teaching requires knowledge of developing capacities of instructional technology. Some professors keep up to date with these developments, but most do not have the time to do so because they are spending most of the time they have writing papers and keeping up with developments in their own scholarly and scientific fields. Again the solution is organizational: an office of instructional technology, often complete with course designers, is put under the management of experts in information technology.

These are a few illustrations of a manifold reality. To sketch the circumference of this reality, I will provide an (incomplete) catalog of university offices that have become common surrogates for professionals in what can be considered primary areas of professional responsibility. In the domain of research, these offices include federal and foundation relations; research ethics and protection of human subjects boards; grants administration; environmental, health and safety; capital planning and construction; purchasing; economic development; and technology park administration. In the domain of teaching, these offices include instructional technology; undergraduate and graduate advising; academic support services; prestigious scholarships and awards; assessment; new faculty preparation and mentoring; equity, diversity, and inclusion; off-campus study opportunities; and career counseling. In the domain of service, these offices include community relations; government relations; strategic communications; K-12 outreach; educational resources management; campus tours; athletic administration; website managers; and conveners of citizens-university committees. Selected faculty members are recruited to serve on advisory committees for these offices, but the primary "professional responsibility" lies with the division of functional offices to represent not the professional body but the university.

The university's responsibility exceeds professorial responsibility because the costs of ignoring vital relationships are too great; the expectations of students and communities for services have expanded; and, perhaps most important of all, because regulatory requirements have greatly increased (Ehrenberg 2012). Coming

into conflict with these rising expectations are the fixed number of hours in the day and, in many institutions, the increased expectations professors face for achievement in the three major areas of merit evaluation. When evaluation expectations are high and time is scarce, professors are happy to consign components of an expanding environment of "professional responsibility" to organizational surrogates.

What I have said about universities is also true of other organizations in which professional judgment is central. Doctors, for example, are typically too busy working in patient care (and, in some cases, also research) to manage many new areas of professional responsibility. They do not, for example, know enough about Medicare reimbursement to advise patients about it. They have not studied enough of the literature to develop protocols for maintaining antiseptic conditions. Some are qualified only to talk about treatment of disease and not about the maintenance of healthy lifestyles. Most are not experts in insurance and therefore cannot advise patients well on what is and is not covered by insurance. They are not all experts in communication and therefore cannot always explain to patients what is required for improvement in a way that patients can understand. In a health maintenance organization, these tasks (or backup for these tasks) are assigned to offices staffed by trained surrogates.

Some responsibility functions performed by organizational surrogates may over time migrate into ordinary professional practice. This seems to be happening (slowly) in universities in the area of utilization of instructional technologies. It also seems to be happening in HMOs in the area of maintaining healthy lifestyles. Values and practices that are central to the technical core of professional occupations are likely candidates to become embedded in practice, while values and practices that are important to stakeholders but peripheral to the technical core of professional work are likely candidates for continuing to be under the jurisdiction of organizational surrogates. However, in the world of professionals change is often slow and it may take a new generation to inhabit expanded expectations even in areas that align with traditional core activities.

The Contestation of Purposes

When we talk about professional responsibility, we need to ask more specifically "responsibility for what?" and "responsibility to whom?" Tawney's abstractions (health, safety, knowledge, good government, good law) are too vague to be particularly meaningful today. Physicians were once charged with treating diseases and debilitating physical conditions. In addition to treatment physicians are now charged with helping patients maintain a healthy lifestyle through exercise, diet, avoidance of dangerous substances, and listening to their bodies. Our conception of what health signifies has changed due to this struggle of ideals. Similarly, teachers were once charged with providing subject matter knowledge

and basic cognitive skills to their students. Later the capacity to motivate students to learn became an important element in the expectations we have for teaching practitioners. With this new emphasis on motivation came a wider portfolio of learning activities, projects, field trips, lab experiments and other forms of learning by doing. Today, some influential educators have advocated the importance of teaching what used to be called character and have charged teachers to be responsible for helping students to develop resilience, conscientiousness, and other non-cognitive skills (see, e.g., Tough 2012). They have done so because they think these qualities are as important, or more important to the success of students, than cognitive skills alone.

It is important to note that these ideational struggles are not often led by professionals. In fact, it may be that professional associations are one of the last places to look for changes in the ideals of practice. If we believe the social historian Paul Starr (1982), the shift from disease prevention to health maintenance seems to have been driven in part by insurance companies, as well as by physical fitness enthusiasts. The role of the AMA, in the early days, is unclear. The new concern for teaching non-cognitive skills in K-12 education is the result of a coalition of renegade economists like James Heckman, education journalists, and some outlying education reformers. The AFT and the NEA have had little to do with it.

If "responsibility for what?" is an important question, so too is "responsibility for whom?" Treatment of some diseases (such as AIDS) were initially resisted or overlooked by the medical community, because they were associated with stigmatized populations. It took activists to reset the agenda (Epstein 1996). Many other health initiatives have been led by state actors and insurance companies, rather than professionals. My reading of the history of efforts to bring a greater sense of social justice into the educational and medical fields suggests that activists and EEOC lawyers had much more to do with this in the beginning than the professional associations (or the universities) (Lehman 1995). The goals of greater equity in the provision of medical and educational services may be relatively well accepted now, but it took activists' sense of social justice and government's willingness to frame and enforce new policies to bring those ideals to the forefront. Many of the authors in this volume assume that the next frontier of professional morality will be greater emphasis on the needs of underserved communities, but historically professional communities have shown themselves to be interested more often in technical skill building and civilizational horizons than in underserviced groups. The latter will find allies in the professional ranks but their natural advocates are social justice activists, liberal parties, and government enforcement agencies.

We live in a world in which the work of professionals is prescribed by what publics are willing to pay for; what intellectuals, activists and policy entrepreneurs convince them they should pay for; and by the regulations governments insist on. These interchanges provide fertile ground for a political sociology of professional responsibility – one that has not yet been written.

The Professional and the Organization

I do not take these points as rendering the values and moral actions of individual practitioners unimportant or beyond discussion. Universities can become machines for generating tuition revenues if value-oriented professors and staff do not continuously remind their administrative colleagues that the institutions are worth supporting, first of all, for their devotion to learning, education, and disinterested research. Similarly, medical groups can become machines for generating patient revenues if value-oriented doctors do not make cost-conscious, high-quality patient care part of the organizational environment. Value-oriented agents, including their leading professional specialists, can prevent organizations from slipping into the goal displacements to which they seem chronically prone.

In high-functioning organizations, senior managers and professional staff share the responsibility for value orientation and find consistency in the values they espouse. Managers can in fact do a great deal to reinforce commitments of professionals to the ideals of client service. Ritual occasions, such as quarterly or annual meetings, provide regular opportunities to celebrate the ideals of the profession and the professional organization. Organizational leaders who want to appeal to the idealism of their staffs typically use these ritual occasions for exactly this purpose, among others. Awards and recognitions that are fairly distributed for outstanding contributions and exemplary performance of duties are another reinforcer.

In other cases, a system of checks and balances can help to keep the client in focus. Where professionals are prone to feather their own nests, as is often the case, a high functioning organization can help them to maintain focus on efficient and effective delivery of services. Where organizations are prone to focus on revenue, which is also often the case, value-oriented professionals can insist that pursuit of revenue remain conditional on quality of service. These checks and balances lead to many compromises in organizational life, compromises that are fully satisfying to no party but that generally preserve more than a semblance of value commitment.

Mutual responsibility and checks and balances can go only so far, however. No single mission or broader social purpose exists for any large organization or any large professional body. Conflicts of purpose are normal. In a public university, for example, the value of maintaining educational standards and the value of serving underserved populations may be equally appealing, but the two will not always easily co-exist. In a hospital, the value of patient-centered care and the value of seeing many patients who would otherwise remain untreated are both appealing values, but again they produce an inherent tension. Leaders in both organizational and professional life are not defined solely or principally by their ability to speak to larger social purposes, although that is a qualification. They must also be skillful political actors in order to be effective agents of substantive rationality. They create the conditions to manifest the values (and the related interests) they represent. They contend with competing values and interests when they come into play. They provide a compelling case, where necessary, about the priority of one set of values over others. And they identify acceptable compromises where compromise is the advisable course of action.

The Social Responsibility of Individual Practitioners

What, finally, of the responsibility of individual practitioners in the context of these multiple layers of organizational and political embeddedness? Individual professionals are in many cases oriented to ideals that they may, under the right organizational conditions, be put into practice. At the same time, it is essential to recognize that ideals related to responsibility come in more than one "flavor." I will focus on three ideal types of moral thinking that are common in the professional stratum: nurturance, duty, and exchange. The idea of care for non-related dependents is an appealing rhetoric and moral regulator for political liberals, as James Hunter (1991) and George Lakoff (2002) have both emphasized, based on the concept of nurturance. This orientation is frequently aligned with the ideals of serving the underserved. For those with a more conservative outlook, the idea of performing one's duty to abide by a set of transcendent principles will be more likely to resonate, because conservatives tend to see the world in terms of obligatory absolute principles (see Hunter 1991; Brint and Abrutyn 2010). The specific transcendent principles occupational conservatives honor undoubtedly reflect differences among the specializations that make up the professional stratum. In the world of academe, for example, they include scrupulous treatment of evidence, skepticism in relation to truth claims, conscientious sourcing, engagement with the literature – and of course many others that would not be as relevant to lawyers, doctors, or engineers. Utilitarians, another prominent group, are a much more difficult party to engage in discussions of professional responsibility. But some utilitarians have an ethic that can be influenced by ideals of professional responsibility. This ethic is built around a sense of the reciprocal benefits of exchange. Many utilitarians who are not simply oriented to their own self-interest can see that clients bring benefactions in the opportunities they provide for stable practice and good salaries. Their desire to add value for their clients is in its own way both moral and responsible.

Conclusion

The argument I have advanced can be summarized concisely: It is tempting to call for a restoration of a sense of social responsibility among professionals, given the strong ethical claims that have been part of the cultural and political construction of professionalism since the time of the gentry professions. In my view, it will not be possible to revive social trustee professionalism – or any derivation from it – in an effective and honest way without emphasizing the centrality of professional skill and the moral potential inherent in the social relationships affected by skill. It will also not be possible without appreciating the fundamental significance of organizations for absorbing society's claims on professionals and for shaping the contours of professional responsibilities. Finally, it will not be possible to do so without acknowledging the contested terrain of social responsibility and the role of

non-professional actors in definitions and redefinitions of this terrain. We can describe this terrain as "broader social purposes," if we like, but we should be aware of the extent to which these purposes represent abstractions of interested parties' successful claims, a selection from a spectrum of possible purposes.

This is the broader context in which the value-oriented practitioner will continue to matter. What values might practitioners hold that will help to bring the moral element back into professional–client relations? The answers to this question fall roughly along a political spectrum, with care-giving images appealing to liberals, transcendent occupational principles appealing to the duty-bound, and the gratitude owed for benefits appealing to at least the more exchange oriented among utilitarians.

The "responsibility" concept cannot be revived in a single dominant form in our age of experts and large organizations, but it can be cumulatively powerful in its many distinct active lines of organizational design, practitioner training, and moral thinking joined to practice.

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Part III
Leverage Points for Reform

Introduction

This part examines key leverage points for creating and maintaining high levels of professionalism. The chapters in this section cover recruitment, selection, and training of professionals; induction into professional work cultures; the organization of medical and educational service delivery systems; the organization of professional workers; the role of public policy in creating and/or deflecting professional work; the incentive systems that serve to encourage or discourage professionalism; and the relationship between structuring professional work and organizing professional workers.

Chapter 7 by Simmons, Allen, and Schiller opens a discussion of how to enhance the production and deployment of professional physicians by first underscoring the fact that medical service weaknesses are not primarily financial or technological. These authors reiterate the conclusion, reported in Chap. 3, that although this nation's health care is the most technologically advanced and receiving the greatest financial support in the world, it does not produce the best or most equitable health services. The American system, they report, "has an oversupply of inaccessible and expensive specialists and an undersupply of affordable primary care doctors." Medical education has given too much weight to quantitative measures, and the financial incentive system provides too many rewards for tertiary care specialists. The social costs are substantial because primary care physicians are not only less expensive, they are also the primary agents of preventive care and public health services. It is encouraging to these authors that organized medicine has begun to address the primary care problem, taking an interest in medical professionalism and starting to seek ways of ameliorating health service disparities. Looking closely at the recruitment, selection, and training of young physicians, these authors conclude that there are multiple steps that need to be taken, some immediately and others over the long term, to recruit and retain dedicated medical students and maintain their commitment to primary care medicine throughout their training and induction into medical practice.

The authors of this chapter link improvement in health-care access and cost control directly to the performance of the public school system where children form

their career aspirations and where they must secure the appropriate cognitive foundations for entry into the field of medicine. They report that the University of California, Riverside, School of Medicine is engaged in building aspirational and intellectual "pipelines" to help students prepare for selection into the rigors of medical school training. They also report a strong commitment to selecting students from underserved communities and providing them with an education and training system that maximizes the chance that their graduates will remain in and serve effectively these underserved regions.

In Chap. 8, O'Connor and Beach focus attention on the relationship between research universities and public school systems in order to explore how strengthening this relationship can be expected to support professional responsibility on the part of both scholars and practicing educators. These authors highlight the long recognized but inadequately addressed disconnect between scholarly analysis of educational problems and application of that analysis in the day-to-day practice of schooling. They note that research knowledge derived from studying the challenges faced by special education students and by English language learners is substantial but is too often not well incorporated into the practice of teaching. To make this connection, it is essential that strong working relationships linking university faculty with public school teachers be created.

O'Connor and Beach report on the strategies used in the special education graduate studies program at the University of California, Riverside. In reviewing the Riverside approach, they identify four core elements in the effort to develop a more responsible professionalism in this program. These elements are: (1) assuring all students are given a meaningful "apprenticeship in research," (2) connecting students to the latest findings and familiarity with a national research agenda, (3) providing a meaningful apprenticeship in teaching, and (4) utilizing an ongoing research seminar to raise questions about professional responsibilities and develop the habits of mind and the technical and social skills needed to fulfill them.

Chapter 9 by Michael Wilkes poignantly describes the dilemmas of induction into medical practice. The induction process, he asserts, constitutes a "hidden curriculum" which teaches medical students ways of coping with time pressures, limitations on their ability to handle important patient relationships, and gaps in their own knowledge. These coping strategies, Wilkes makes clear, are often destructive to the norms of professional responsibility presented in the formal "stated" medical school curricula. He notes that the hidden curriculum often conveys to the medical school student that there are multiple classes of patients, with some deserving more diligent care than others. He also recognizes that the induction process often teaches the neophyte physicians that it is okay to concentrate on medical procedures and neglect patient relationships. By surfacing the hidden curriculum and helping young physicians understand how the taken-for-granted norms of practice that they are being exposed to undermine professional idealism and teach them morally and ethically diminished forms of practice, Wilkes believes that medical professionalism can be substantially enhanced by clarifying for students the nature of the hidden curriculum. Toward that end, he has worked with students to create a series of video vignettes to highlight some of the seriously destructive hidden curriculum lessons.

In Chap. 10, Deolalikar and Jones bring the discipline of economics to bear on the development of professional responsibility by providing a rich textured discussion of how differing types of incentives may serve to encourage either more or less professional responsibility depending on how the incentive systems are structured. These authors raise the question of whether seeking to develop responsible professionalism through structuring incentive systems is an "oxymoron" because professional actions involve such noble values as concern for others, collegiality, self-regulation, and willingness to sacrifice personal gain in the service of others – characteristics which most common sense incentive systems are unlikely to promote. But they are quick to point out that misaligned incentive systems can undermine these professional norms. Moreover, there are other important dimensions to professionalism and a variety of distinct types of incentives (e.g., material, solidary, and purposive) with which to influence them. Hence, they conclude that to globally pose questions of the relationship between incentives and responsible professional actions too often deflects attention from important nuances of incentive mechanisms and obscures adequate understanding. On the negative side, for example, the use of static, time-in-grade-based rewards for professionals may encourage organizational and systemic loyalty, but such incentive systems are quite unlikely to produce creativity and innovation. On the other hand, pay-for-performance incentive systems are likely to cause professionals to focus their attention on the performance measures rather than on the well-being of clients. In medicine, relying heavily on a fee-for-service-based reimbursement incentive system, it is observed, can actively encourage nonprofessional behavior among health providers. Identification of these kinds of incentive system dilemmas leads Deolalikar and Jones to urge recognition of the need for careful planning and persistent evaluation of the actual effects of the incentive systems being encountered by professionals in both education and medicine. They identify five factors that will influence the effectiveness of professional incentive systems: (1) the form (financial or nonfinancial) of the incentives, (2) the purpose or objectives being pursued, (3) measurement reliability and accuracy, (4) potential unintended consequences, and (5) the cost (for both the incentives themselves and for managing their distribution).

In Chap. 11, Mitchell tackles two dimensions of responsible professionalism as they arise in occupations where moral and fiduciary responsibility for client well-being is assigned to workers. First, he elaborates a phenomenology of the task structures separating laboring, craft, artistic, and professional work tasks. He contrasts these four primary work structures across 15 dimensions, showing that each has a unique relationship to work organization and management, that each calls for a different set of worker rights and responsibilities. He points out that execution of each type of task relies on different accountability norms, knowledge requirements, and training regimens and that each is amenable to a different approach to reform and improvement. Mitchell also adds to the Deolalikar and Jones' discussion of work incentives by arguing that performance of each type of task is encouraged by a different form of incentive system.

In the second section of Chap. 11, Mitchell examines the nature and functions of the professional associations to which professional task performers are introduced

during their professional training. The most important part of this argument is that the proper role of the professional association is to establish the standards for the performance of professional tasks and to provide a source of legitimacy for professional workers to reinforce their capacity to endorse appropriate and resist inappropriate pressures from political regimes and organizational managers, on the one hand, and to confirm legitimate service demands from the civic cultures, while deflecting inappropriate, biased, or unrealizable expectations for particular types or amounts of service, on the other.

Taken together, these five chapters show layout pathways for reform and improvement in the recruitment, selection, training, employment, and regulation of responsible professionals.

Chapter 7
Erecting the Pipeline for Socially Responsible Physicians

Emma Simmons, Scott A. Allen, and Neal L. Schiller

The Problem

The United States has the most technologically advanced, state-of-the-art medical schools and health care institutions in the world. We also spend the most money on health care. However, this does not translate into the best health outcomes, nor does our system provide equitable access to health care for all who are living in America. We remain 27th out of 34 industrialized countries in life expectancy and 32nd in infant mortality rates when compared to these other countries even though we spend twice as much on health care (Centers for Disease Control and Prevention 2013; Murray et al. 2013; Starfield et al. 2005). While some patients with good health insurance policies and the financial resources to afford comprehensive medical care are able to access the best technology and expertise that the United States has to offer, many have strict limitations and restrictions on the medical services that they are allowed. A popular tradition in most medical schools is that students pledge to follow the Hippocratic Oath, which broadly states that physicians have a responsibility not only to their individual patients but also to society. Despite this pledge, physicians continue to participate in a health system with unacceptable rates of health inequity, high infant mortality rates, and a tragically high number of physicians who are censured by medical boards or other legal entities for unprofessional behaviors.

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The public expects much more from physicians than merely competence. They expect professionalism, a social contract that exchanges the public's trust of, and compliance with, doctors for a deep commitment to healing and improved health outcomes. Fulfilling these expectations requires self-awareness manifested as the ability to express compassion and altruism, interpersonal relationships, and acculturation with community values (Cooke et al. 2010). In addition to public expectation, many leading medical organizations and governing bodies demand increased professionalism. In 2002, the American Board of Internal Medicine (ABIM) Foundation in collaboration with the American College of Physicians – American Society of Internal Medicine (ACP-ASIM) Foundation and the European Federation of Internal Medicine (EFIM) developed a Physician Charter to promote three fundamental principles required for the medical profession: primacy of patient welfare, patient autonomy, and social justice. While one could argue that satisfactory progress has been made on the first two, the principle of social justice, which includes the fair distribution of health care resources, is a clear failure in the American health care system (The ABIM Foundation et al. 2002).

Access to cost-effective primary care is constrained. Even those patients who have private health insurance may not have timely access to primary care due to an inadequate number of practicing physicians or the distance that patients need to travel in order to reach a physician. Yet, despite the acknowledgement of a national shortage of primary care physicians, the majority of students graduating from US medical schools elect to enter non-primary care specialties. Among the reasons cited for this decision are lifestyle, financial remuneration, and the perception of greater respect given to subspecialists. Other explanations include disproportionate exposure to procedural-based specialties within medical training programs and inpatient training experiences (Robert Graham Center 2009). To ameliorate this tendency, medical schools will need to undertake measures during recruitment and training to ensure that communities have access to capable, compassionate, and service-oriented primary care physicians (Freeman et al. 2007). As the first new public medical school on the West Coast in over 40 years, the University of California, Riverside (UCR) School of Medicine (SOM) is committed to engaging in this process and promoting a strategy for national emulation.

Improving health care for Inland California requires that more physicians be either recruited into the area or "grown locally." The shortage of primary care physicians represents an especially difficult problem in many areas due to an inability to attract or retain the nationally limited supply of primary care doctors. Securing a higher ratio of primary care providers to specialists is important for providing access to the urban poor and rural communities as well as for improving the overall efficiency of the health care system (Council on Graduate Medical Education 1998). Although many students enter medical school with an intention to go into primary care, a minority actually ends up choosing a primary care discipline such as family medicine, or primary care internal medicine and pediatrics. Only 7.8 % of US allopathic medical school graduates in 2013 elected to go into Family Medicine (Biggs et al. 2013). Strengthening efforts to counteract this pull of students and doctors away from primary care is the focus of this chapter. Our approaches include supporting a pipeline program for K-16 students educated within our local

communities, designing an admission process which helps select, admit, and recruit "mission-appropriate" applicants for medical school, devising undergraduate medical and graduate medical training programs that match mission objectives, and ultimately rewarding practicing physicians with competitive salaries, benefits, and work hours.

Pipeline Programs

Students as young as elementary school frequently profess an interest in medicine and the health sciences. Many factors, including but not limited to academic, personal, social and economic circumstances, can derail these students from reaching their goals. Nationally, K-12 schools are under-resourced. California, the state where the UCR medical school seeks to overcome health service barriers and disparities, currently ranks 49th in the nation in spending per pupil (Hightower 2013). In economically challenged regions of this state, neither families nor public schools have sufficient resources needed to reach educational goals. Although medical schools are not equipped to address many of the challenges facing K-12 schools, they can assist some students by recruiting them into pipeline training programs that provide medical role models and mentors, tutoring classes, sessions on study skills and time management, leadership opportunities, and constant but candid encouragement. Supporting a pathway or pipeline program can greatly assist with feeding a steady stream of at-risk or undeveloped, yet highly qualified and capable, students into colleges and universities so that they can adequately prepare for medical school. This pipeline program, working in close collaboration with K-12 educators and administrators, could include students from underperforming and struggling school systems who would otherwise be less likely to persist in the sciences without the pipeline's assistance. It is important to note that the pipeline does not end at admission into college. Student success initiatives in college and even in post-baccalaureate programs must be positioned to ensure that aspirants to primary care medicine continue to be fostered and mentored. These programs can easily be tailored to the type of physician being targeted for development. For example, if one is interested in training rural physicians, the pipeline program should be established in a rural area and with the support of enthusiastic rural physicians who can serve as advisors and motivators for the students as they progress along the pipeline. Moreover, if these young men and women are raised in medically underserved communities, and have experienced, first-hand, the challenges of accessing the health care system, they may be more inclined to aspire to personally remedy this social injustice.

However, developing and maintaining a pipeline program is not without its own unique challenges. A common challenge is student mobility as many children move multiple times during their K-12 education experiences. It is a challenge for the mentors to remain positive – recognizing that this is a long-term investment with each student. Also, additional staff time and resources have to be found to track and develop these students at this earlier, more impressionable stage in their educational career. This is both cost and labor intensive while yielding variable returns in terms

of program-targeted student success. Limited available resources would also restrict the number of students who can be enrolled in the program. Most pipeline programs require assistance with funding from either or both governmental and private funders. This is a competitive process and, when it is successful, tends to provide funding for short 2–3 year cycles with re-applications typically dependent on successful outcomes. These short-term program supports make it difficult to sustain the longer-term commitments necessary for K-12 pipeline programs. The student's level of maturity may also interfere with the program's ability to assess their true or developing attributes and characteristics. Some students, after having had significant time and energy invested into their ability to become a physician-scientist, may elect to pursue other non-medical careers or those medical specialties that were not consistent with the mentoring that they were provided. However, done correctly, society will still benefit from the students' contributions in any profession. Finally, if the mentors are based in academic institutions that do not value their efforts as academic capital that can be counted toward promotion and tenure, they face a significant disincentive to continuing this type of student advocacy.

Admissions

Medical schools and their faculties, both public and private, training both primary and tertiary care specialists, have a social contract to improve the health of the public. An excerpt from one version of the Hippocratic Oath states:

> …I will prevent disease whenever I can, for prevention is preferable to cure. I will remember that I remain a member of society with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm… (Lasagna 1964).

The current US health care system has an unbalanced distribution of health care providers (specialists vs. primary care MDs) which makes it difficult to meet the most basic of health care and preventative needs for many in society. There is an increasing need to recruit and train future doctors who will focus more on the neediest members of society, placing patient needs above their own. Changing the way medical schools choose and subsequently teach medical students who can fulfill this responsibility is needed. The admission committees of medical schools have an obvious role to play in recruitment and selection of students. They sift through literally thousands of applications each year to determine which of the many talented applicants will be interviewed, much less admitted (often more than five interviewees for every medical school seat). These interviews provide insight into the temperament and character of those ultimately offered admission into medical training program. In order to promote more empathetic physicians, the admissions committee needs to be strongly encouraged to look at the humanistic, psychological and intrinsic characteristics of the applicants early in the process and give those attributes substantial weight, balancing attention to academic qualifications. This process helps bring into the medical schools the type of student/physician who would be

passionate about, and more willing to work within, underserved areas (Hughes 2002; Walker et al. 2010). National licensing, credentialing and re-credentialing organizations are starting to recognize this important aspect of physician preparation and are beginning to require and measure these qualities of humanism and professionalism in their medical school applicants (Edwards et al. 2001). This trend will facilitate the development of coherent standards for defining professionalism across medical training facilities and entities.

The current medical school application system is based on a review of grades in traditional science-based prerequisites and scores on the national Medical College Admissions Test (MCAT). One can understand the propensity of admissions committees to focus on these easily quantified metrics to help rank order thousands of medical school applicants. The problem with this process is that it results in medical schools that are disproportionately serving students who have had advantages, are over-achievers, are singularly career focused, and lacking in the social and ethnic diversity representative of the general population – characteristics that weaken their ability to meet the needs of a diverse community population. These metrics are also not particularly helpful in the identification of the commitments and requirements for a physician whose goal is to improve the health of their community and to have a larger focus on disease prevention. Furthermore, students who excel at the traditional metrics are also more likely to aspire to or be nudged toward the more competitive specialties – thus tending to overlook the lower paying and currently less well-respected primary care specialties (Walker et al. 2010; Hughes 2002; Hunt et al. 1996). Although it has been widely accepted that an academically gifted student demonstrating aptitude for the science and mathematics fields makes a good doctor, even this "fact" has come under increased scrutiny. A study conducted by UCSF scientists concluded that those students who excel in the "hard" sciences are less suited to interpersonal relationships, a skill that is critical for good patient care (Barr 2010; Gough 1978).

To look beyond the numbers, admission committee members should focus more on qualitative metrics including comments provided in letters of recommendation, the applicant's experience of working in medical facilities and around medical personnel, and their professed interest in the medical profession. The level of community service, including the duration of activity, the type of organization and the role that the student played in the organization can also be very informative (Elam et al. 2002). A recent study suggests that community service (a marker for humanism) prior to entering and during the first year of medical school predicts community service beyond medical school. Thus, this kind of community service experience is a likely predictor of a deeper commitment to community focused, primary care medical practice. In this study, community service was defined as "activities where the applicant has helped others by providing support or assistance, apart from their simply seeking exposure to the medical profession." Of particular relevance in this respect are volunteer activities that involved schools, charitable/community organizations, and both pediatric and adult populations (Elam et al. 2002).

Adopting holistic qualities into the admissions process must not and should not be totally subjective. If educators are to change the health outcomes of the medical

profession, they must standardize their ability to identify, develop, and then recruit those students who exemplify the "ideal physician" – demonstrating those characteristics that they would value in his/her own physician. A 2006 Mayo Clinic study identified the following seven key traits for physicians: confidence, humanism, forthrightness, respectfulness, thoroughness and the ability to treat patients with empathy and as a person (Bendapudi et al. 2006). The American Association of Medical Colleges (AAMC) has further identified key attributes that medical schools should look for in their applicants which include the following: integrity and ethics, reliability and dependability, service orientation, social and interpersonal skills, capacity for improvement, resilience and adaptability, cultural competence, oral communication, and teamwork. These attributes are deemed extremely important and in 2011, the AAMC issued a report detailing "core competencies" of clinical practice that included the professionalism requirements of ethical behavior, clinical competency, and service orientation (Association of American Medical Colleges 2011). Medical school admission committee members are urged to focus attention on all of these holistic qualities in selecting their applicants for admission.

Although case law has sharply restricted the use of race as a factor in admission decisions [cf. Gratz V. Bollinger (2003), Grutter V. Bollinger (2003), Fisher V. University of Texas (2013)], achieving diversity is a widely recognized goal and aspiration for most medical schools. Defining diversity requires attention to multiple applicant characteristics including, but not limited to, the distance traveled in their personal life, their maternal or paternal history of undergraduate degree completion, their ability to speak a language other than English, or their residence in an underserved medical community or rural area. Importantly, all of these attributes are crucial in helping to predict those students who are more likely to choose primary care as a specialty. For example, students who are from racial and ethnic populations that are underrepresented in medicine are more likely to practice in primary care specialties and also to disproportionately serve socio-economically disadvantaged populations. Similarly, students who grow up in sparsely populated and widely spaced rural areas are more likely to practice in rural areas that are also medically underserved. More specifically, students inclined to choose family medicine are more likely to be married, non-traditional students, raised in smaller towns, and have a larger number of humanities courses and extracurricular activities on their applications to medical school (Freeman et al. 2007; Glasser et al. 2000).

Interviews can play an important role in determining the personal or humanistic qualities in the medical school applicants. Although most U.S. medical schools conduct interviews as part of their admissions process, they remain a primarily subjective method to evaluate students. Different interviewers may focus on different criteria or traits, based on personal preference (Albanese et al. 2003). There has, however, been a recent trend toward admission committees conducting holistic interviews that take into consideration an applicant's personal, psychological and service experiences in addition to the traditional metrics of their academics, research and clinical experiences, but this is certainly not universally practiced (Barr 2010; Witzburg and Sondheimer 2013). One scientifically vetted and practical method to make the non-cognitive factors more reliable and objective is to employ the mini

medical interview (MMI) format that was created by McMaster University (Eva et al. 2004). The MMI is a series of short interviews with pre-determined questions at each of the interview "stations" that offer expertise in assessing the applicant's humanistic qualities, interpersonal skills and assets other than grades and test scores. The results have been determined to be more reliable than those of the traditional one on one less fully structured interview (Uijtdehaage et al. 2011).

While appealing, the qualitative characteristics that are increasingly being used for the selection of medical students are not without significant challenges. For example, each medical school's admission profile is listed annually in the AAMC's Medical School Admission Requirements (MSAR) publication. In this report, each school's selection factors, including average and range of grade point averages (GPAs) and Medical College Admission Test (MCAT) scores for admitted students, is documented. Higher scores are typically interpreted to mean that the school is more selective; and by inference, indicate a more prestigious institution. Thus, the admission process outlined above may put the medical school's reputation at risk if the qualitative criteria used suggest that the medical school is not attending to the objective GPA and MCAT scores making it appear "less selective" and therefore less prestigious. Additionally, medical schools are currently ranked for status and prestige by *US News and World Report* and other journals/reviews on the basis of their research grants and activities, not their commitment to primary care or population health (Mullan et al. 2010). These rankings can directly or indirectly influence the admissions process. Many admission committee members will consciously or unconsciously seek applicants who boost their school's overall rating.

In addition to the challenge of resisting the urge to pick applicants that "look good" on their school's roster, other barriers are present. Adding additional, more qualitative measures (i.e., humanism) to the preferable qualities of applicants takes additional time in the form of training, reviewing, and discussing these attributes (Edwards et al. 2001). Admission committee members are not typically compensated for time spent reviewing applications, and must add this responsibility to their regular responsibilities. Another challenge is the fear of taking a chance on a student who presents with exceptional humanistic qualities and medical experience, but has academic metrics deemed marginal. If offered admission, the problem occurs if this student does not meet the academic expectations of the committee while in medical school. This choice can have a lingering negative impact for future qualified applicants in similar situations. In order for this paradigm to change, the administration, faculty and staff must buy into the process and commit additional resources, if needed, to ensure student success.

Medical School Training

The work of preparing a primary care physician is not complete with admission into medical school, regardless of what criteria and metrics have been used in the selection process. The training is arduous and requires a committed faculty. Many entering

medical students earnestly desire to help the economically less fortunate and those who are uninsured or underinsured, which is quite in line with the professionalism expected by society. These students are not, or at least not yet focused on medicine as a business. All too often, however, at some point in the 4 years of medical training, often around the third year, the empathy that the students once felt quickly dissipates (Hojat et al. 2009). It is important for medical schools to preserve and hone those humanistic and empathic qualities that first-year students too often lose, despite their embodiment in the Hippocratic Oath and the AAMC attributes. While these qualities are vitally important for physicians as they work closely with patients, the medical specialists that have less frequent or direct patient interaction and are more procedure-oriented should not be exempt.

In addition to becoming more cynical during the medical school education and training process, fewer students are deciding to enter primary care fields (Biggs et al. 2011; AAMC.org 2013). One potential reason for this decline is that medical training, especially when hospital based, is heavily geared toward teaching and training under the guidance of specialists. This can easily overshadow the more limited experiences and exposure to primary care practitioners during required rotations (Indyk et al. 2011). This intensive exposure to inpatient care often influences residency choices encouraging young physicians to move away from the primary care specialties. For example, students could initially choose to go into a primary care field such as internal medicine or pediatrics, but after exposure to and supervision by specialists switch to a specialty within these disciplines (such as cardiology or pediatric endocrinology).

In order to counteract the increase in cynicism and loss of humanism among medical students during their clinical rotations, the medical schools need to introduce role models of continued professional commitment across the various levels of the medicine hierarchy early and often. A longitudinal clinical program beginning during the first 2 years of medical training with active student involvement is a start. This allows the students to directly observe and experience the impact that primary care has on patients and their communities, thus allowing students to gain opportunities to use more reflection on direct clinical experience to better understand and "own" the complexities of the professionalism required of them (Monrouxe et al. 2011). This longitudinal clinical training program will assist in counterbalancing the fragmented approach to patient experience that is commonplace at many institutions, and better prepare students for their third-year clinical clerkship training. This experience also helps students understand the non-clinical and civic roles that physicians play in their communities (Kassebaum et al. 1996). A concerted effort of teaching medical students the knowledge, skills, attitudes and behaviors of professionalism and of their importance in the role of improving public health is needed (Elam et al. 2002). Having enthusiastic primary care mentors who are willing to share their professional as well as their personal journey and help with this reflection and processing is also important (Cooke et al. 2010; Indyk et al. 2011).

It has long been documented that cynicism increases in medical school (Eron 1958; Feudtner and Christakis 1994; Testerman et al. 1996). There is some evidence to support the observation that cynicism does decline among those physicians who

have more time to bond by talking and interacting with their patients (Rezler 1974). The Cornell Comprehensive Care and Teaching Program studied a comprehensive training program in Family Medicine to determine its effects on medical student attitudes and skills. The authors concluded that participation in a comprehensive program can help control cynicism – but with several caveats that must be recognized if we are to influence students more effectively. The change in attitudes and behaviors learned are short-lived and regress when students return to traditional clinical training experiences unless similar characteristics are valued by all medical services. The program must train the students in the social and emotional aspects of medicine early. The program must recognize that students are more excited by physical or organic disease. Students were more likely to want to know their patients solely on a professional doctor–patient basis (Rezler 1974). Other studies found that comprehensive training did not significantly change the student's willingness to take a social history primarily due to the student's perception of its lack of importance as evidenced on several of the other rotations. In addition, the authors observed that there was a self-selection of students to choose Family Medicine as a specialty (typically those who are less authoritarian and dogmatic).

Medical school administrators and faculty can also change the culture of students' perceptions of primary care by increasing the status and rewards that are associated with primary care and with those qualities that society expects primary care providers to embrace. There is often a "hidden curriculum" that is present in many medical institutions that must be extinguished. This hidden curriculum embraces values of efficiency and impersonality that are in conflict with professed values and that threaten professionalism (Cooke et al. 2010; Indyk et al. 2011). Primary care physicians have frequently commented that during their core clerkships and rotations, attending physicians (post-residency training physicians who teach in hospital or clinic settings) and faculty advisors opined that he or she was "too smart or talented" to go into primary care. Increased recognition of the importance of primary care and the role it can play in improving the health of our community and nation is essential to counteracting this "hidden curriculum." Numerous observers have insisted that greater recognition and high profile awards need to be given to students who value the more humanistic and altruistic characteristics of the profession in addition to recognizing their commitments to both their patients and their community. This is in contrast to the more traditional awards commonly provided to those who perform well academically in the medical subspecialties (Edwards et al. 2001; Hearst et al. 1995; Hunt et al. 1996).

By the time they graduate from medical school, students have already determined the specialty career that they plan to follow. However, there is still time to prevent further erosion of primary care and to influence the practice location. Students who choose Family Medicine are almost always destined to practice primary care. Hence, finding ways to increase the percentage of medical students choosing this specialty will increase primary care medical practice. Family Practitioners are also more likely than the other primary care specialties to practice in underserved and rural areas (Grumbach et al. 2003).

Mentoring, modeling, and training in professionalism remain important even after medical school. As mentioned above, students who choose residencies in primary care disciplines (with the exception of Family Medicine) can still elect to subspecialize within their field, and thereby reduce their contribution as a primary care provider. In pursuit of expanding primary care medicine, residency training in these areas provides additional opportunities for faculty and mentors to influence resident specialty choice reinforcing the importance of commitment to primary care. Exposing residents to more outpatient practices and rewarding them for choosing to set up practices in underserved areas as well as decreasing the number of subspecialty positions for them to choose may help to increase the number of doctors choosing primary care (DeWitt et al. 1998; Robert Graham Center 2009). While the type of residency practice shapes decision making with regard to a primary care career, the location of the residency practice is an important predictor of the ultimate practice location for young physicians. To be ultimately successful in the goal of increasing access to primary care physicians, training residents in underserved communities provides optimal exposure and experience aligned with the goals and mission of the UCR School of Medicine.

Putting Reality into Practice: The Ultimate Product

Underserved areas in particular have a difficult time recruiting an adequate supply of primary care providers. Family doctors can more easily practice in smaller, more rural areas than other medical specialties; however, a critical mass of primary care providers is needed in order to improve health equity, improve the health of the community and prevent physician burnout and dissatisfaction (Freeman et al. 2007; Walker et al. 2010). Furthermore, the imbalance of primary care to specialty providers creates higher health care costs (Robert Graham Center 2009). Personal factors, such as being from an underrepresented population, being from a socio-economically disadvantaged background, raised in a rural area, educational factors, the experiences one has with primary care providers, patients and staff during rotations and in training, the amount of debt accrued, perceived autonomy (Dwinnell and Adams 2001; Phillips et al. 2010; Senf et al. 2003) as well as strategic and competitive incentives, such as work hours or increased compensation, can influence where a physician chooses to practice. However, belief in the mission of the practice and feeling a unique connection to the community that a physician serves are equally or more important than work hours and lifestyle when choosing to work in an underserved area. Training residents and immediately recruiting them to work in an underserved area are critical, as once a physician has worked in an area that is not underserved, it becomes increasingly more difficult for him or her to make the transition to an underserved area (Walker et al. 2010). It is also important to recognize that in order to attract newer physicians (i.e., Generation X'ers and beyond) into any practice, particularly underserved and under-resourced practice areas, one

must have additional resources such as the availability of technology, flexibility of schedules and increased job security (Bryan 2011).

Although it is difficult to change the intrinsic motivators (personality, background, sense of obligation) for students/young physicians, there is room to influence the career motivators. These include the logistical, family and/or relationship and personal preferences that contribute to where one ultimately chooses to practice. Loan repayment, concurrent spousal employment, salary and benefits, and work hours can also be influential (Walker et al. 2010). Offering community service-learning opportunities during medical school can encourage students to consider working with underserved communities.

Conclusion

To summarize, physicians have an implicit social contract with society that many are not fulfilling and as a result, America has an oversupply of inaccessible and expensive specialists and an undersupply of affordable primary care doctors. Medical education – including recruitment, selection, training, and early career induction processes – are compromised by an overemphasis on the quantitative attributes of GPA and MCAT test scores while financial compensation and rewards systems have encouraged creation of an undersupply of primary care physicians and an oversupply of tertiary care physicians. Primary care doctors, who offer lower cost health care and preventative medicine, have suffered from our current model of education and rewards. This inequality has an impact on the care, or lack of care, that is provided. The encouraging news is that organized medicine has taken an interest in primary care, medical professionalism and its role in ameliorating health care disparities. Society expects compassionate physicians who are continuously committed to improving their expertise while also improving the health of their communities. This requires a commitment from medical schools to mentor students prior to entry into medical school and to develop criteria that more accurately select students who are dedicated to the community health mission. Medical schools need to teach the knowledge, skills, and values related to the care of the population and the improvement of the delivery system. Medical schools have an obligation to instill in young doctors a commitment to life-long learning and professional development, and to teach cultural competency, collaborative learning, and the exploration of the students' role as a physician citizen so that they can employ practice-based improvement and policies in an effort to improve and analyze their medical practice for the betterment of their patients and community (Cooke et al. 2010). Although all physicians, regardless of specialty, are expected to be responsive to the health care of their community, primary care physicians are able to provide a more robust contribution to a larger number of people. Making all medical students aware of the barriers, pitfalls and consequences in addition to the more positive and attractive aspects of their specialty choices, at early stages in their career, is key.

Because of the important role of the primary care doctor in providing low cost and effective medical care that can reduce health disparities and improve the health of their communities even when dramatically under-resourced, we advocate enhanced selection and nurturing of future primary care providers. As described in this chapter, there are multiple steps that can be taken both immediately and in the long term to promote and retain students and later residents and young physicians who are passionate about primary care. Changing the recognition and reward system during medical school to emphasize the non-academic qualities of being a good physician is also very important. There needs to be constant vigilance and support for the students and their primary care mentors in order to avoid reversion to a specialty-dominated learning and training culture. Medical schools can and should play a significant role in ensuring a continuous pipeline of medical doctors dedicated to a more humanistic profession with a clear responsibility to social justice.

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Chapter 8
How Linking University Research to School Needs Influences Scholars and Schools

Rollanda E. O'Connor and Kristen D. Beach

Introduction

Professional responsibility in education and in medicine focuses on the public good. In our field of special education, the public good includes providing students at risk for poor school outcomes with the opportunities they need to optimize the benefits of public education. Faculty in special education study multiple dimensions of service delivery to students and their families, with the ultimate goal of improving school environments by supporting students, their families, and their teachers. In this chapter, we begin with a broad overview of students with disabilities and other special learning needs within the school context. In this overview we make special note of issues facing children who have disabilities and are also English Language Learners (ELLs). We then consider the professional responsibility of faculty across a range of roles expected in a research university, attending to how these roles can be integrated into a coherent framework that hones and perpetuates the professional responsibility of university faculty and simultaneously nurtures professionalism among the teachers and future faculty they prepare. Next, we turn our attention to exploring concrete examples of university responsibility for working toward continuous improvement in teaching and research in ways that protect and support the university's clients: the students and teachers in schools. These examples are drawn from our reflection on the character and effects of the doctoral training program at the University of California, Riverside where the authors of this chapter live and work.

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This overview of special education in the public schools must be brief, but before addressing the nature of professional responsibility for this population we need to highlight the sharp and persistent challenges they routinely face. How to manage and improve the quality of public schooling has been debated in local, state, and national venues over the past several decades. These debates polarize communities because, although a free public education is considered a right of citizenship in all states, the quality of schools that are publically supported varies widely within and across states. Within a single school, the organization of classes, teachers, and resources varies across student constituencies. Services are often differentiated depending on whether students are gifted, are considered typical learners, have special needs due to disabilities, or speak languages other than English. These last constituencies—students with disabilities and students learning English as another language—are particularly vulnerable when schools face political pressures for various curricular emphases or funding cuts requiring reallocation of teachers and resources.

Student vulnerability becomes a particular focus of professional responsibility in the study and practice of special education. Historically, access to high quality education has been curtailed for students with disabilities and English language learners. Although access to quality public education has improved in the last 30 years, substantial gaps in access, quality, and outcomes persist for these groups of students. The University—nested as it is between policy and practice—can serve a key bridging function, clarifying for policy makers promising intervention strategies and assisting practicing educators to pursue policy goals with workable instructional programs. By integrating research and practice in the educational experiences of students, in the training of future teachers, and in the application of research knowledge to school program design and implementation, the University can help assure that knowledge is appropriately applied.

Students with Disabilities in the Public Schools

Since the advent of the Education for All Handicapped Children Act (1975), the number of students with disabilities eligible to receive special educational services has increased to six million, according to the 31st Annual Report to Congress (U.S. Department of Education 2011). School districts are obligated by the federal law to provide a Free and Appropriate Public Education (FAPE) that targets their specific educational needs. Providing appropriate education has become increasingly entangled with standards-based reform.

The No Child Left Behind Act (2001) and the current vision of shared outcomes embodied in the Common Core State Standards Initiative (National Governors Association Center for Best Practices 2010) are encouraging standardization of curricula while the FAPE policy was designed to foster curricular differentiation for students with special needs. Hence, the curriculum priorities for school personnel are competing, with some focusing on the individual needs of students with disabilities

as specified in the student's individualized education plan (IEP), others working on providing these students with access to the general education curriculum that enables systemwide standards to be achieved, and still others working toward narrow preparation to improve a student's performance on standards-based tests. When teachers provide meaningful access to general education courses for students with disabilities, indicators such as the National Assessment of Educational Progress (NAEP) suggest that performance of students with disabilities improves slightly (U.S. Department of Education 2010). Providing such access requires collaboration across general and special education (McLaughlin et al. 2008) and knowledge of additional instructional strategies for teaching content and skills in inclusive classrooms (Bulgren et al. 2009); however, preservice teachers are rarely trained in cross-disciplinary collaboration or instructional adaptations found to be effective in experimental research. Moreover, teachers who earn general education credentials often enter the teaching field lacking confidence in their ability to incorporate learning strategies that improve access to high standards for students with disabilities, students who are English learners, and others who may be at-risk for poor academic outcomes (Shippen et al. 2005). Teachers who earn special education credentials may be underprepared to teach content to the high levels required in the Common Core State Standards. This mismatch between requirements for providing meaningful access and limitations of teacher preparation suggests changes in the types of basic and applied research faculty conduct, alongside changes in how teachers in each discipline are prepared.

Special Education and Students Who Are English Language Learners (ELL)

Changes in research focus and teacher preparation are also required for the growing proportion of students who are learning English during their public school experience. According to a 2012 report from the National Center for Education Statistics (NCES), the percentage of ELL served in public schools increased from 8 to 10 % from 2000 to 2009, with more than 4.8 million ELL served in 2009. California claims the highest percentage of ELL served in public schools at just less than 30 %. Spanish is the most common of 325 languages spoken in homes of students who are ELL in 44 states and the District of Columbia; Spanish speakers comprise more than 80 % of the ELL population in 14 states.

Attention to issues of primary language development and special education eligibility is important particularly given the rise of ELL in school populations nationwide. Researchers have explored relationships between first and second language acquisition, but rarely have these relationships been considered in terms of special education (Orosco 2010). In general, lower proficiency in the primary language creates interference as a student learns a second language, because the higher a student's ability in the primary language, the more reinforcing each language is to the

other (Cummins 2009). First language development can be stimulated by access to literacy events in the home or inhibited by deprivation related to poverty or other factors. Cross-language relationships also influence how well and how soon students learn to read, which then influence learning opportunities afforded students in schools. For example, Spanish and English share similar orthographies and transfer occurs in areas such as phonemic awareness, decoding, and blending (Linklater et al. 2009; Slavin and Cheung 2005), and so reading ability in Spanish influences reading acquisition in English. Despite evidence for the positive impact of developing students' primary language, opportunities for Spanish language development of Hispanic English learners is often discontinued abruptly in many states; as a result, some students experience learning difficulties that eventually lead to identification for special education (Guerrero 2004; Orosco 2010).

The complexity of disentangling language development opportunities from learning difficulties and disabilities looms large in identifying students who may need special education and are ELL (Klingner et al. 2006). Representation of students who are culturally and linguistically diverse (CLD) in special education has been studied since the 1980s (Donovan and Cross 2002; Kauffman and Landrum 2009). In the early school years, students who are ELL and CLD may be underrepresented as having special learning needs due to the difficulty of distinguishing between language acquisition difficulties and broader learning difficulties that may be due to disability (Klingner et al. 2006). When struggling learners remain unidentified for support in the primary grades, they may become overrepresented in special education by middle and high school (Artiles et al. 2005). For students at risk for disability, the issue of primary language development is particularly salient, making it important for teachers to acquire Bilingual, Crosscultural Language and Academic Development (BCLAD; see Jones, Chap. 15 in this volume). Meeting the language and learning needs of ELL students is a key element in the professional responsibility of classroom teachers, and therefore of the university faculty who prepare teachers.

The Role of Graduate School of Education Faculty

Should these concerns of public schooling affect university research, teaching, and service? If so, how? The answers may lie in notions of professional responsibility that figure throughout the essays in this volume (see especially Sullivan, Chap. 4; Montgomery, Chap. 5 and Brint, Chap. 6). Simmons, Allen, and Schiller (Chap. 7, this volume) raise the issue of disparate levels of medical care across communities and this problem resonates in education, particularly in regard to public schooling in large districts with growing proportions of children who live with low-income families, whose risk for disability is higher than the national average, and who are struggling to learn English alongside skills and content.

Professional responsibility for university faculty and public school personnel mandates acknowledging community need and seeking to understand and improve

community resources and opportunities. Improving opportunity is tightly linked to improving classroom instruction at all levels. Without a firm foundation in language and literacy in the primary grades, students lack access to the courses in middle and high school that enable them to attend college. For college graduates to become our future excellent teachers, their university mentors and role models must come to grips with the realities of practice as they are enacted at the point of service delivery: the public school classroom.

When university faculty are distant from the school as a primary point of service, their efforts to prepare teachers and conduct meaningful research aimed at generating feasible educational improvements may be wasted, or even harmful. By contrast, when research aims directly at problems identified as important to local schools, feasibility is improved. This research approach begins with collaborating with local school personnel to develop and field-test stronger instructional routines for students who respond poorly to existing practice; however, it does not end there. A next step requires studying teacher implementation of these improved routines and the feasibility of implementation with teams of teachers in these schools. Yet another step involves incorporating improved instructional approaches in teacher education programs in universities so that new teachers develop the skills to teach formerly marginalized students more effectively.

For special education faculty in a research university, professional responsibility extends to the training of doctoral scholars. By conducting collaborative research with teachers of diverse learners in schools, scholars will come to appreciate the conditions of students' lives, as well as cultural and ethnic backgrounds and needs. This in-the-field enculturation is essential because cultural ways of learning are not attributable uniformly to ethnic group members (Gutierrez and Rogoff 2003), but rather evolve within histories of engagement with particular cultural activities; activities that vary by individual and family, as well as community (Orellana and Bowman 2003). Teaching students with disabilities who are ELL or who live with families from minority cultures does not suggest alternative standards, but rather ways of including and accommodating their needs to work toward meeting standards established as valuable for all students (Zetlin et al. 2011).

Collaboration with public schools will be necessary to accomplish these tasks. Nevertheless, collaborative research is sparse in research universities and unusual among education faculty. Research in education is often conducted alone, or in small teams of a lead researcher alongside doctoral students. Typically, an idea is explored or technique "tried out" on students or teachers as "subjects" of experiments. At the close of the experiment, the researcher leaves the school site, and the innovation leaves also. Conversely, schools tend to work as collaborative communities of teachers, administrators, parents, and students (see Adler et al., Chap.18 in this volume). To impact schooling, researchers will need to enter those communities, learn from them of the barriers that impede their best efforts, and work alongside them to explore potential solutions. These changes impact not only how faculty conduct research, but also, as emphasized by Simmons et al. 2015 (Chap. 7 in this volume), *who* faculty recruit into doctoral programs. Even as selectivity of potential doctoral candidates who are inclined toward and capable of collaborative research

with school personnel and communities becomes increasingly imperative, the need for more doctoral graduates in special education is urgent.

Since the mid-1980s, the demand for college and university faculty trained in special education has far exceeded the supply (Hardman and West 2003; Smith et al. 2010). Nationally over 1,400 colleges offer special education teacher preparation (Duncan 2009), but only about 100 also offer doctorates in special education research and teacher preparation (Smith 2009). This inhibits the translation of research into routine practice in schools. Moreover, although the number of special education doctoral graduates annually has been steady, the proportion of them who take academic positions has declined (Pion et al. 2003). Hence, while the special education student population swells, the shortage in qualified special education teachers has become a national crisis (Billingsley 2011; Evans et al. 2005; Guha et al. 2008; U.S. Department of Education 2009). The crisis is chronic and severe. In an article titled "Roundup: More Ph.D.s in Special Education Needed," USA Today (2011) concluded that "too few doctoral graduates are produced while the demand for new faculty remains high."

Unfortunately many doctoral graduates nationally are either not interested in higher education as faculty or are unwilling to relocate to assume faculty jobs some distance from their homes (Pion et al. 2003). In the 1960s, over 85 % of special education doctoral graduates took jobs in universities (Bunsen and Bullock 1988). In 1992, this figure dropped to 55 % (Pierce et al. 1992), and 10 years later fewer than half of all special education doctoral graduates chose careers in higher education (Evans et al. 2005). Currently, we still hover around 50 % for graduates with special education doctoral degrees accepting faculty positions. It is encouraging, however, to find that funding through fellowships and teaching assistanceships increases the likelihood of choosing a college teaching career by about 60 % (Tyler et al. 2012).

Faculty shortages impact the potential to meet the needs of students with disabilities and their families. Although many states, including California, resort to alternative means of filling these vacancies, research shows that fully licensed special education teachers teach significantly better than those with emergency certificates (Brownell et al. 2010; Nougaret et al. 2005). Rosenberg et al. (2007) reiterate that the answer is to improve production of faculty to prepare teachers. Although important, we argue that *more* faculty may be less essential than *who* these new faculty are and how they are prepared to accept professional responsibility to ease the larger problem of providing the best possible service to students at risk for poor outcomes in schools and their families.

Most entry level special education faculty position announcements seek individuals with a research background and teaching experience with diverse cultures and students at risk (e.g., see postings in the *Chronicle of Higher Education*). Universities located in diverse communities have the potential to provide more and better opportunities for collaborative research and apprenticeships in schools serving primarily low income, multilingual families. These experiences can be incorporated into university teaching apprenticeships to prepare special educators who can effectively teach and nurture students with disabilities and who can work effectively

within multicultural communities. But how do we find doctoral students willing to undertake these efforts? How can we support them through timely completion of a PhD and commitment to seek a faculty career?

University of California, Riverside, as an Example

As important as it is to model and train professional responsibility, the first stages likely reside in the individual prior to admission to a training program. Simmons et al. 2015 (Chap. 7, this volume) refer to "mission-driven students" in the medical school, and this description is apt for the doctoral candidates sought in graduate schools of education. As an example, the University of California, Riverside (UCR) strives to recruit doctoral students who want to work amid the diversity of current school environments. For future researchers and teacher educators to be adequately prepared, they must understand the demands on teachers who work with students at risk for learning difficulties. When doctoral candidates have teaching experience in high-risk schools, their experience enables them to collaborate more effectively with school personnel by understanding the possibilities and challenges faced by these students. As a minority-serving institution, UCR is strongly committed to recruiting qualified applicants to doctoral programs from diverse ethnic, cultural, and socioeconomic backgrounds. Many of these students are "home-grown," representing the diverse communities of California's Inland Empire.

Engaging in ongoing collaborative research and practice development work with school teams requires a substantial commitment by doctoral students – a commitment that exceeds the evening course work commitment typical of many doctoral programs. It requires that doctoral trainees leave the day-to-day teaching positions that many have used to support themselves and that often inspired them to pursue a research career in order to improve the educational experience of their students. The U.S. Department of Education demonstrates a commitment to support this kind of intense doctoral level training in areas of national need by awarding competitive grants to faculty in universities that have plans to train scholars who will fill those needs. In the sciences, these are the Graduate Assistance in Areas of National Need (GAAN) grants; in special education, they are called Leadership grants (U.S. Department of Education 2011).

Leadership grants are not uniform across the country. Rather, special education faculty with established ties to public schools propose a plan to prepare future faculty who can maintain and expand these ties. Each grant provides funding for five to seven doctoral students for up to 5 years of full-time study. In return, faculty who are awarded these grants commit to work in university and school district teams to ensure that future faculty in special education can work effectively with teachers, administrators, students, and parents in public schools.

Faculty help our doctoral candidates to envision themselves as future faculty by working alongside them, and by providing opportunities for doing a faculty-like "day job"—preparing themselves to work with school personnel to solve problems

of mutual interest. This new job includes benefits such as payment of university fees, health care, and a monthly stipend. The heart of this model of doctoral preparation builds on four types of active engagement: (1) apprenticing in collaborative school-based research, emphasizing feasibility studies of educational improvements in local classrooms, (2) linking to a national research community to learn about and disseminate research outcomes, (3) learning to teach complex, research-based concepts and practice techniques at the university level, and (4) participation in peer collaboration in ongoing professional seminars, which allows candidates to discuss and extend their training experiences and provides for them time to think critically about their work in the field and their place in the education of children with special needs in multicultural environments. As described more fully below, concurrent development of these program components prepares scholars for future faculty careers.

Professional Responsibility Through Apprenticeship in Research

Public media lament the inadequacy of our schools to solve problems of poverty, intolerance, and illiteracy. The diversity of the population of the United States is reflected particularly in public schools, and the Inland Empire of California provides rich opportunities for research that can generalize to other diverse communities across the United States. But most special education Ph.D. teacher and doctoral candidates come from white middle class America; they may have little or no interaction with the ethnic groups they will be preparing teachers to teach and understand little of students' backgrounds and culture. In contrast, just half of the students enrolled in teacher education programs at UCR are white, with the largest minority representation stemming from the Mexican American/Latino group. By focusing research on special education and risk in public schools in the Inland Empire, we introduce future teachers and doctoral scholars to issues affecting the education of culturally and linguistically diverse (CLD) and at-risk students. Doctoral candidates receive the necessary experience to develop a research agenda that supports CLD schools, and to work as leaders and train teachers to work in diverse school settings.

Special education research work at UCR is centered in public schools where the majority of students come from groups regarded elsewhere as minorities. Beginning with the first term of doctoral study, each scholar spends 15–20 h every week throughout the first 2 years of their doctoral studies in research apprenticeships with faculty who are studying the nature and needs of students with disabilities, alongside teachers in the schools where findings will be implemented. Doctoral students begin working as "an extra pair of hands" and attend weekly research meetings associated with collaborative school district-university research to experience the thinking, planning, instrument development, training, data collection, and analysis procedures that are part of any research enterprise.

This apprenticeship creates essential experiences to shape our scholars' understanding of local needs and potential solutions. Some of these apprenticeships include longitudinal intervention and monitoring students' response to reading and mathematics problem solving intervention and developing assessment tools for which the largest ethnic group in each study is Hispanic/Latino. Other apprenticeships, also longitudinal in nature, focus on families of individuals with autism or intellectual disability, examining family relationships and coping behaviors.

Professional Responsibility Requires Connecting to National Research Agendas

Doctoral students preparing to accept and discharge professional responsibility for training the next generation of scholars and practitioners master the insights provided by existing research-based methods for improving service to students with special needs, and develop new avenues of research and methods of practice. Training for this kind of responsibility works best when doctoral scholars work in an environment that facilitates exploring the intersection of ELL and special education in diverse schools and neighborhoods like those found in Inland Southern California. In this region, students who are ELL experience difficulties across all phases of special education, including accurate identification, evaluation, and placement (Zetlin et al. 2011). O'Connor et al. (2013), Orosco (2010), Swanson et al. (2012) and their doctoral students are exploring these issues longitudinally, including using Spanish and English versions of literacy and mathematics assessments and interventions to evaluate the progress and risk for special education of ELL. O'Connor's students (Ayala and O'Connor 2013; Beach and O'Connor in press; Healy 2007; Linklater et al. 2009; Sanchez 2011) have compared alternative measures and interventions to predict response to intervention among ELL students in kindergarten through fourth grade. Additionally, Blacher and students explore risk and resilience in families of Hispanic students with disabilities (Kraemer and Blacher 2008).

To enable their emerging sense of professionalism, grant funding from the Office of Special Education Programs also reimburses candidates' attendance and presentation at local and national professional conferences that focus on these issues, including the Council for Exceptional Children, the American Educational Research Association, and the Gatlinburg Conference on Research and Theory in Intellectual and Developmental Disabilities. Presenting locally driven research at conferences widely attended by pre-service and in-service teachers, as well as other school district personnel, helps doctoral scholars recognize multiple avenues and opportunities for serving at-risk student populations. In the last 2 years, students participated in pilot studies that resulted in funded research in reading comprehension, collected data for efficacy studies of early intervention, analyzed videotapes of parent/child interactions, implemented video self-modeling to intensify

interventions, and developed bilingual assessments and instruction for mathematical functioning and problem solving in special education classes. Because scholars take six quarter-long methods courses in their first year, they assimilate the research methods knowledge to generate successful conference proposals at the outset of their doctoral student experience.

As students present their research at these conferences, they engage in conversations with students, faculty, and school district personnel nationally who share similar concerns. Doctoral scholars learn first-hand the research agendas proposed by panels of experts along with the agendas originating from the focus groups of teacher leaders and university faculty that culminate in the Institute of Education Sciences practice guides. The scholars bring these discussions back to their ongoing professional seminar at the university to consider application of these research topics in public schools.

Professional Responsibility Through Apprenticeship in Teaching

Although successful experience in teaching students with disabilities in public schools provides valuable insights into methods and issues in working with this population, it is insufficient preparation for university level teaching. To develop doctoral candidate's university-level teaching competence, UCR trainees apprentice alongside experienced faculty to teach one or more courses in teacher preparation. This experience differs from the teaching assistant positions offered in many graduate programs, in that the trainee does not teach a course solo until the summer after they have successfully engaged in teaching experiences alongside and been coached by faculty, who teach the majority of the course. The apprentice model allows a gradual transition from assistant to instructor, and provides time and collaborative assistance to incorporate the best practices trainees learn from existing and current research with school personnel into preparation of future teachers. Thus doctoral trainees learn how to design special education teacher preparation that highlights the knowledge needed to implement documented best practices within diverse communities and the larger framework of general education.

Working in school districts with a majority of minority enrollments means that teacher preparation, as well as research studies, will emphasize high quality instruction for multiethnic students with disabilities. The UCR program facilitates integration of research and teaching at the university level in the implementation of school–university partnerships with local schools. Upon graduation, graduates will help to ameliorate shortages of faculty and of classroom teachers. After gaining experience conducting meaningful research in local schools and designing and executing high-quality teacher instruction covering educational issues for CLD and at-risk student populations, six Ph.D. graduates can contribute to the preparation of about 150 skilled special education teachers each year.

The Professional Seminar: A Professional Responsibility Development Venue

All the components of the UCR Leadership program are subjected to review and analysis through discussions in an ongoing Professional Seminar, in which doctoral scholars in special education participate at least 21 times per year. The Professional Seminar builds community among students, because they all take this course from their first term through their last. Scholars at all stages of development mingle. Advanced scholars help new students master core concepts and navigate program requirements and stresses. New students build relationships and come to understand the steps to completing their studies and learn about applying for faculty positions. The Seminar extends dialogue among scholars with faculty and students at other university campuses.

Special education professors across the UC system participate with doctoral students statewide for at least two meetings annually. Additionally, school district personnel, including intern and experienced teachers, attend an annual statewide meeting with UCR students. Thus, along with experience in research and teaching, the Professional Seminar invites scholars to participate in professional issues and decision-making regarding futures of students with disabilities and considerations that enter into research, instruction, service delivery, and policy.

Forging the Link

To summarize: this chapter has examined the importance of linking university-based training with participation in the public schools and in the preparation of special education teachers. The doctoral studies in special education at the Graduate School of Education at the University of California, Riverside was offered as an example of how programs can link thoroughly across the national community of research scholars, students who study special education issues and practices, and also to local schools where the insights of this research experience are tested and validated. This program focuses on preparing new faculty to train teachers and to advance research. The model developed here gives substantial attention to English language learning issues, as well as problems related to other learning difficulties. It could be employed in other university communities where school districts grapple with educating students who come to school with varied and considerable needs. The Riverside, San Bernardino, and surrounding school districts—large multicultural districts with significant English Learner populations that surround UCR—provide sites for collaborative research among faculty, doctoral scholars, and teachers, and also field placements for pre-service special education teachers. Our longstanding relationship with these school districts enables the integration of intervention studies in reading, math, and behavior with doctoral training and teacher preparation.

In addition, the funding from OSEP Leadership grants encourages scholars to commit to full-time study and complete the degree in 4–5 years, depending on the dissertation. For doctoral scholars who come to programs with little experience working in diverse communities, these years of research and collaborative experiences bolster their understanding of, and eventually their ability to impact, CLD schools. In addition, fellowships from doctoral training grants make it financially feasible for more teachers representing diverse backgrounds to consider advanced degrees and to work in higher education positions. To illustrate, half of O'Connor's funded doctoral graduates in the past 8 years have been Latina and now work in universities raising teachers and conducting research. These aspects of Leadership training grants make them especially promising avenues for reducing the shortages of dedicated faculty with experience working within CLD communities.

The training program model described here is grounded in research that has demonstrated the value of "hands-on" experience in socializing graduate students into professional roles (Brouwer and Korthagen 2005). The model addresses professional responsibility by supporting doctoral scholars in the development of research agendas central to the mission of schooling. By graduation, scholars are well-versed in how special education is and could be enacted in high-risk environments; they bring this knowledge to their leadership roles in the educational community. Collaborative university/community partnerships are central to the development of worthwhile research agendas and to the dissemination of research findings to improve the quality of schooling, especially for students who have special needs and who are CLD. Collaborative experiences also enrich scholars' skills for preparing teachers to be highly qualified and able to perpetuate professional responsibility in school cultures. In the end, this kind of collaborative work could lead to improved instruction, intervention, and learning for all students, and especially those who are most in need of these improvements.

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Chapter 9
Hidden Agendas Teaching and Learning in Medicine

Michael Wilkes

Introduction

Each night, in academic hospitals across America tired trainees seek to balance learning with clinical service. What happens to a junior medical student who is on call overnight with a senior resident, when the resident feels he needs some sleep?

Don't Wake Me Up[1]

Resident: *(walking toward the on-call sleeping rooms) The last thing I need to do right now is take care of Mrs. Smith's IV. Why don't you go put in an IV for Mrs. Smith so I can get a little shuteye? It's a pretty simple task – even a student can do it. She really needs to get the IV so she can get her meds.*

Student: *Actually, I've only done one IV before, but I'll give it my best shot.*

Resident: *Ok. But give it your VERY best shot because I don't want to be woken up. You can call me if you need me, but make sure you REALLY need me. Understand?*

This chapter draws heavily on the personal experience of the author who has spent 25 years training young physicians

[1] The dialogues reported in this chapter are drawn from videos produced by fourth year medical students in order to capture and communicate the essential features of their induction experiences.

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In this chapter we will look at the forces that drive both this resident and the student's thinking. We will explore what lessons this student is learning and what impact it will have on his future approach to patient care. What will he do when he fails at starting the IV – something for which there is a 30 % chance of happening?

The traditional relationship between society and medical schools, what Collotan calls the "traditional covenant," is based on the belief that society benefits from the contributions of academic medicine. In exchange for this covenant, academic medicine receives substantial public financial incentives that seek to assure that academic medicine will innovate, conduct relevant practical research, enhance the health of the community and train a group of highly qualified, devoted, humanistic physicians. In addition, the public provides academic medicine with its most trusted asset – it members – for students and housestaff to learn and practice their art. This trust between academic medicine and a perceived social need started with an educational mission, but has gradually shifted such that academic medicine is now intensely focused on the creation and maintenance of large biomedical industrial complexes. The drivers of academic medicine are no longer patient care and community health, but rather biomedical research, the acquisition of technology, the construction of new buildings and far larger faculties than are needed to deliver an educational mission. Academic medicine has drifted so far afield that the public trust has started to erode and the public is growing increasingly skeptical of the medical profession. As such, the public has started to remove some of the covenants that have been provided in the past that allowed the profession of medicine to oversee and govern itself. Some of these changes include re-examining self-policing of those who fail to conform to social expectations, re-defining its fees, re-defining its moral and ethical imperatives, and rethinking unofficial adherence to the Hippocratic oath. The public is now demanding accountability, transparency, and value for money. Substantially eroded is the assumption of a fiduciary responsibility. This is increasingly replaced by constant monitoring of task competence, recertification exams, board recertification, and investigative reporting by journalists.

Perhaps a recent clinical encounter can make this point most clearly. In this case an 85-year-old man with prior dementia developed multi-system organ failure including kidney failure, liver failure, and a wide spread infection whose source was not clear. The clinical team called a wise and experienced kidney doctor (nephrologist) to provide some guidance on how to manage the kidney failure. The nephrology consultant suggested a list of diagnostic tests (costing well over $3,400) and the initiation of renal dialysis. When asked why he had made such aggressive recommendations given the patient's age, grave condition, and very short life expectancy, he thought for a moment before acknowledging that he had been consulted as a nephrologist. He had answered the primary care doctor's questions thinking only of what was best for the person's kidney. It was not his job to consider the entire person that, he responded, should be left to others. This is a profound change from how a nephrologist would have perceived his role a decade or two ago when he would have considered the kidney in the context of the whole person.

Academic Medicine

For most medical schools, the education mission is no longer the predominant mission – in fact it is often number three behind research and obtaining income from patient care. Our medical schools are faced with a difficult task – they can change the pedagogy of medical education (although this is no easy task), but they cannot change the external practice environment – the health care delivery system. We have largely failed to acquaint our graduates with the needs of society or the many insights related to health gained from the social sciences or from the recent past (the history of medicine). In my medical school, like in most others, there is not a single lecture devoted to the history of medicine including serious mistakes that were made that should never ever be repeated. Clinical education remains predominantly hospital based, despite the fact that more than 90 % of health care is provided in outpatient setting and is community based. American academic medicine has not lived up to its social contract with the local, national or global health community and this is our great loss. Certainly there have been some changes in medical education, but medical education has remained essentially unchanged for 103 years. In 1910 Abraham Flexner wrote his report and devised the two plus two curriculum that created 2 years of basic science curriculum and 2 years of apprenticeship-based clinical curriculum. There has been some tinkering around the edges but no real wholesale changes particularly as they relate to the culture of medicine, medical education, and the role of the community in our work.

By any standards, training to become a physician is intense. Those selected to join the club are unique, and the ultimate work they will perform is more a life calling than a job. The practice of medicine is defined both by intraprofessional and extraprofessional norms. The editors of this book define four types of work tasks (labor, craft, art, and professional) and remind us that the practice of medicine includes all four types. Professional work takes the labor, craft, and art and adds to this a strong fiduciary responsibility. Over the last 100 years the driver for formal medical education was the vast amount of knowledge that could be crammed into a student's brain (and then quickly forgotten). Student assessments measured primarily ability to recall small obscure bits of information. Absent in medical education was attention to cognitive processing, decision-making, application of knowledge problem solving, communication skills, team and interprofessional work, the application of the social sciences to the practice of medicine, or training around moral and professional development.

It should be no surprise that well intentioned teachers and institutions often have unintended, and at times, undesirable consequences. In thinking about professional (or un-professional) behaviors it is helpful to consider the profession, the school, the teachers, the practice environment, and of course the individual. Only by understanding the impact and interaction of these various elements can we design better programs that return us to our covenant with society.

Professional Training

Let us look at medical education through the lens of social scientists. Max Weber defined sociology as the science of interpreting social actions and explaining the effect they produce. Today such interpretation is shared by a variety of social scientists including anthropologists, psychologists, and of course sociologists. Collectively they share the perspective that politics, economics, history, culture, and politics all play a role in shaping and maintaining norms of clinical practice. Early in their education students begin the process of indoctrination, socialization, and the creation of a shared culture – what I will refer to as the *culture of medicine* (as opposed to cultural issues related to our patients). Berger and Luckman (1966) describe this indoctrination process as the formation of a *shared mental conception of norms* that govern relations, behaviors, and self-perception. In education this indoctrination process is almost always silent, covert, and sub-rosa.

This script, like the others in this chapter, was written by one of our fourth-year medical students based on a personal experience in the hospital:

Faculty member and Resident are standing at nurse's desk as faculty writes a discharge note:

Faculty member:	*(to resident). We need to discharge some of these patients to lighten our load. Let's get the contraceptive consent form signed on all these postpartums. You speak Spanish, right?*
Student:	*Yeah, pretty well.*
Faculty member:	*Great. Just tell them we're giving them a shot that prevents pregnancy for 3 months, get them to sign. Don't spend a lot of time with them or we'll never get done.*
Student:	I *thought you told me yesterday that patients don't like the Depo shot because of side effects like weight gain.*
Faculty member:	*Yeah, those are my own private patients. They're able to remember to take a pill every day. You need a certain amount of responsibility to take a pill every day. In this population, it's a different story. We need to do the best we can, given what we've got to work with.*

This is a good example of the three parts of the medical curriculum. A quarter of a century ago F.W. Hafferty described three medical curricula that we teach. The first, the "stated curriculum" is what one finds described in the school's course catalog. It is a syllabus that tells you exactly what the lectures are, what should be read, and what content the exam questions will cover. The second curriculum is the "unscripted" or "ad hoc curriculum." This curriculum is delivered in the hospital or clinic. It is informal and not written down anywhere. It depends on which patients get admitted from the emergency department (ED) the night before, who gets discharged, and what diseases they have. In many ways, from the student's perspective, the unscripted curriculum has a great deal to do with which faculty member is present for the teaching. When Mrs. Rivera gets admitted from the ED, each faculty member will have a very different approach to teaching around her illness with

some focused on pathology, others on pharmacology, and still others on social and political issues related to reproduction. All faculty will teach medical content, but each student will leave the clinical rotation having focused on different topics. Rarely is this learning tracked or measured against a standard or template.

Our chief concern with medical education should be focused on the third curriculum that we teach – the silent, covert, sub-rosa curriculum mentioned above that is referred to as the "hidden curriculum." This curriculum is the set of influences that work at the level of an organization to define an organizational and professional culture. These learning events are unscripted, often unplanned, and usually deliver unintended messages that are conveyed by different people at different levels on the medical hierarchy – the faculty, the residents, the nurses, and others. Through observation and modeling of health providers, students acquire behaviors and traditions that they are likely to adapt and model and eventually pass on to others as they move from students to teachers. Perhaps an analogy might be that how we treat a beggar on the street is based far more on how we see those we respect (our parents) treat such people than on how we are told to treat them.

The above script is a classic example of the hidden curriculum at work. The physician's intended curriculum (stated) was to teach the student about a type of injectable reproductive contraceptive. This is not the place to review all the nuances of pregnancy prevention, other than to point out that the doctor is correct. Patients do not like this injection due to its side effects. The *ad hoc curriculum* was to teach about how to manage a busy clinical practice. The *hidden curriculum* is his unintentional modeling that there are two categories of people "us" and "them." He has included the student in the "us" category. He has separated patients into "my patients" and "ward patients" with health care being defined differently for each group. The fact is that neither group likes this injectable drug, but that does not matter as the ward patients will not be asked their preference and will not be informed of the unpleasant side effects. What this student will do with this hidden curricular lesson is unclear, and much depends on the status and respect provided to the faculty member. When this message persists through repetition and becomes associated with practices of the profession rather than with this one professor it is likely to be incorporated into new behaviors and attitudes by the trainee as the trainee seeks to conform and be accepted by this respected group of peers.

Medical Content

The traditional "stated" medical curriculum, which is overly heavy on basic science and departmental ownership, has crowded out other essential topics. Many of these crowded out topics are in the areas of communication, public health, health policy, community medicine, ethics, professionalism, health care organization, and financing. Even if these topics are taught in the first 2 years of medical school, they are likely to be ignored by many students because of the pressure of the basic science course load and the perception that these areas are not heavily represented on their examinations and in clinical practice.

If medicine is to remain a profession (as opposed to evolving into a trade) it will need to re-establish some early covenants that assure social needs are addressed.

Some attempts have been made in recent years to bring social science issues such as social determinants of health care disparities, preventive medicine, and health-related behaviors into the curriculum. Yet, these topics remain woefully under-taught in most medical schools, perhaps because for a long period of time these areas were considered the sole domain of public health. Great potential exists to include these topics in the third and/or fourth year where students may be more receptive to the topics and they have more clinical application, but this is rarely done. It is not done because clinical training is divided into specialty rotations (e.g., internal medicine, surgery, and psychiatry) and these social science topics are orphans belonging to no one specialty. This is unfortunate given the enormous health burden caused by problems and diseases that have a large behavioral and public health component (e.g., obesity, diabetes, smoking, substance abuse, etc.). The continued under-teaching of these topics has potentially serious negative consequences for the US population

The Culture of Medicine

Not only what we teach, but how we teach our medical students is very traditional and has implications for how they learn and practice. Medical school faculty insist on the importance of maintaining traditional lecture-based teaching despite a new educational environment filled with new options and opportunities for learning. Many faculty firmly believe that only lecture-based learning leads to long-lasting knowledge acquisition, after all, they report this is how they learned the material. They perceive new tools and approaches as "games and gimmicks." Yet, they fail to see that it is in our small groups, informal discussions that take place during surgery, jokes in the cafeteria, creation of habits and routines, patterns of academic promotion, and participation in medical rituals (grand rounds, morbidity and mortality conferences, clinical rounds, etc.) that we create the moral training that shapes tomorrow's doctors. Faculty are not willing to admit what research has shown us most of the knowledge acquired in a lecture theater will be quickly forgotten, proven to be wrong, or be determined to be irrelevant to clinical practice. However, the hidden curriculum is powerful, sustained, and regularly reinforced.

The practice of medicine is more than a collection of scientific truths – at its core it is a culture. Anthropologists define culture as a set of meanings, norms, beliefs, and values shared by a group of people. These attributes are learned, practiced, and passed along from generation to generation. Hendry Ton, a Californian psychiatrist who specializes in caring for recent immigrants, has spent years training junior doctors in approaches to care for people from very different cultures. He recently asked, "how do you convey the struggle of immigrants to those who have no concept of what it means to be a foreigner"? In the words of one recent immigrant:

> Coming here was difficult. I didn't know how to behave, what words to use, when to laugh or cry. I was either made fun of, or completely ignored. There were rare occasions when I was finally asked to do something and it made me feel wanted. But, then I didn't understand what I was being asked to do, or how to do the task. Only reinforced my immigrant status – I was an outsider who just couldn't break in. It was clear no one wanted me around.

Small linkages between cultures can make a huge difference. Ton points out to students the amazement of a recent immigrant from a rural community who, in a fog of social complexity and new rules, first notices that America also grows corn and rice. For this immigrant, this small observation – a link with their prior life – provided some solace. Most immigrants can easily recall vivid sights and events that, even years later, stand out from those first weeks in a new land.

Not surprisingly, one of the most significant barriers for any immigrant is language. Without language fluency integration and education is nearly impossible. Developing a sense of belonging to a new group is a slow process. New rituals can be complex and often cannot be understood through logic and reasoning because rituals are based on traditions and history whose origins are long forgotten and in current context they may not make sense. Immigrants are often the butt of jokes, prejudice and bias. As mentioned above, other times they are simply ignored. Their skills and value are assumed to be non-existent and they are often expected to work long hours for little pay. Isolation and loneliness is worsened by being torn from their friends, and family and traditions.

A medical student's journey from the role of interested observer to medical practitioner requires immigration from one world into another – from outsider to insider. The ultimate goal is membership in a new tribe with all the risks and hazards thereof. The quotation from the immigrant above is actually taken from an essay written by a new third-year medical student who has just left behind 16 years of classroom learning and is now placed into an intense clinical apprenticeship whose focus is perhaps 30 % on the acquisition of new content and 70 % on social indoctrination. This indoctrination requires learning behavioral norms, a new language, the expectations of various roles, a rigid hierarchy, rules around engagement with members of other tribes (nurses, pharmacists, etc.), a belief system and values that are expected to supersede the person's own personal ethnic/cultural background. There is a new language – both written and oral – with symbols and utterances that separate the tribe from the public and allow internal communication.

Acculturation begins with the competitive medical school admissions process. The women and men selected to be tomorrow's doctors are nearly always academic superstars. They come with strong values, a social commitment, a well-developed work ethic, and an impressive formal education. It is the process of medical education that pounds much of this out of them. They are taught that "outstanding" medical students are those who engage in biomedical research, have strong standardized test scores, and are committed to their training and practice and little else. Lost is any sense of work–life balance, perspective, questioning of the system, or value on diversity of thought or approach.

A Changing Medical System

American Medicine is at a crossroads not only because of the Affordability Care Act but because of profound changes in the external environment. The demographics of the American population are changing as the population ages. Disparities between

subgroups of people are becoming less and less acceptable. There is a new emphasis on evidence-based practice, which at its core questions orthodoxy and asks for credible evidence that something works before it is accepted into practice. This is in stark contrast to the tradition of simply accepting someone's word that a treatment works because that that is how it has always been done. Cost of care is rising, there are more non-traditional care providers, and more traditional care is being provided by a tremendous group of midlevel medical providers (PAs, NPs, midwives, etc.).

The organization of clinical practice is changing such that the vast majority of doctors are, or will soon be, employees rather than working in solo or small practices. As physicians become employees, the policies and expectations that govern their work are no longer determined by professional standards and self-enforcement but rather by rules set up by a myriad of institutional committees. No longer can a doctor even accept a hand shake and "thank you" or a dozen eggs in exchange for providing care. These acts of kindness have been replaced by billing rules and documentation codes that need to be entered into databases, and then there are concerns about malpractice that replace kindness with paranoia.

The expectations of the public have changed such that many people no longer completely trust their doctor believing that their doctor no longer has their best interest in mind. They question whether the doctor's primary allegiance is to saving their employer money, completing their day's work early, or getting gifts from a drug company. They cannot see that it is the system that is driving many, but not all, of these behaviors. Other members of the public complain they have lost any ability to communicate effectively with their doctor – in some cases because the doctor is rushed and in other cases the doctor just seems to go through the proscribed motions but fails to connect with them. In still other cases the doctor seems not to care, or not be able to listen – perhaps because she is burned out or trying to juggle many obligations at the same time.

Tomorrow's doctors will be asked, or perhaps required, to play a very different role in society. Are we ready to address this new role? Are we preparing tomorrow's doctors to address the problems that they will encounter? It was not very long ago that the doctor's black bag was filled exclusively with tools to treat "acute care problems," – infectious diseases, heart attacks, or an inflamed appendix – the sorts of things that would bring you to the emergency department. Illness has changed enormously over the past 40 years. Medicine has moved from treating primarily acute illness to treating primarily chronic illnesses such as hip arthritis, diabetes, obesity, chronic pain, hypertension, asthma, and even slow-growing malignancies. There are increasing problems related to declining cognitive function including Alzheimer's disease and vascular problems, families that cannot, or will not, care for their parents, and there are growing expectations that soon parents will be able to select more than the gender of their child including their hair color and IQ. Are we preparing tomorrow's doctors to deal with these ethical challenges?

American medical school curricula are focused on producing physicians capable of diagnosing and treating "disease" and there is an important distinction between an "illness" and a "disease." Disease is something that happens to an organ in a body – the brain, heart, liver, pancreas, or bladder. These diseases result in damage

to cells that impact on organ function. In contrast, an illness is a disease in the context of a human being, and that human is a member of a family, and that family belongs to a community. Medical education has done a good job of teaching around disease, but not such a good job of teaching around the ecology of illness.

This concept of disease has led to America spending more money per capita on health care than any other nation on earth. However, as measured by the health of our nation, we rank 46th in the world (just ahead of Serbia but behind Iran and China). It is time to go back and look at what role medical education plays in all of this. What is clear is that if we keep doing what we have been doing, we will be getting what we have been getting. What we do not teach – prevention, public health, and evidence-based medicine – might be having a huge impact on our population.

Too much attention is placed on what is often called the "basic science curriculum." It is driven by basic scientists who teach according to what they *think* doctors need to know, which is based on what they think their basic science graduate students need to know. All of this is in stark contrast to what clinicians need to know. We have implemented problem-based learning, case-based learning and team-based learning, but these new approaches still focus on teaching the same content with the same emphasis on evaluations (exams that reward recall).

Faculty are notorious for resisting change of the curriculum (the diagnosis is "curriculo-sclerosis" – a hardening of the curriculum such that it cannot be changed). While some argue that a reduction in curricular time devoted to the basic sciences would result in a "dumbing down" of the curriculum, the real fear may well be that if curricular time for basic science is reduced that some might question whether medical schools really need to employ such a large number of scientists at a medical school devoted to training physicians.

What all this basic science teaching has done is crowd out the opportunities to teach physicians about humanism and the art as well as the science (including social science) of topics relevant to the practice of medicine. No doubt that neurologists, radiologists, and surgeons may need special knowledge but does this content really need to be taught to every single graduating medical student? Why not create specialty learning tracks, akin to "majors" in undergraduate school, where medical student learn core material and then in their track learn what is relevant to their specialty?

How we learn is equally important to what we learn. As I teach medicine to groups around the world I have come to see American medical students as engaged, interactive, and inquisitive. However, a physician trained in the 1950s would be shocked (or perhaps pleased) at how little things have changed particularly in clinical teaching. We still teach by intimidation, by embarrassment, and by conformity. The student who asks "why" or "how do we know that works" is often labeled a troublemaker. There are lots of things that we are not teaching our clinical students. We are not teaching about the maintenance of health. We are not teaching about the prevention of disease or the management of chronic disease. We are not teaching about how to appropriately allocate resources, interface with hospice care, and streamline care. We are not talking or addressing the needs of our communities, which define health perhaps very differently than how we in medicine define health.

Failure to Change

In 1994, the American Association of Medical Colleges surveyed all graduating fourth-year medical students, just as they had done for a decade. Nearly a quarter of the nation's medical students felt that the teaching of basic sciences, biochemistry, physiology, and anatomy was excessive. At the same time, these graduating students felt a number of important topics were inadequately addressed included nutrition, pharmacology, medical ethics, sexuality, prevention and behavioral medicine. If we look at the list from a similar survey in 2013 very little has changed. Global health has entered the list of under-taught topics. It seems that our students recognize that we have a bigger obligation than perhaps just our own American health care. But the same topics continue to be both over taught and under taught. Perhaps, it might be suggested that students are too junior to know what is really required in practice, and that our faculty know best? However, when we look at surveys of medical school *graduates* who are 5, 10 or 20 years out of school, physicians do not tell us that they wish they had learned more biochemistry, anatomy, or molecular pharmacology. They tell us what was overlooked in their education were these same topics – nutrition, clinical pharmacology, communication skills, prevention, psychology of team work, substance abuse treatment, and management of chronic illness. So, clearly we in academic medicine have a collective mural dyslexia (failure to see the writing on the wall).

Our failings are not just in the area of content. We are also failing to model ideal behaviors and failing to talk about our service commitment. Our faculty are often overworked, stretched to the maximum, and living unbalanced and unhealthy lives. These are the doctors with whom our students engage. These are the lives that they are asked to model. Is it any wonder so few of our graduates have any interest in academic medicine?

Our students are disproportionately trained in the temples of medicine; few venture outside. That few students are devoted to serving underserved communities may be due to their lack of exposure to these communities. While most medical schools have optional community experiences students are often jettisoned into a community for a few weeks to "learn about the locals." However, there is no real engagement with these communities – no interaction with community leaders, teachers, teens, industrial workers, or religious leaders. The problem is that our medical schools are not really part of those communities. We do not see and understand the people living in these communities. However, when members of the community get sick we desperately need them to come to our hospitals so that we can learn on them, and we need them to donate their bodies to us so that we can use them for learning.

We constantly confuse teaching and service. What follows is another script by a third-year medical student who is again on the wards in gynecology. He has worked all day and it is nighttime. He has been asked to see a woman who is concerned about vaginal bleeding and to report his findings to his resident who is quite busy. His skills are appropriately still in development, as he is just in the third year of medical school.

Resident: *(speaking on the phone) How far apart are the contractions? Was there any movement?*
Student: *(trying to get the resident's attention) Toni? Toni, can I tell you about a patient?*
Resident: *Yeah. (speaking to the phone) OK, I'll be right up to deliver the baby.*
Student: *(speaking to resident) Toni? Yeah, I just looked at that vag bleed you asked me to see. I'm not sure if there was a vag bleed. I didn't see any blood. But I did find a white cottage-cheesy discharge though. But I've only done a couple of pelvics in my life.*
Resident: *So you didn't see any blood?*
Student: *No, not really, no blood.*
Resident: *In that case, it's probably just a yeast infection. (handing the student a paper prescription) Here, give her this script. She'll be fine.*
Student: *Yeah, but I told her that you were going to come down and check her out. She knows I'm only a student. She's still in the stirrups.*
Resident: *Look, I have three patients in labor I have to get to. I completely trust your exam. Just give her the script. I've got to go now.*

This medical student is now in a position of being uncertain about his own observations and his diagnosis. He is concerned that his oral report to the resident has impacted the woman's treatment. However, he is not certain and feels uncomfortable committing to something he has not seen before. He is unskilled at telling someone more senior than he that he does not know what he is doing; that he has never seen this condition before. He omit push the issue because he knows she is grading him. The resident might describe her goal as teaching the student "responsibility" and "commitment" for making decisions. But, as Kathleen Montgomery points out (Chap. 5 in this volume), responsibility has both *normative* (voluntary) and *coercive* (non-voluntary) elements. In this case, the normative response would assure the student accepts the moral requirement to help his patient. The coercive elements of this encounter are driven by the pressure for the student to follow the instructions of his superior, in this case his resident, who will be evaluating his performance. He is caught in a moral dilemma – admitting his ignorance and wasting his resident's time, or going along with a concocted diagnosis that puts his patient in jeopardy but does not risk shame or humiliation in front of the resident. He is quickly indoctrinated to be part of this system; it is better not to upset the resident as she will grade him and will control his life for the next 4 weeks.

What we teach is of course different from what others learn. This moral issue is not part of our intended curriculum. It is not described in any curriculum syllabus or medical school database. It is not defined as a competency to be mastered. However, at the end of the day, he has not learned anything about vaginal bleeding. He has not learned anything about cottage cheesy discharge. But he has learned how to survive in a medical hierarchy, how to treat patients in the face of uncertainty and how to cover for yourself when you do not know what you are doing. This is our hidden education system.

Medical education is a cultural process in flux. It is constantly being pulled and pushed both by internal and external forces. When a new school or a new curriculum is announced, the very work of developing and implementing that curriculum conveys to the faculty, the students, and the community messages about what is and what is not valued. Within the school, that which is selected to be taught has an existence and therefore a potential impact. What time a lecture is given, who gets the primo spot at 9:00 or 10:00 or 11:00, and who gets the spot at 17:00 or 13:00 in the afternoon conveys a great deal about worth. So, do how people are treated.

In this next script an intern has inserted a catheter into a sick person's neck vein to administer medication and fluids. Protocol would have her check an x-ray after the procedure. In fact, she ordered the x-ray, but over the course of a busy night she needed to care for other patients and she forgot to check the x-ray which would have revealed a partially collapsed lung. The patient died in the early morning. Note how the faculty member handles the intern's oversight. The intern is clearly distraught with her mistake and wants to engage with the patient's wife but that is not how things will unfold.

Dr. Maxwell (faculty physician):	*It helps that this man was terminally ill and was going to die soon anyway, but I can't believe we didn't check the x-ray.*
Intern:	*I'm so sorry, Dr. Maxwell. We did order the film right after I put the neckline in. We meant to check, of course, but we just got so busy overnight that it slipped our mind…*
Dr. Maxwell:	*Meant to just doesn't cut it. When we're doing procedures on people that have life-threatening complications, you have to check if there are complications. If you fail to do that, people are going to die, like this man died.*
Resident:	*Well, Dr. Maxwell, if it's anyone's fault as the resident I take responsibility I should have checked to make sure the x-ray was cleared.*
Dr. Maxwell:	*Actually, it's my responsibility. I'm the faculty physician of record here. I'm responsible for all these patients. When the lawsuit comes, I'm going to be the one named in the lawsuit. On the other hand, (directed to intern) this was your case, wasn't it? You were the intern. You were responsible for the care of this patient. As the intern, you ordered the x-ray. You failed to look at the x-ray. That is not acceptable, it's not professional and this man died because of it.*
Intern:	*I'll tell his wife. I know her from last night.*

Dr. Maxwell: *We shouldn't tell the family anything at all about this. It won't help them, it won't help us, and it won't bring the patient back. I'll talk with them now, and tell them he died but none of the details. We'll resume rounds here in an hour.*

This chapter is about the culture of medicine. The hidden lessons that have been conveyed to the intern, resident, and medical students who were standing around is profound. This intern is low on the totem pole of seniority. She messed up, and she knows it. She is smart, and was trying to work hard, trying to care for all the patients who came in after Mr. Finley. But, she should not have been left alone with an excessive amount of work. And, now following an error, that might have left a man dead, she should not be left alone to deal with her error. The system needs to stand with and provide her support and model practice-based learning. It was the system that also messed up. There should have been checks and balances to prevent this common type of oversight.

How is she going to deal with her error? Will she go home and cry and engage in self-blame and consider what a poor physician she is? Will she ignore the problem; push it under the rug, because that is emotionally easier than dealing with her fallibility? Will she turn to drugs, alcohol, or take it out on her children? How will team members who are watching all of this deal with their own errors in the future? Perhaps now they would not even admit to them, since as the faculty member has taught them, it would not make a difference. The reason it would not make a difference is because the doctors, the institution, and the team have not taken any steps to prevent this from happening in the future. Each member of the team will absolutely make mistakes in the future. What a wonderful opportunity to teach around truth telling, admitting an error, dealing with the office of risk management and looking at prevention of error? All of these are missed educational opportunities that are part of the hidden curriculum of medical school and part of its culture.

The Way Forward

Few in medicine are teaching how to question conventional wisdom, yet the public's health depends on physicians and students questioning why we do things and what comes next. The educational outcomes that we have traditionally held as sacrosanct (memorization and good test taking) have changed. There is no need to memorize long lists of items anymore. Everything can be easily found on a smartphone. Every dose, every nerve connection, every anatomic bone, every metabolic pathway is on a smartphone or tablet. What students need to learn is how to think critically, how to reason, how to be ethical, and how to communicate and connect with people.

Education is at the bottom of the academic medical totem pole. Our faculty get very little attention or reward for their teaching. The expectation is that faculty are supposed to be so excited and enthralled with teaching that they fight with each other to do it for free. However, this in not happening. Faculty need to invest their

time to create high quality, active curriculum and this takes time away from reimbursed activities. The end result is that teaching in a medical school is often like horse trading with everyone trying to trade out of it. We need to think of new ways to incentivize faculty to be good teachers and curriculum developers.

We can, and will continue to, lecture our students. We can talk to them about sensitivity, ethics, professionalism, and cultural awareness day in and day out. But how we behave and how we serve as role models is what is learned remembered and practiced. Substantial student learning takes place outside of formal learning environments instead occurring in operating room waiting areas, elevators, hallways, and in the cafeteria. Planning and developing what has been hidden curriculum to make it explicit and visible requires a culture of openness and self reflection. It requires a multidisciplinary perspective and team work. It also requires that people from the community move from being our "patients" to being our partners and planners and advisors.

For fundamental change to really occur in the practice of medicine, major structural barriers internal and external to academic medicine need to be overcome. There exists here a Catch-22 in that medical education cannot be successfully changed until the larger practice environment and culture of medicine changes. However, the larger culture and practice environment cannot change without new thinking and practice behaviors required of a new breed of practitioner. But, we can start this change and hope that the Affordability Care Act will bring new external changes and realign power structures some of which have propped up the old and sagging system of medical education. In medical school important topics remain under-taught while others are over-taught or significant time is spent addressing unimportant topics (e.g., the life cycles of 8-10 different parasites) that may be critical to graduate students or faculty but are not relevant to medical students. If medical education is to reach its full potential, serious issues including admissions criteria, incentives for learning, the role of standardized testing, the impact of the hidden curriculum, student anxiety and depression, and support for faculty teaching need to be considered and addressed.

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Chapter 10
The Role of Incentives in Promoting Professional Responsibility

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Introduction

Law and medicine are among the two most recognized professions in the world. Providers in medicine and law, in particular, are regarded as professionals based on (1) superior learned knowledge and skills, (2) care, concern and assumed responsibility for an aspect of the public's wellbeing, (3) provider–consumer relationship built on a foundation of trust, (4) work that is regarded as having moral and/or ethical implications, and (5) power advantage on the part of the provider relative to the consumer due to information and knowledge asymmetry.

The concept of teacher professionalism on the other hand is debated among scholars and practitioners alike. The notion of professionalism in education is largely discussed in the literature on sociological, educational, and ideological bases (2010). While many today do in fact regard teaching as a profession, opponents characterize teaching as a semi-professional occupation due largely to the lack of research-based standards and procedures and limited teacher autonomy (Demirkasimoglu 2010; Petersen et al. 2006). However, professionalism may be aptly regarded as an ideological construct of worker activity, attitude, and behavior encompassing: (1) expert knowledge and high skill level, (2) a relationship of trust between the provider and the consumer, (3) a reasonable degree of autonomy, (4) ethical and moral code of conduct, (5) priority of consumer interest ahead of self-interest,

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and (6) responsibility for consumer outcomes (Demirkasimoglu 2010; Deci et al. 1999; Wynia 2009). Given this perspective of professionalism, both medicine and education can be considered as professions.

Although physicians are the dominant provider of clinical services within the health care system and their work embodies the ideological construct of a professional occupation, the health care sector continues to grapple with many issues and challenges. Even with the passage of the Affordable Care Act in 2010, a major piece of reform legislation, significant concerns remain regarding the efficiency, efficacy, and equity of the U.S. health care system. The United States spends substantially more per capita on health care than any other nation; however, by various mortality and morbidity measures, it achieves significantly worse health outcomes than many other developed countries. Over the past few decades reform efforts have focused on addressing the challenges of: unsustainable growth in costs, increasing financial burden on individual families and government budgets, inefficient care delivery, and increasing number of uninsured and underinsured. The complexity of the health care system with its multiplicity of stakeholder interests, and vast array of policies, regulatory requirements, and programs is daunting. The need for leadership, improved practices and different attitudes among the sector's key stakeholder, physicians, is an imperative of some urgency. Strengthening professionalism and professional responsibility among physicians will foster progress toward improvements in health care that are essential to its long-term viability and effectiveness.

As with the health care system, the educational system in the United States faces substantial challenges. The United States has a pressing need for a highly educated workforce to continue its leadership position in the increasingly knowledge-based global economy of the twenty-first century. Thus, according to Ravitch, "[t]he nation faces a daunting challenge in making sure that we have a sufficient supply of well-educated, well-prepared teachers for our children" (Ravitch 2003). The education sector is challenged by several issues that it must overcome if it is to succeed in adequately preparing the next generation of leaders and workers that are desperately needed. Among these challenges are: underperforming schools, achievement gaps among socio-economic and ethnic groups, relatively lax academic standards, a lack of readiness for higher education for those seeking a college degree, and shortages of teachers in Science, Technology, Engineering and Math (STEM) fields. For the education sector, enhancing professionalism is an ultimate goal as well as a tool to improve performance outcomes and the practice environment (Evans 2008; Glazer 2008).

Health care and education have several commonalities beyond their professional framework. Both are important determinants of individual well-being and form the basis of "human capital." Indeed, the often-used Human Development Index is composed of three indicators: gross national income per capita, mean years of schooling attainment, and average life expectancy at birth (Stanton 2007). In addition, health care and education are two of the largest sectors in the U.S. economy, together representing a quarter of the economy (Sawhill 2013). Both sectors have been

plagued with issues and concerns related to cost, quality, and access. Further, education and health care have consistently been high on policy agendas at the local, state, and national levels. While policy makers, government officials, industry leaders and consumer groups are in general agreement pertaining to the need for education and health care reform, there is no consensus regarding effective solutions to address the persistent and multi-faceted issues ailing these two sectors. What seems essential is that dominant professionals in these two sectors must play important roles in shaping the reforms of the future.

One way in which educators and physicians are seeking to address care and cost issues (as well as access and efficiency) in the education and health sectors is through enhanced attention to professional behavior of teachers and health workers. While one hopes that individuals with professional values self-select into the teaching and health professions, there may nevertheless be a role for incentives in encouraging and inculcating professional conduct among workers in these two sectors. This chapter examines the role of incentives – both financial and non-financial – in promoting professional responsibility among providers in the health care and education sectors. The chapter evaluates the evidence on the current use of incentive schemes within these sectors, and assesses whether and how these incentive schemes have led to more professional responsibility on the part of educators and physicians. Finally, based on the evidence surveyed, the authors propose key elements of an effective incentive scheme that can lead to greater professionalism among educators and physicians.

Understanding Incentives

The concept of incentives is central to the field of economics. Price incentives play an important signaling role in the efficient allocation of resources in an economy. When a good is in short supply, its price increases, thereby providing an incentive for producers to produce and sell more of that good and providing a disincentive for buyers to buy the good. This aligns supply and demand. Likewise, by signaling a shortage of labor in a profession or occupation, rising wages provide an incentive for workers to enter and provide their labor to that profession. Incentives can shape all kinds of behavior, not just among individuals but also among firms, governments and societies. Increasingly, conditional cash transfer programs are being used by governments around the world to combat poverty and bring about social change by providing money to poor families contingent on certain behavior (e.g., vaccinating their children or keeping their children enrolled in school). Thus, welfare payments are used as an incentive to alter recipient behavior in a way that promotes investment in human capital (e.g., increasing schooling or improving children's health) (Rawlings and Rubio 2005). Organizations and other entities, including governments, have long used incentives to attract, retain, and motivate their staff. However, incentives often produce both intended and unintended consequences and

outcomes. There are different types of incentives; Clark and Wilson (1961) identify three types:

- *Material incentives* – monetary rewards such as wage and salary compensation, fee reimbursement for services, etc.
- *Solidary incentives* – intangible rewards from the act of association (e.g., sociability, status, identification)
- *Purposive incentives* – intangible rewards related to the goals of the organization.

Freidson (1990) distinguishes between three types of labor markets. The first is the perfectly free labor market, where workers are primarily motivated by monetary gain and have little interest in the kind of work they do, or the manner in which they do it. In such a market, workers have no attachment to any particular workplace and will move from one job to another on the basis of differences in pay. The second type of labor market is the bureaucratic labor market, where the actions of the worker are considerably more circumscribed and the employer (usually a government agency) is in much greater control. Bureaucratic jobs are often characterized by security of (often lifetime) tenure and well-established rules for promotion. The professional labor market is the third type of labor market where only workers having certain (occupational) qualifications can compete for jobs. Within this type of labor market,

> While there is some economic competition among members of the occupation within their sheltered position in the labor market, their occupation's emphasis is on community and 'brotherhood' or collegiality… their central commitment is to do the work well and to gain the approval and respect of their colleagues… what is applauded is the quality and virtuosity of work irrespective of cost and even outcome… Committed to their work, professionals believe it to be both intrinsically valuable and beneficial to others. In performing their work, therefore, they believe they are contributing to the well-being of others, and that their commitment to their work represents commitment to serving the good of others (Freidson 1990).

Thus, the extent to which any particular type of incentive matters will depend upon the type of labor market. In the perfectly free labor market, monetary incentives will matter a great deal as workers are motivated entirely by pay, not by the kind of work they do. In the bureaucratic labor market, monetary incentives will be much less important than the predictability and security of employment as well as promotion within the hierarchy, all of which can be gained by workers conforming to the strict standards put in place by the bureaucracy. In the professional labor market, the incentives that matter will be recognition from fellow-workers and colleagues in the occupation that the worker is doing high-quality work and contributing to the well-being of others (especially his or her clients).

Yet in reality, these distinctions are too extreme. It is unrealistic, for example, to think that workers in perfectly free labor markets will only be motivated by monetary incentives and not be influenced by the quality of their work. Likewise, professional workers do face competition from within and outside their occupation and are likely to be influenced somewhat by monetary and solidary (e.g., promotion) incentives.

Prevalence and Effectiveness of Incentives in Heath Care and Implications for Professionalism

That pervasive issues threaten the U.S. health care system is a commonplace observation in the press and in an extensive and well-documented scholarly literature. Other authors in this volume confirm the general agreement that reform of the health care system is needed to address unsustainable growth in costs, large numbers of individuals lacking adequate health coverage, uneven quality of care, and large disparities in health outcomes. However, the proposed reforms vary considerably. They include the following:

- Reducing the role of the pharmaceutical industry in funding medical research
- Reducing direct marketing of pharmaceutical products to patients and doctors
- Replacing the fee-for-service reimbursement model with bundled payments to teams of primary care physicians, nurses, specialists and physician assistants based on improvement in patient health outcomes
- Reorienting medical education toward primary health care and community medicine
- Devising new incentives for professional behavior in the health sector.

Other authors in this volume have noted that distorted market incentives have reduced professionalism in both medical education and in medical practice. For instance, as Simmons, Olds, and Schiller point out (Chap. 7, this volume), large disparities in salaries across medical specialties have skewed the orientation of medical education, resulting in the over-production of specialists and an under-production of primary care and family medicine physicians. In addition, because of the asymmetry of information that exists between suppliers and consumers, suppliers are able to encourage consumers to demand more health care services than is optimal ("supplier-induced demand"). In addition, fee-for-service-based reimbursement systems encourage greater utilization of services (sometimes unnecessary or even harmful), increasingly specialized interventions and procedure-based medicine, resulting in diminished focus on patient and community health outcomes. The fee-for-service payment structure has also driven up health system costs and encouraged increasing specialization in the practice of medicine and thereby in medical education (Allen et al., Chap. 3, this volume).

The presence of perverse incentives in health care is not limited to physician services. Misaligned incentives also exist in other segments of the health care sector. In the pharmaceutical industry, drug companies undermine the doctor–patient relationship through the aggressive marketing of prescription drugs and, more recently, have been accused of influencing research priorities and research findings in the medical community. Thus, it must be asked whether incentives can be designed and implemented to insure that health system improvements are achieved or to facilitate greater levels of medical professionalism.

Medical professionalism includes a range of responsibilities related to such matters as clinical quality and outcomes management, patient safety and errors related

to informed consent, accreditation and compliance, and accountability for services provided. Medial professionalism also requires a commitment to clinical, business, and organizational values and ethics and a striving for excellence in standards of care and service delivery. The key to addressing these issues may lie in the cultivation of professional behavioral norms that include inquiry, introspection, and integrity. Medical professionals can hold themselves accountable by placing the utmost importance on patient welfare, using systematically applied treatment regimens, obtaining knowledge and skills which develop their professional capacity, and being able to explain and be answerable for clinical actions (Deci et al. 1999).

Financial incentives are increasingly being used by government and private organizations as a vehicle to encourage desired provider behavior (Woolhandler et al. 2012). Because the health care sector is primarily in the business of providing clinical services to vulnerable patients, it creates a moral and ethical obligation to continually evaluate the value of these services and the motivations for providing them. This moral and ethical obligation may also be defined as a professional duty that is demonstrated by attitudes, knowledge, and behaviors that align with the standards, regulations and principles of a complex health care environment (Deci et al. 1999). Therefore, the question becomes whether financial incentives can be truly viable tools to achieve the type of medical professionalism that has been described while safe-guarding its historic moral and ethical tenets.

Pay-for-performance systems are increasingly being used by many health care organizations, including Medicare and Medicaid in the United States, the Joint Commission, the National Quality Forum, the Agency for Health Care Research & Quality, and the American Medical Association – not to mention a variety of corporate and insurance interest groups in an effort to enhance quality and desired outcomes (Hendrickson 2008; Woolhandler et al. 2012). Pay-for-performance incentives in medicine seek to address the issues of self-interest that are intrinsic to the usual fee-for-service setting, in which rewards are based on quantity rather than quality of care leading to suboptimal utilization of health care services (Hendrickson 2008). The current fee-for-service payments system encourages physicians to induce demand in order to obtain higher incomes (Luft 2009). Studies that criticize the fee-for-service payment model in medicine show that physicians respond to incentives, as expected, by providing more services – even though these services may be of questionable value or even harmful (Wynia 2008; Welch et al. 2011). Additionally, under the fee-for-service payment structure, time spent performing procedures is more highly compensated than time spent with patients or managing care. The model also does not offer incentives for physicians to efficiently coordinate care supplied by other providers (Petersen et al. 2006). Ensuring fair and adequate compensation via salaries rather than fee-for-service methods can help combat this issue, but it may also lead physicians to reduce the quality of their care or even refer their patients elsewhere just to lighten their workloads (Mechanic 2008).

Examining the literature on pay-for-performance and other quality-based financial incentive systems currently being used in health care will allow us to gain insights into their potential potency for cultivating greater physician professionalism

and how best to design them to foster higher-quality health care service delivery, better patient outcomes, and a more efficient use of scarce health care resources.

The basis for the confidence in incentives to influence human behavior is grounded in micro and behavioral economics, agency theory and cognitive psychology (Woolhandler et al. 2012; Conrad and Perry 2009). It is well established that people respond to rewards. Research findings confirm that in some settings financial incentive programs can and do improve employee performance. Studies have shown that pay-for-performance systems in medical care have been somewhat effective in increasing desired performance measures because pay-for-performance systems seek to align physician self-interest with professionally desired outcomes (Petersen et al. 2006; Wynia 2008). According to Petersen et al., partial or positive effects of financial incentives on measures of health quality were noted in several studies of both physician-level and provider group-level incentive programs (2006). However, other meta-analyses have shown that this is not always the case in complex systems such as the medical field (Mechanic 2008). Studies have also shown that if more cognitive, open-ended thinking is involved in a task, people will perform it poorly if they have been led to do so for a reward (Wynia 2008). As Wynia notes,

> [T]he central premise of pay-for-performance is that if you pay people to do something, they will do it more often… [But] a great deal of experimental evidence from both social psychology and econometrics suggests that when an activity is largely driven by internal motivations—such as professionalism or pride in the quality of work one achieves—adding an external (e.g., financial) motivator can actually backfire, often dramatically (2009).

Thus, it is unclear the extent to which financial incentives actually facilitate improvements in the provision of high-quality health care services is unclear. However, what seems to be clear is that using financial incentives to improve health care quality in a professional medical context poses both moral/ethical and operational challenges and risks (Hendrickson 2008).

In many instances, opportunities for physicians to increase their incomes have caused financial pursuits to trump health care professional responsibility and ethics (Luft 2009). Over the long term, financial incentives do alter the relationship between the worker, the payer, and the task at hand in a counterproductive manner (Wynia 2008). Financial incentives are likely to produce unintended consequences such as adverse selection (avoiding more acutely ill patients), reduction in intrinsic motivation, attention shift (incentives in one area of practice can decrease activity in another), gaming (attempting to achieve incentives with disregard for patient benefit), harm to the patient–clinician relationship, and a reduction in equity of the age, sex, and race of those receiving rewards (Woolhandler et al. 2012; Mechanic 2008; Petersen et al. 2006).

Improvements gained by using financial incentives are difficult to maintain in the long run due to the law of diminishing marginal return (Conrad and Perry 2009). Further, claims data are often the primary source of information upon which the evaluation of pay-for-performance programs is based. The use of this information has been criticized because it does not reflect the complexity of a patient's condition and has potential for high levels of inaccuracy, sometimes due to falsification (Hendrickson 2008). Clinical behavior can be modified through many different

interventions, such as education, audits, collaboration, performance feedback, regulation, public reporting, and financial incentives. However, evidence to support specific intervention strategies is weak because no one strategy is consistently effective (Mechanic 2008).

There is considerable risk in giving rewards to individuals rather than teams, rewarding very specific tasks, rewarding in ways that are externally controlled, and using rewards that are too small (Wynia 2008). Rewards succeed at acquiring momentary compliance – once they run out, people will return to their old behavior. Incentives cannot successfully change the attitudes that cause and justify behaviors, nor can they generate a resilient commitment to ethical or moral actions. Moreover, rewards that produce an environment which emphasizes control rather than exploration and development will likely result in less innovation, less effort, and a decreased personal interest in the task (Hendrickson 2008). Evidence seems to suggest that financial incentives/rewards reduce intrinsic motivation and may lead to poorer performance of complex tasks (Woolhandler et al. 2012). A common concern that has been widely studied is that physicians who participate in pay-for-performance will act to improve their outcomes by refusing to provide care for patients who are poor or very sick. Inadequacy of care for patients who are the sickest does remain an unintended negative outcome for this program (Hendrickson 2008). Few studies have examined group rewards and have gathered little data on unintended consequences of incentives such as attention shift, competition, and lack of motivation (Mechanic 2008).

The key conclusion from the empirical evidence contained in the literature on the effectiveness of financial incentive programs to enhance health care quality is that such programs must be well-designed if there is any hope that they will achieve their stated objectives and desired outcomes. Given that professionalism is associated with diverse behaviors and attitudes, using incentives to positively influence them is a proposition that all the more requires careful design and thoughtful implementation.

Prevalence and Effectiveness of Incentives in Education and Implications for Professionalism

As in the health sector, the issue of reform has loomed large for several decades in the education sector as well. Prevailing concerns include: improving student learning, eliminating educational disparities, enhancing teaching practices/pedagogy, curricular improvements, cost, access, and accountability, among others. The importance of a quality education has significance both for the individual as well as society. The demand for a highly skilled and educated workforce is considerable in the knowledge-based global economy in which the United States competes. Further, the ranking of the United States in international comparisons of educational outcomes have stagnated over the last decade (Washington Post 2013). The future competitiveness

of the U.S. economy will depend on how effectively the next generation of Americans is educated and trained.

There have been numerous efforts to professionalize education and the teaching vocation. These efforts have not only sought to secure for educators higher wages and greater autonomy, but also elevate performance outcomes, increase standardization of best practices, and improve equity. While not immediately apparent, there are many incentives in the education sector that detract from professional behavior. Teacher tenure does not assure quality teaching and can lead to ineffective teachers remaining in the classroom indefinitely. Seniority-based teacher pay can stifle innovation in the classroom and offer little incentive for teachers to improve their teaching effectiveness. It is also believed that the goals of teacher unions are not in line with the goal of improving teacher performance, as contained in most collective bargaining agreements (Eberts et al. 2002). Most public school teachers are salaried, and these salary scales are generally determined by a teacher's educational level and experience, not by their performance (Figlio and Kenny 2007).

Can incentives be designed and implemented that facilitate and encourage greater levels of educator professionalism, yielding better educational outcomes, greater accountability, increased standardization, and also the cultivation and fostering of innovation and creativity in educators? Examining the empirical evidence of the effectiveness of incentive systems and programs in the education sector provides some insight.

Historically, incentive-based pay schemes for teachers were not that uncommon. For example, the percent of U.S. school districts using merit pay was as high as 48 % in 1918. However, the single salary schedule began to be increasingly adopted with the changing nature of school (from small rural schools to large school districts), and the proportion of school districts using merit pay declined to 20 % in 1939 and then to 4 % in 1953 (Figlio and Kenny 2007). More recently, however, the tide has turned, with increasing recognition that teachers are the most important input in the "production" of student achievement. This has led to researchers attempting to measure teachers' "value added" – the net increase in student test scores attributable to a teacher, after controlling for household background and socioeconomic status of neighborhoods (Chetty et al. 2011). As a result, performance-related pay for teachers is being introduced in many states (and even countries) despite widespread controversy and opposition from teachers and unions. A few states have mandated merit pay programs in public schools. Yet the actual use of merit pay has not been subjected to rigorous evaluation as to its effectiveness (Figlio and Kenny 2007).

Though it is true generally that most people respond to incentives, in the particular case of teachers there are many barriers between performance measures and the actions of teachers that diminish the effects of incentive-based compensation measures. In general, the research on the effectiveness of performance-based compensation and other incentive programs in education is sparse. There is some observed evidence on the effects of merit pay on student success, but, for the most part, what has been studied is too limited for the results to be generalizable on a broad scale. For example, Woessmann (2011) found that there was a significant correlation between student achievement in math, science and reading and the use of teacher

salary adjustments according to performance levels, and this is true across several countries. Woessmann also noted that math scores were one-quarter standard deviations higher in countries with performance-related compensation systems, after controlling extensively for other variables. Similarly significant associations were found for reading and science achievement, though not as substantial.

Performance-based pay can promote both incentive effects – increased motivation and effort among teachers – and sorting effects – attracting and retaining teachers who anticipate success under these types of compensation schemes. These two factors are especially relevant to improving student outcomes when considering recent evidence that teacher quality is highly important for student achievement. These results suggest that students in countries that utilize teacher performance pay have higher test scores in math, science, and reading than students in countries that lack these incentive programs in schools. This association is illustrated by about 25 % of a standard deviation for math and reading tests, and 15 % on science. There is evidence suggesting that these associations are stronger where parents have higher socioeconomic statuses, and when students speak a foreign language at home. Teachers with any post-secondary degrees in education are positively correlated with student achievement, but only in countries that do not incorporate performance-based pay. Controlling for a wide variety of alternate salary adjustment devices which are based on different criteria, such as teaching conditions and teacher qualifications or demographics, confirms that these results do not illustrate the overall effectiveness of a general flexibility in pay scales, but rather is specific to performance-based systems (Woessmann 2011).

A positive correlation between individual teacher incentive systems and student achievement in Israel was documented in a study by Lavy (2002), who found that large incentives were associated with increases in test scores directly rewarded by the program.

There are two different interpretations of the finding that individual teaching incentives and student achievement are positively correlated. The first is that the incentives must then prompt more effort from teachers, resulting in higher test scores. The second is that schools that are effective in ways which are not as easily measured as test scores would be more likely to integrate individual teacher incentives, indicating that such results are spurious (Figlio and Kenny 2007).

However, in a study of a school district in Pennsylvania, no correlation was found between improved student achievement and teachers who were awarded merit bonuses. Yet, it was noted that the incentive system placed great significance upon student outcomes such as attendance, participation, professional development, and extracurricular activities. In a study conducted by Eberts et al. (2002), merit pay incentives did improve course completion, though average student success was negatively affected, and no standardized testing measures were used to measure learning outcomes. Eberts' conclusion was that the merit pay system at this particular high school did "work," because the system's outcome variable was student retention. However, student GPAs, attendance rates, and course passing rates in fact declined following the system's implementation. In addition, there were anecdotal indications that course content was weakened.

According to Figlio and Kenny's 2007 study, student test scores were higher at schools that offered individual financial incentives for high performing teachers. However, it was not clear whether the correlation was due to the incentives themselves, or because better schools typically are those that would implement these programs. Further, the findings could also reflect students learning more in schools that use merit pay systems because of teaching innovations rather than the incentives. Another interpretation issue occurs, because better schools are more likely to implement performance-based pay schemes for teachers, and because teachers and students will probably want to work at/attend these schools on the basis of their performance-based pay program, presenting a significant selection bias problem (Woessmann 2011). There simply is no possible way to remove all doubt that the positive association between teacher incentives and student achievement is actually due to the school's unobserved, already high levels of quality (Figlio and Kenny 2007).

There is also some evidence from outside the United States on performance-based pay for teachers. One of the most rigorous studies of teacher performance pay comes from a 4-year randomized control trial (the "gold" standard in evaluation research) undertaken by Muralidharan and Sundararaman in 500 rural government schools (with a student population of 50,000 in grades 1–5) in the Indian state of Andhra Pradesh (Muralidharan and Sundararaman 2009, 2011). Four interventions were piloted randomly across the schools: two incentive schemes, an individual teacher bonus and a group teacher bonus; and two input schemes, provision of an additional contract teacher and of a block grant to the school. The experiment also included a comparison group of 100 schools. Two years after the experiment began, all four schemes had improved student learning. However, students in schools with performance incentives for teachers performed significantly better than those without, by 0.28 standard deviations in math and 0.16 in language tests. Incentive schools also showed better performance in subjects for which there were no bonuses, suggesting positive spillover effects. In the first year, the team-incentive and individual-incentive schools performed equally well, but in the second year, the latter schools outperformed the former. Incentive schools also performed better than schools that received additional schooling inputs of the same value. It was also found that combining incentives with training and improved inputs increased teacher effectiveness.

Teachers perform multiple tasks within their discipline, including but not limited to curriculum development and planning, instruction, and assessment. This implies evaluation based on multiple corresponding performance measures, putting a strain on incentives-based compensation systems, especially when the measures themselves are difficult to obtain. Multiple stakeholders also cause problems for incentive-based compensation programs because they tend to create conflicting standards and organizational goal misalignment. These sorts of issues limit the effectiveness of incentives-based compensation programs – as do poorly measured outcomes, assigning individual incentives when team production is required, and conflicting demands from multiple stakeholders, which are common elements of current teaching and learning processes. These results suggest that, while pay-for-performance

incentive schemes in education can produce desired outcomes, such schemes used in such highly complex institutions as schools involve factors that can undermine incentive effectiveness and may actually produce unintended negative consequences. Learning outcomes in the U.S. education system are evaluated through standardized testing, even though there are many additional dimensions of student success and development that are either assessed in this same standardized, objective metric, or worse, not assessed at all (Eberts et al. 2002).

One significant issue with the implementation of a merit pay system in Eberts et al.'s study arose from the need for output measures to be agreed upon ahead of time and measured in easy, inexpensive, and accurate ways. As a result, teachers were tempted to change their course content to appeal to potential drop-out students by making their classes more interesting and easier in order to earn their student retention bonus, as well as get better student evaluations – the second component of the merit pay plan at the school being studied (Eberts et al. 2002).

Powerful and effective non-monetary incentive strategies include frequent performance reviews and threats of dismissal. There is also evidence to suggest that students learn better in schools where there exists a wide range of salaries for teachers with a variety of experience and education, or in which a few specific teachers receive bonuses or raises for these same reasons, and this correlation is strongest among schools that serve low-income communities. Other studies have shown that teacher incentive programs can lead to manipulation of test scores and "gaming the system." This has also been found to be true when implemented in other countries such as Kenya (Figlio and Kenny 2007).

Incentives have the potential for unpredictable, unintended consequences – sometimes called "dysfunctional behavioral responses" or, perhaps even more appropriately, "opportunistic behavior" (Eberts et al. 2002; De Fraja and Landeras 2006). These responses occur as a result of institutional factors, like poorly defined or measured outcomes, which lead to a reliance upon flawed, subjective evaluations as well as multitasking among job incumbents, team production, and multiple stakeholders (Eberts et al. 2002). The interactions and communications between the participants in the learning process – namely teachers and students – can cause competition and have adverse effects, making the incentives backfire (De Fraja and Landeras 2006). More research is needed to better understand the relationship between learning and teaching before incentives can be successfully implemented and their effects analyzed. However, it may be more effective to influence student effort directly, rather than utilizing incentive mechanisms for schools and teachers (De Fraja and Landeras 2006) – meaning that perhaps incentives should be provided for students instead.

The major conclusion from the empirical evidence reviewed on the effectiveness of financial incentive programs to enhance education quality and outcomes is much the same as it is for health care: incentive programs must be carefully designed if there is any hope that they will achieve their intended outcomes. Because education professionalism is associated with several different behaviors and attitudes, using

incentives for this purpose creates an even greater imperative for careful design and thoughtful implementation.

However, it is likely that non-financial incentives, such as career progression, play a more important role than financial incentives in encouraging professional behavior among teachers. Career progression in teaching is often based upon years of service and provides individual teachers with few opportunities to move into administrative or leadership roles. This absence of opportunities for teachers to develop as professionals stymies the potential of talented teachers and robs them of motivation. Countries that perform well in student achievement, such as Singapore, provide teachers with multiple options for rising in the profession. For instance, Singapore's Education Service Professional Development and Career Plan (Edu-Pac) offers teachers with different aspirations to pursue one of three different tracks: a teaching track that allows them to continue in the classroom while advancing to the new level of Master Teacher, a leadership track that allows them opportunities to take on leadership positions in schools, and a Senior Specialist track which permits them to move to the Ministry of Education headquarters to become experts with deep knowledge and skills in specific areas of education (Organization for Economic Cooperation and Development 2013). Each teacher's performance is monitored through an elaborate performance management system, which links a teacher's performance both to the annual bonus for the teacher and to promotion decisions.

Creating More Effective Incentive Systems to Enhance Professionalism in Health Care and Education

John Gregory, an eighteenth century Scottish physician, created a three-part structure for moral quality in health care. First, physicians should accept the discipline of science in order to remain free of bias. Second, physicians' primary concern should be the protection of the patient's health and best interest. Third, physicians should hold self-interest, in any form, as secondary to the interests of the patient. Gregory also contextualized these principles within his four virtues of medicine: integrity, compassion, self-effacement, and self-sacrifice (Hendrickson 2008). These virtues, while originally conceived in the context of medicine, are equally applicable to education and form core attributes of professionalism in these two important sectors. As this chapter has discussed, reforms are needed in both health care and education, and enhanced professionalism on the part of physicians and educators is vital to securing the needed improvements in efficiency, effectiveness and equity. While incentives are powerful tools to influence human behavior, empirical evidence is inconclusive regarding their likely potential to enhance professionalism in health care and education. Nevertheless, the literature does offer some insights into designing the type of incentive systems that foster greater professionalism. These insights pertain to four broad areas of intervention: leadership, design, cost, and implementation.

Leadership

The U.S. health care and education systems are complex and exhibit high degrees of variability in structure, organization, and financing in part due to the multiplicity of stakeholders with diverse interests. Reforms, whether comprehensive or incremental, will require strong leadership to establish shared goals and objectives, standards of quality, priorities for resource allocation and research, among other important service delivery and financial reform matters. Given the central role of educators and physicians in the education and health care systems respectively, strong leadership among these key stakeholder groups is essential to any successful reform effort. It is difficult to imagine how successful and appropriate incentive systems targeting physicians' and educators' attitudes and behaviors could be designed and implemented and then accepted by these groups if professionals are not actively and fully engaged in these efforts.

Accordingly, it is incumbent upon education and physician leaders to play a significant role in developing and implementing incentive systems and programs aimed at enhancing professionalism among their ranks. They must grapple with the challenge of creating incentives that support institutional and professional goals while also eluding their potentially damaging consequences, including discrepancies in delivery of services (Biller-Andorno and Lee 2013). They must work to address key questions of design and implementation such as the following:

- Can incremental changes in incentives work given the distortions imposed by the entire system?
- Is there the political appetite and will to introduce and implement widespread education and health sector reforms that rely on incentives?
- Can the entrenched interests of the various segments of the professional ranks be brought into sufficient agreement to facilitate the adoption of new incentive systems that foster greater professionalism?

The literature on incentive programs, such as pay for performance and other compensation-related reward schemes, identify leadership and active participation of the target group as a potentially important critical success factor. Physicians and educators need to be the loudest and most dominant voice articulating the need for and offering solutions to system reforms. Otherwise significant and important decisions will be made without their expertise and unique perspective.

Design

In order for incentive systems in education and health care to have a reasonable probability of achieving desired outcomes and minimize negative unintended consequences, these systems must be well designed. Although the empirical evidence supporting the effectiveness of the use of incentives in health care and education is inconclusive at best, there is general agreement in the literature that the following design considerations are important:

Form of Incentives

Careful attention must be given to the likely efficacy of financial and non-financial incentives. Professional behavior of educators and physicians is about much more than simply improving student test scores, patient satisfaction, and patient health outcomes, although these are extremely important indicators. Some would argue whether the notion of professional behavior loses its entire meaning if incentives need to be provided to encourage such behavior. Financial incentives usually operate on a rational self-interest basis (Biller-Andorno and Lee 2013), but they can be constructed in such a way that actually enhances consequences for both clients and providers as a group rather than as individuals, lessening the potential degradation of intrinsic motivation of the professional. The use of nonfinancial team-based incentive systems, such as group performance rankings and score cards, can increase peer pressure and positively affect intrinsic motivation among team members. These methods can facilitate peer critique through a process of continuous improvement, but they are only effective when used in an environment in which the opinions of colleagues matter to the community of professionals (Biller-Andorno and Lee 2013). Combining financial and non-financial incentives that are aligned can be more potent than using either of them singularly.

Focus/Objectives

An incentive program with a shared-purpose orientation that emphasizes an organization's commitment to goals which align with the medical profession, such as improving patient outcomes, bettering population health, and reducing costs, is more likely to be effective (Biller-Andorno and Lee 2013). Rather than using simplistic incentive models that reward participants for desired actions, the collective profession should form a shared purpose and then measure their own performance and the performance of colleagues against these agreed-upon standards on a group or organizational level rather than at the individual level. Incentive models that rely on shared purpose validate and promote ethics and responsibility in such a way that encourages education and physician professionals to hold themselves accountable for their own actions rather than having standards imposed upon them. It allows professionals to engage in a continuous development, evaluation, and critique of incentive programs. A shared-purpose incentive model is not always efficient on its own, and other types of incentives should be utilized in conjunction with it to encourage pursuit of the shared purpose (Biller-Andorno and Lee 2013).

Measurement

Thought must be given in any incentive system to the indicators to be used to assess performance outcomes. To what extent should process vs. outcome measures be used? Which outcomes are most important and how can they be measured? Do the

data exist or are they readily and inexpensively obtainable? These are just a few of the questions that must be answered when establishing outcome measures to be used in incentive systems. Over-reliance on student test scores, patient satisfaction, and patient health outcomes as the only indicators of professional behavior among educators and physicians can be problematic. The key is to have measures that are valid, reliable, and deemed associated with desired professional behavior.

Empirical validation is important in figuring out whether incentive mechanisms put in place for more professional behavior are working or not. But professionalism does not lend itself well to empirical measurement. In addition, while economists have come up with clever ways of isolating the effects of the education professional (independent of socioeconomic background or school characteristics), these methods are not perfect, and there is potential for errors. Another challenge in establishing valid measures associated with educator and physician work is the limited amount of empirical evidence linking processes and outcomes. This issue is exacerbated by the lack of agreement concerning standards of practice. There is wide variation in approaches to patient diagnosis, clinical intervention, student assessment, and curricular content, among others. Hence, there has been great interest in more evidence-based practice in education and health care alike. Evidence-based practice obliges professionals to make use of scientific evidence as a key factor in efforts to provide the best possible services to clients. It also provides a framework of tools that allows for systematic improvements in processes and outcomes to increase professionalism by utilizing the highest-quality scientific evidence available (Deci et al. 1999). In addition, it facilitates more valid and reliable measures that can be used in incentive systems.

Another issue is that ultimate outcomes of education and health care, namely health status and student learning, are the product of numerous variables including the patient's or student's socioeconomic background and actions. Controlling for variables not associated with the professional's action, in understanding and interpreting outcome measures, is a daunting task.

Unintended Consequences

It is important to think through the likely unintended consequences of incentives and take steps to minimize those that would result in negative or unacceptable outcomes. Performance-based teacher incentives can result in "teaching to the test" with teachers and schools focused on simply raising standardized test scores. Likewise, focus on patient satisfaction can result in health workers caving to patient demands (e.g., for more tests, more interventions, and more medicines), so as to improve their patient satisfaction rates. The configuration and design of incentive systems should not create an environment whereby well-meaning professionals are encouraged to work in contradiction to their professional responsibilities and moral and ethical values to pursue a reasonable level of compensation (Hendrickson 2008).

Cost

While there is no empirical evidence of the cost-effectiveness of incentive systems or programs, the consideration of the costs of such initiatives is an extremely important issue that must be evaluated. As with the design of most systems, desired outcomes should be produced for the least cost. When designing incentive systems for educators and physicians, cost considerations should include the following:

- The size and frequency of the incentives
- How long the incentives are to be provided
- Expense of data collection and performance monitoring
- Expense of needed technology and personnel required to administer the system
- Expense of development of new administrative systems and structures to operationalize the incentive program
- Expenses related to security, fraud, system gaming, and unintended consequences

Educator and physician incentives systems and programs must be designed giving careful consideration to the numerous cost-related issues. Cost–benefit analyses should be conducted to ensure that projected costs are worth the anticipated benefits in the short as well as the long run.

Implementation and Evaluation

Even the best-designed systems and programs fail if they are poorly implemented. Of course, no program or system is designed or implemented perfectly; thus there is always a need for evaluation and continuous improvement. In the implementation of incentive programs, one must consider whether a new system or structure is needed for the change to take place, as well as how the rewards of the incentive scheme will be delivered (Mechanic 2008). An additional risk for an adverse outcome occurs when the widespread implementation of pay-for-performance programs is coupled with the lack of widespread standards for their measurement and reporting. The use of a rotating panel of measures has been suggested as a way to avoid this problem (Hendrickson 2008). When implementing incentive systems, it is imperative to avoid needless complexity, lay the foundation for success by building strong coalitions of support and weakening opposition, and seek to control key interactions. Additionally, it is advisable to establish an implementation timeline with achievable milestone goals. Incentive systems should also be implemented with strong accountability structures in place to help control liability risks, foster agreed-upon values, and encourage compliance with established standards and ethical codes (Deci et al. 1999). Implementation and chess are analogous in that they both are games of strategy, tactical foresight, and informed calculations.

Unquestionably, educator and physician performance-based incentive mechanisms are data-intensive, requiring extensive collection of data on student achievement

and patient health outcomes on an ongoing basis. Evaluation of an incentive's effect on a desired outcome must be valid (measure what is intended), reliable, and practical. An assessment should also be made of barriers to and enablers of the improvement toward measured outcomes (Mechanic 2008). New research on incentive programs should examine the impacts, disadvantages, and cost-effectiveness of incentives. Most importantly, research should evaluate financial incentives in comparison with other approaches in other contexts. These studies must also assess the long-run outcomes and intended and unintended consequences of incentives and assess when incentives should be eliminated or changed (Mechanic 2008). The primary obligation of assessing the impact of educator and physician incentives programs falls upon professionals themselves (educators and physicians). The professional responsibility of physicians and educators toward their clients makes their input in both the design and implementation process integral to its success (Hendrickson 2008). Evaluation data and results should inform improvements to incentive programs and determine their costs and benefits.

Conclusion

Can professionalism be promoted and sustained through incentives? Initially, it may appear that "incentive-promoted professionalism" is an oxymoron, since professionalism often entails such noble values as concern for others, collegiality, self-regulation, willingness to sacrifice personal gain in the service of others, and commitments to quality improvements. How would it even be possible to encourage and sustain such deeply held intrinsic values with monetary incentives?

This chapter has suggested that there are different elements of professionalism and there are many types of incentives (e.g., material, solidary, and purposive). Different types of incentives can play an important role in promoting narrowly defined modes of professional behavior among health care and education providers. For instance, career progression is an important consideration for some teachers. The absence of clear merit-based career progression and opportunities for teachers to develop as professionals stymies the potential of these talented teachers and robs them of motivation. Countries that provide teachers with multiple options for rising in the profession based on their differing levels of aspiration and performance, such as Singapore, perform well in student achievement.

Likewise, there is plenty of evidence that, with its fee-for-service-based reimbursement system, the U.S. health care system actively encourages non-professional behavior among health providers. Providers are incentivized to provide more services (some of which are not only unnecessary but even harmful), more interventions, and practice procedure-based medicine. These distortions have affected the entire medical profession by driving up costs, creating large disparities in salaries across medical specialties, and skewing medical education toward over-specialization (to the detriment of primary-care medicine).

The empirical evidence on whether narrowly defined financial incentives, such as pay-for-performance, actually promote professional responsibility among health providers and educators is mixed. Some studies suggest strong effects, while others find weak effects and even negative unintended consequences. What comes through clearly though is that context matters. Where there is an overall enabling environment, financial incentives can encourage providers to improve the quality of services they provide. But where the overall environment is distorted, financial incentives may not work, or may even backfire.

The literature on incentives also suggests that incentive schemes must be carefully designed and implemented, with the full participation of professionals at every stage of the process. Careful attention needs to be paid to the form of incentives that are used, the way provider performance is measured, the transparency of the incentive tive system, the possible unintended consequences of the incentives, and the ease and cost of implementing the incentive system.

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Chapter 11
Getting Task Structures and Institutional Designs Right

Douglas E. Mitchell

This chapter summarizes two central threads in the analytic fabric of professional responsibility.[1] The first thread articulates the professional responsibility from the perspective of individual workers, examining the task structures that define their work. As noted in Chap. 1 of this volume, the literature on professional occupations encompasses three distinct conceptions of what it means to say that one is engaged in professional work. Some analysts see professional work as an attribute of specific occupations. Studies from this perspective look at law, medicine, architecture, etc. as professionalized occupations and see other occupations as semiprofessions (like school teaching and nursing) or as nonprofessional occupations. A second line of analysis sees professional workers as a subset of the workers in an occupation that also accommodates nonprofessionals with the same or similar job titles and work roles. This view, for example, is embedded in the work of the National Board for the Certification of Teachers which seeks to identify and certify the truly "professional" teachers in public schools and distinguish them from other teachers who hold the same job title but do not possess sufficient professionalism in their skills, actions, or attitudes. A third line of scholarship uses the concept of professional to refer to a specific set of tasks—tasks where the worker takes on responsibility for the well-being of clients (in this volume students and patients) and require creating a relationship of trust between the workers and their clients. This chapter accepts this last framework for analysis and argues that the realization of professional

[1] To avoid the need for repeated citations, I begin by acknowledging that several key ideas regarding professional task structures developed in this chapter were originally formulated in Mitchell and Kerchner (1983). Some ideas have been significantly refined since the original work, especially the recognition here that task structures are hierarchically organized with each higher level depending on those below.

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responsibility involves execution of the professional tasks associated with one's work responsibilities. This implies that what we call professional work is never composed exclusively of professional tasks. Quite to the contrary, professional tasks can only be properly conceptualized and competently executed if they are supported by appropriate execution of an array of subordinate tasks. It is, therefore, a basic premise of this chapter that professional workers engage in four distinct and cascaded task structures. The four structures are (1) labors—tasks requiring diligent effort but no sophisticated skills, (2) crafts—tasks requiring technical or cognitive skill for successful performance, (3) arts—tasks requiring sensitive and creative engagement to adequately apply one's skills, and (4) professions—tasks relying on trusting relationships and requiring acceptance of responsibility for clients' well-being. These four types of work tasks are hierarchically organized in the sense that each subsequent task structure presumes the capacity and commitment to perform tasks at each of the preceding levels.

The second theoretical thread developed in this chapter springs from looking at professional responsibility from the perspective of institutional theory. Institutional theory posits that complex social organizations depend on an array of social forces located in their environments for social legitimacy as well as for the resources to fuel their productive processes. Thus, while productive organizations display a system of more or less functional and rational processes of decision making and work organization, their organizational processes must accommodate and integrate the environmental forces that turn independent social organizations into embedded and interdependent social institutions. For purposes of this chapter, the institutional environment will be conceptualized as composed of three large-scale social structures: (1) *Political Regimes* with governance structures that provide rules and regulations (and often resources) aimed at setting behavioral expectations and articulating the rights and responsibilities of workers, (2) *Civic Cultures* that establish the values and status systems that define institutional purposes and responsibilities, and (3) *Professional Associations* that articulate a system of work norms and define standards of practice. These structures all operate within the framework of their own marketplace structures—structures that guide exchanges of status and resources and provide incentives that motivate personal, social, and political actions. After developing how these two threads are woven together, a concluding section of the chapter identifies nine "pillars of professional responsibility".

Task Structures

Table 11.1 examines the four basic task structures that define different types of productive work. The four types of work are shown in the columns of the table, and the characteristics on which they can be compared are shown in the table rows (and labeled in the left-most column). As noted above, the four task types are Labors, Crafts, Arts, and Professions. These task types are cascaded in the sense that tasks shown to the left of any column need to be adequately discharged in order to lay a

Table 11.1 Four basic task structures

Task characteristics	Labors	Crafts	Arts	Professions
1. Cascaded characteristics	Requires diligent effort	To effort, add technical skill	To effort and skill, add creative sensitivity	To effort, skill, and sensitivity, add responsibility
2. Task controls (for those employed)	Directed	Licensed	Directed	Licensed
3. Task definitions	Routinized		Adaptive	
4. Work organization	Jobs	Tasks	Artistic works	Clientele services
5. Oversight approach	Supervision	Management	Direction	Administration
6. Workplace structure	Factory	Shop	Studio	Practice
7. Worker organization	Industrial union	Craft union	Artistic guild	Professional association
8. Bargain for	Employment rights	Task control	Product ownership/talent recognition	Right to practice
9. Responsibility	Loyalty	Competence	Authenticity	Trustworthiness
10. Accountable for	Compliance	Accuracy	Inspiration	Outcomes
11. Recruitment based on	Accepting direction	Attention to detail	Artistic creativity	Commitment to clients and society
12. Incentive structure	Wage/effort	Price/value	Appreciation/ acclaim	Reputation/ prestige
13. Training/ induction	On the job	Technical education	Coached performance	Mentored practice
14. Knowledge required	Supervisor wishes	Craft requirements	Expressive meanings	Diagnostic judgments
15. Logic of reform	Efficiency	Quality	Potency	Effectiveness

proper foundation for those to the right. That is, workers exercising professional responsibility for the well-being of a client need to have artistic sensitivity, technical skill and diligent effort in order to make their professional work effective.

Rows two and three in Table 11.1 describe task characteristics that are shared by two of the four task types. As row two reports, when laborers or artists are employed, their work is directed or supervised by a manager presumed able to recognize when these tasks are properly executed and responsible for seeing to it that tasks are coordinated in ways that produce a coherent whole. In contrast with the direct supervision approach used to create quality control in the performance of labor and artistic tasks, the mechanisms of quality control for craft and professional workers includes licensure-based training and examination programs aimed at insuring that these workers have the capacity to do competent work. The licensure approach seeks to assure quality task performance when the actual work undertaken cannot be easily subjected to

direct supervisory control. In the case of craft work, supervision is difficult because this work typically involves technologies that the craft managers have not, themselves, fully mastered. Professional work is hard to directly supervise because it typically requires development of a trusting and private relationship between the professionals and their clients—relationships that protect vulnerable clients' privacy and enable them to be more responsive to needed professional services.

Row three in Table 11.1 identifies an important task feature distinguishing labor and craft work from artistic and professional tasks. Labor and craft tasks typically involve routines of action that can be preplanned and executed according to plan, but artistic and professional tasks typically require the workers to utilize analytic and diagnostic procedures to determine how to adapt task performance to situational exigencies that are not easily forecasted in advance. Laboring work is routinized by managerial direction; direction that is often developed through time-and-motion studies seeking the most efficient use of laboring efforts. Craft work is routinized by the technologies required for successful task performance. These technologies may be quite complex, beyond the ability of managers to observe and supervise directly. By contrast, artistic work requires adaption to the various contexts within which it is being performed. Different audiences respond differently, different performance venues require differing presentations of one's art, jointly performed works depend on artists adapting to one another's styles and performance emphases. Professional tasks are also adaptive, requiring that the professional workers diagnosis client needs and marshal appropriate treatment/service task options.

Rows four through eight of Table 11.1 describe the alternative ways in which the four different task structures are organized and how oversight of task performance is typically structured. Laboring work, for example, is organized into jobs with supervisors providing the oversight needed to see that workers produce the appropriate results. These workers and their supervisors work in factory or social service organizations where work is preplanned by employers or executive management and often structured through the application of time-and-motion studies to maximize efficiency. This organization of laboring work into jobs lays the foundation for industrial union structures like those legalized by the National Labor Relations Act (NLRA). The NLRA assumes that workers performing the same jobs have the same interests and that it is therefore appropriate for them to be organized into bargaining units based on job titles. The bargaining relationship set up by the NLRA assumes that unions will bargain for factory work rules and organize to protect worker interests. And in the bargaining relationship with management, industrial labor unions assume that their primary power tool is to quit the job or strike the firm, closing down work performance preventing employers from benefiting from performance of laboring tasks.

Craft workers are subject to managerial oversight rather than supervisorial control. Managers differ from supervisors in that they allocate work assignments and workforce deployment, but do not directly supervise the execution of the work because the workers are expected to apply craft skills, sometimes skills that are beyond the understanding of their managers. The workplace for craft workers is more likely to be called a shop than a factory because this work involves independence of effort by

workers with diverse special skills. The craft work itself is organized into tasks rather than jobs, which is why craft unions seek to control the performance of specific tasks rather than blocking all workers' job performance. Craft unions seek to enroll all workers with the same skills, across multiple firms and over a fairly large geographic region. They also have historically organized training programs for new craft workers so as to shape the spread of craft knowledge.

Artistic work is directed rather than supervised or managed. The artistic director is the person responsible for seeing to it that sensitivity and creativity are nurtured and preserved in an artistic performance. Artistic effort is organized into artistic works rather than jobs or tasks. That is, artistic production is recognized when a work of art is displayed rather than when a task is complete or the artist is appointed to a specific job. The workplaces of artists are frequently referred to as studios to highlight the fact that artistic tasks require that the artists study their subjects in order to acquire the depth of understanding needed to creatively express its essence. There are at least two important characteristics of artistic worker organizations, typically called guilds: (a) they do not seek to negotiate identical wages for their members, but expect artists to be compensated in proportion to the value of the artistic work being displayed, and (b) they seek to negotiate control over the artistic works (or at least to share in their market value) rather than seeking compensation for the hours of productive work or the completion of defined tasks. That is, artists market their talents, not their time or their technical skills.

The artists' guilds do, of course, try to negotiate a basic compensation "scale" in order to secure a lower bound for wages, but they do not seek an upper bound which is expected to depend on the quality of the artistic products produced. Artistic worker organizations also seek to insure that their members have the talent to produce quality art by recognizing them for membership only after an initial display of talent.

Professional work is organized as the provision of services to an identifiable clientele. While labor, craft and artistic work can be done alone and for oneself, professional activities necessarily imply the existence of a recipient of the professional's care and attention. The clients generally may be, and typically are, known by name to the professional worker as when teachers teach a class of students or physicians treat their patients, but they can also be anonymous and collective as when a research biologist seeks new treatment drugs or medical diagnostic methods. Oversight of professional task performance emerges through administration rather than direction, management, or supervision. That is, apart from review by peers, professional workers are expected to be the arbitrators of what to do, when and how to do it. Administrators provide oversight by organizing the service delivery system to create the conditions under which professional services can be effectively and efficiently provided. Administrators, more or less adequately, provide organizational support, establishing the material, social, fiscal, and policy conditions conducive to effective service delivery. The organization of professional work is typically called a practice to emphasize the autonomous control over the work by the individual professional. Because professional tasks require substantial autonomy from managerial direction, professional worker organizations—typically called professional associations—do not generally bargain with employers.

They, rather, focus on controlling who gets access to the performance of these tasks by controlling licensure of professional practitioners and influencing public policy debates regarding the scope of professional worker rights and responsibilities.

Rows nine and ten in Table 11.1 describe the essential responsibility and accountability elements shaping work performance for each of the different kinds of tasks. When engaged in laboring work, workers are responsible for loyalty to their employers. This loyalty is what Frederick Taylor (1911) had in mind when he referred to Schmidt, the pig-iron hauler described in his *Scientific Management* treatise, as a "good man." Schmidt was a "good man" because he was willing to believe that he should follow the dictates of his supervisor rather than his own intuitions regarding how best to perform the simple task of moving iron pigs around the shop floor. Hence, the laboring worker is accountable for compliance with supervisor directions, not for the efficiency or productivity of the work itself. Supervisors are accountable for the adequacy of the directions they give.

Craft workers are responsible for competent application of craft technologies to their assigned tasks. They are, of course, expected to accept managerial definition of what tasks are to be performed. With regard to the tasks to which they are assigned, however, craft workers are accountable for the expertness and accuracy of their task performance. They are expected to resist managerial direction if it is urging upon them task structures that are inadequate or inappropriate to the work being performed.

Artistic workers are responsible for the authenticity of their works. Authenticity is what distinguishes art from kitsch. While authenticity is sometimes hard to recognize, art critics and connoisseurs serve alongside artistic directors to establish standards of accountability for artistic inspiration—an essential ingredient in authentic artistic works. This feature of artistic responsibility is a principal contributor to the tendency of artists to be social nonconformists.

For professional work, the essence of responsibility is trustworthiness. The performance of professional service work requires that clients trust the professionals and rely on them to diagnose problems and prescribe treatments that are more efficacious than solutions the clients could identify for themselves. Because of the centrality of this trust–reliance relationship, professionals are accountable for outcomes, not just for the exercise of craft technologies or engaging in the work with artistic sensitivity. Among professional workers, the Hippocratic principle of "do no harm" is the starting point for the trust–reliance relationship.

Rows eleven through fourteen in Table 11.1 describe some of the essential features of recruitment, motivation, training, and essential knowledge for performers of each type of task. For laboring tasks, the most important element in recruitment of workers is their willingness to accept direction from supervisors. The incentive system intended to assure quality laboring work is the development of a wage/effort bargain. Whether negotiated collectively with worker organizations or individually with unorganized workers, the presumptive structure of employee motivation is that they are prepared to sell their diligent efforts for an acceptable time-structured wage. Moreover, when laborers have been properly selected and suitably incentivized, they are expected to be able to learn the requirements of their work through

on-the-job training (so long as they bring a set of appropriate "basic skills" with them into the workplace). The emphasis on basic skill development in the public schools is not intended to produce craft work capability, but to prepare workers to take supervisorial direction because they have the essential literacy and numeracy skills needed to understand and follow these directions. Craft work is presumed to require more specialized training, but the essential knowledge requirement for laboring workers is that they know and understand their supervisors' wishes and directions.

Craft workers, by contrast, are recruited on the basis of their willingness and ability to give close attention to the details of their work. They are incentivized by a price/value contract in which employers are expected to compensate craft workers for the value of their products rather than simply the time involved in their production. Different craft workers performing essentially the same tasks may, and often do, justify higher prices for their efforts because their skills enable them to produce higher quality products. Thus, master plumbers or electricians can expect to be compensated more handsomely than their journeymen counterparts. Training programs for craft workers involve technical sophistication as well as basic skill development.

For artistic workers, selection is based on assessments of creativity that extends beyond basic skills and technical expertise. This work is incentivized by an appreciation/acclaim contractual process in which the reputation of the artist receives acclaim in proportion to the appreciation of his work by directors, critics, connoisseurs, and audiences. Training for artistic work is primarily through coaching and individual artists display their current capacities for creativity as their coaches and directors elicit from them higher levels of authentic creativity.

Aspiring professional workers are selected on the basis of the level of their commitment to clients and to the social structures that support them. The incentive structure for professional task performance is a reputation/prestige bargain in which the professional workers are granted prestige and status in relation to their reputations for competent practice and trustworthy client service. Typically, professional task performance is learned through a process of mentored practice in which novice workers perform professional tasks under the watchful eye of more experienced professionals who treat the novice as a protégé and seek to mentor their successful development of the full range of professional capabilities. Of course, the subordinate skill sets needed for the underlying labor, craft, and artistic components of any given professional service are learned in the mix of on the job, technical education and coached sensitivities needed to prepare for preprofessional task execution.

Row 15 of Table 11.1 provides an initial hint as to what sorts of criteria might be used to motivate reforms for task design and execution of various types of work. Laboring work is almost always open to challenges claiming that there is a more efficient way to execute required tasks. It is this efficiency perspective that guided Taylor's (1911) scientific management approach to work improvement, and it is this perspective that led Callahan (1962) to decry as a "Cult of Efficiency" business led efforts to reform public schools in the 1930s and 1940s. Craft work, by contrast, is more appropriately challenged by claims that there are ways to improve its quality.

New techniques and designs for craft tasks are one of the primary targets of applied research in education and medicine. The development of new instructional techniques in education, new treatment strategies in medicine, new data management processes in both occupations, or any of a thousand other recognizable innovations, over the last half century reforms in these occupations has emphasized craft technique improvements rather than labor, art, or professional task changes.

Improvement in performance effectiveness or performer efficacy motivates reform in artistic task performance. Art criticism has more of a focus on potency than on the technical quality of the art form. It is quite possible for simplification of an art form, rather than its technical sophistication, to produce major improvements in potency. This was certainly a major source of Meis Van der Rohe's career success in architecture. And, in the same field, Frank Lloyd Wright's architectural marvels were often less technologically sophisticated than those of his contemporaries. In the world of painting, Wassily Kandinsky made simplification a source of substantial artistic impact.

The reform of professional task performance is not grounded so much in efficiency, quality, or potency as in the effectiveness of client services. There are, of course, inefficiencies, quality weaknesses, and low potency in various aspects of occupations deemed professionalized, but these limitations refer more to the subordinate task structures in the field and less to the professional tasks themselves. The delivery of education and medical care involve, to be sure, some in efficiencies in low-level task performance, some clear technical limits on quality, and various weaknesses in the artfulness with which practitioners engage their clients. But the nurture of professional responsibility in these occupations is brought into clearer perspective if we ask about the effectiveness of the service delivery by asking how well the clients are faring.

Institutional Structure: The Importance of Professional Associations

Up to this point, we have been looking at professionalism and professional responsibility from the perspective of individuals: their task structures and their incorporation into work groups and worker organizations. We turn now to the question of how professional responsibility relates to the development and operation of complex social institutions—the agencies that define tasks, coordinate their execution, and interact with political, cultural, and economic environments to secure resources, develop social and political legitimacy, and maintain working relationships with other organizations. One thing that is quite clear from the literature on professions is that the capacity to exercise professional responsibility is routinely threatened by managerial and market forces that tend to overrun professional commitment by individual workers because they are bound, by their employment, to particular organizations. As Leicht and Fennell (1997) put it, one result of the growing professionalization of managerial workers is that

> the concept of professional work is no longer necessarily vested in peers, or even in the administrative elite of the profession; hierarchical control over professional work is often vested in professional managers of the employing organizations (p. 217).

Unionization of employees, the typical remedy for overly constraining managerial direction, is proving inadequate to the development of professional responsibility. Indeed, in the current period of globalized economics, unions are even proving to be too weak to protect worker rights or to secure significant redistribution of corporate wealth. Executive and owner incomes are rising rapidly while worker wages remain stagnant or declining.

The unavoidable conclusion, therefore, is that professional responsibility must be vouchsafed from a vantage point outside the capacity of individual workers to control their own working conditions, and outside the control of the firms that hire and manage them. That is, professional responsibility must be articulated within the institutional environment of employing firms and be effectively pressed upon production processes as a set of expectations, norms, or demands for professionally responsible modes of production. In short, professional responsibility must not only be taught to neophyte professional workers; it must be *institutionalized* in ways that counterbalance the tendency for administrators, regulators, and market forces to remove professional responsibility from individual employees and redefine their work as merely labor, craft, or art (and thus appropriately subject to organizational control).

To say that schools, clinics, or hospitals are *institutions* rather than organizations or bureaucracies is to insist that they display two basic characteristics. First, institutions have strong norms of behavior that define worker responsibilities in ways that are, to some extent at least, independent of the technologies of production. That is, institutions have social norms distinguishing legitimate from illegitimate activities, thus creating a social value system capable of guiding the attitudes and actions of institutional members. Second, institutions are substantially shaped by at least three environmental forces: (a) *Political Regimes* responsible for regulating (and often resourcing) their operations, (b) *Civic Cultures* that are responsible for the core values used to distinguish legitimate from illegitimate institutional actions, and (c) organized *Professional Associations* that define norms specifying the standards for satisfactory work.

Following Powell and DiMaggio (1991), Leicht and Fennell (1997) summarize the pressures exerted by these environmental forces. They report that

> Powell and DiMaggio (1991) outlined three mechanisms through which isomorphic change occurs: coercive pressure from governing bodies or the state; mimetic pressure on organizations to copy existing forms when faced by conditions of great uncertainty; and the normative expectations of powerful professional groups within organizations. However, when the norms are themselves in flux, and the power of the profession becomes unstable, the balance may shift toward coercive and mimetic pressure, both of which may be more influential when uncertainty in a sector or organizational field is high (Fennell and Alexander 1987; Derber and Schwartz 1991) (p. 219).

I interpret Powell and DiMaggio's keen insight in a slightly different way. While I agree that coercive pressure generally emanates from political regimes where

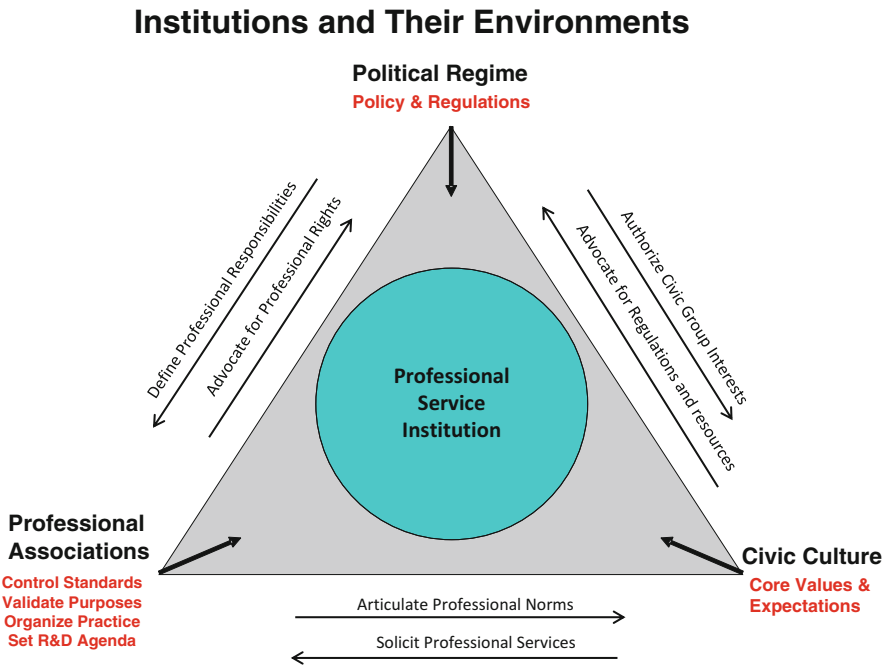

Fig. 11.1 Graphic representation of institutions and their environments

taxing authority, police power, and contractual enforcement responsibilities are concentrated, I see mimetic pressure arising through professional worker awareness of socially accepted and identifiably successful forms of professional work. As individual professional workers become aware of high performance among their peers, and this recognition is endorsed by their professional associations, workers in less legitimate environments modify their work routines to emulate those with greater legitimacy. Normative pressure for isomorphic conformity while recognized and endorsed by professional workers arises, as I see it, from the civic culture where clients and public interest groups stress the core responsibilities and tolerable boundaries of professional actions. Normative public expectations are constantly being articulated, tested, and revised through media exposure and application of deeply held cultural values.

As suggested by Fig. 11.1, the three environmental structures—Professional Associations, Governance Regimes and Civic Cultures—each bring their own priorities to bear on the establishment of professional service institutions. Governance regimes operate through the deliberation, adoption, implementation, and enforcement of policy systems. Operating under constitutional law and democratic elections, the regime is tasked with the responsibility of suitably regulating, incentivizing professional services and, in important cases, resourcing the profession. The civic culture legitimates the practicing of the profession and is the ultimate source of demand for services. While it is often possible to rely on cultural interests to create

a market for professional service provision, quite often it is the case that civic values produce substantial demand for professional services that have clear private and public benefits, but which exceed the capacity of individual clients to bear the cost of producing and procuring them. Under those circumstances, the governance regime is urged by members of the civic culture to stimulate and economically support service providers. This is easily recognized in state and national debates over health care and education service provision. Educational services are widely seen as supporting economic development and inculcating democratic values with public purposes exceeding private interest and capacity. As health policy debates have gone national and international in scope, the public good aspects of health are receiving strengthened political regime support.

Van Mook et al (2009) stress their observation that professional service markets are quite different from ordinary commercial markets. As they put it,

> The contrast between the mottos for commercialism, *caveat empter* ("buyer beware") and the medicine *primum non nocere* ("first do no harm") . . . is a salient reminder of the fundamental tensions between commercialism and professionalism (e82).

This observation underscores the importance of recognizing that professional services are planned and delivered in institutional settings rather than through ordinary market systems.

Defining and Validating Purposes

In the direct interactions among professional associations, political regimes, and civic cultures, the expected form of professional services is delineated and the importance of professional associations clarified. As indicated at the bottom of Fig. 11.1, an important subset of these interactions involves clarification of what services are to be provided by members of the profession and how they are solicited by their clients. Members of the civic culture solicit services from trusted professional workers to meet their felt needs. At the same time, individual professional workers, aligned with their professional associations, articulate for the public what services are most efficacious and what norms of service delivery should be expected. Along the right side of Fig. 11.1 are the dominant terms of interaction between the civic culture and the political regime. Civic culture interest groups advocate for support and regulation of their preferred service providers, while regime politics determines which interest groups demands will be recognized and incorporated into policy. As the regime and the civic culture reach consensus on the desirability of services and the mix of public versus market support for the services, the professional associations negotiate with the regimes to advocate for rights and articulate responsibilities under the law.

There are at least four fundamental aspects of professional responsibility that are the proper purview of professional associations. These include (1) defining and validating the purposes and limiting the scope of the professional work performed by

individual professional workers, (2) distributing the power and authority to control professional work activities and their underlying labor, craft, and artistic supporting work responsibilities, (3) creating and reforming the organizational structures within which professionals will practice, and (4) establishing research and development agendas that support accountability and practice improvement (see Arendale et al. 2009; van Mook et al. 2009; Petrou 2000; Merton 1958 for sample lists of association functions).

Glazer (2008) defines professionalism in terms of occupational "jurisdiction" over a specific set of social problems and the services aimed at ameliorating them. He goes on to assert that:

> three dimensions of clinical practice that directly bear on jurisdictional control . . . . [Include]: (1) the congruence between a profession's conceptualization of the problems it tries to solve and dominant cultural values, (2) the degree to which clinical practice is consistent across the practitioner community, and (3) the extent to which professions remedy the problems for which they claim authority (p. 174).

Note that, in describing jurisdictional control, Glazer is using concepts that must be seen as referring to the actions of professional associations rather more than those of individual professional practitioners.

Because education and healthcare are highly valued by society, their purposes may seem entirely obvious at first glance. A few moments reflection will quickly reveal, however, that these professions are distinctly modern in their origin and that the nature and limits of professional responsibility in both domains has become increasingly complex and often contested. One need only mention recent social and political struggles over a woman's right to an abortion to realize that the purpose of medical care is sometime highly contentious separating groups in the civic culture, dividing members of the governing regime, and even creating disagreement within the occupation. At the boundaries, one easily finds continuing debates about what constitutes professional health care. For example, should first aid for injuries be seen as a medical practice or more of a civic culture process? How about physical fitness training? Some routine aspects of professional responsibility in medicine are well established—like the responsibility to protect patients' medical records even if it interferes with tracking the spread of a disease—but how is it decided that privacy of records is this important?

In the domain of education, the defining and validating professional responsibility is less clear than in medicine. Governing regimes routinely specify (or limit) the content of school curricula and regulate the behavior of teachers and administrators. Civic groups routinely articulate expectations for curricular content, educator behavior, and school social practices.

If the institutional perspective with its emphasis on the importance of environmental forces influencing professional service definition and delivery is accepted, it becomes obvious that we cannot expect professional workers to personally and individually define and realize their professional responsibilities. Their service delivery institutions will be distorted and damaged without the balancing power of a strong professional association able to provide the needed political counterweight to political regimes seeking politically palatable service delivery without a clear understanding of

its professional requirements. And the professional associations must counterbalance the interests of civic cultural groups who appropriately want relief from various complex problems but may not understand the complexities and costs of programs and practices needed to address their interests may expect solutions where none are known to exist.

How Professional Associations Establish Influence

Given the importance of professional associations, how should we think about the mechanisms by which they gain and hold the jurisdictional authority needed to articulate and realize the professional responsibilities of their members? The acquisition of influence by professional associations occurs along three broad dimensions: (a) establishing and influential sociopolitical network capable of influencing regional and national political regimes, (b) normalizing the profession by establishing standards of practice that assure a justifiable reputation for client care and well-being, and (c) enhancing the capacity of the profession by undertaking research, development, training, and dissemination activities.

The importance of developing effective *sociopolitical influence* networks is highlighted in a fascinating study of professional associations in the Middle East by Moore and Salloukh (2007). They point out that there is clear evidence of

> *contestation* and *coordination* in relations between central political authorities and both organized professional representatives . . . and private economic interest groups represented by the chambers of industry and commerce. . . . In most Arab states these organizations have rich histories and have become increasingly important players in domestic politics (p. 53).

They summarize in their concluding section that

> professional associations are artifacts of how regimes built their states and secured support from particular social bases. Yet, associations were also agents of change during decades when these regimes were under pressure (p. 71).

Many other scholars emphasize some political foundation of professional association influence (see, for example, Arendale et al. 2009; Greenwood et al. 2002; Akers 1968; Paton 1968; Merton 1958). The scholarly consensus is that political influence is garnered through establishing statutory control over access to the occupation and using the resources of the professional association to articulate social policy goals and regulatory guidelines.

Normalizing the profession is a second route to enhance association influence. This is done primarily by establishing standards of practice that assure a reasonable level of client satisfaction and well-being and involves aggressive pursuit of organizational control over individual professional practitioners. As virtually all observers of professional associations agree, this begins with creating what Millerson (1964) calls "Qualifying Associations." A qualifying association is one that creates and scores qualifying examinations and other statutory provisions controlling the right

of an individual to enter the profession. Carr-Saunders (1965), in reviewing Millerson's work, argues that the formation of these qualifying associations have substantial social benefits in the creation of public legitimacy and establishment of enforces work standards.

The professional association typically reinforces the control over membership by establishing enrollment procedures and creating at least some form of an accountability policy for disciplining those who fail to maintain established work standards. In most associations, enforcing standards has been haphazard in implementation. Some observers see it as devoted more to protecting certified professionals from external scrutiny than to sustaining quality. Nevertheless, the qualifying associations do generally create review mechanisms that make it possible to hold innovative practitioners responsible for defending their innovations as improvements in client well-being. Professional normalization is enhanced when professional associations gain the knowledge, skill, and authority to provide coherent critiques of public policy—articulating how they enhance or interfere with the ability of individual practicing professionals to fulfill their professional responsibilities

Normalization of professional status involves effectively representing professional norms to political regimes and civic cultures. It not enough to have strong norms of practice, it is equally important to see to it that these norms are interpreted to regime officials and cultural interest groups. This interpretation often involves the professional associations in the negotiation and interpretation of regime regulations. It also involves articulating the core mission of the profession to the civic culture, while simultaneously eliciting from the culture a clear picture of client needs and expectations.

Political influence and normalization of professional practice require that professional associations build a coherent and comprehensive knowledge base from which to define practice norms and establish negotiating positions with political regimes. To secure this operational base need to undertake a number of activities, including:

1. Undertake research into professional service delivery problems. No doubt, this should engage university research scholars, but the association has its greatest interest in research applied to policy and practice problems.
2. Develop a public information system for articulating to the civic culture and governance regimes the standards and norms of practice and the evolution of those norms and standards as knowledge about how to improve effectiveness evolves.
3. Provide explicit public policy analyses that remain credible as sources of wisdom and do not become merely an advocacy for rights and resources.
4. Develop a capacity for political and social intelligence gathering that keeps the profession aware of changing commitments and attitudes in the other institutional environments.

These reflections on professional association roles and responsibilities make it clear that neophyte professionals need to be exposed early and educated explicitly regarding the role of professional associations—linking engagement in the profession to engagement in the Association. Since the demise of the Progressive

Education Association, education has lacked this sort of Association. Unions organized under the model articulated in the National Labor Relations Act (1935) are not able to play the role of Professional Associations because they are explicitly required to pursue the self-interest of the member workers rather than the public interest in professional responsibility.

Conclusion

This chapter has explored two central issues shaping the development of responsible professionalism in education and medicine: the task structure of professional work and the institutional importance of professional associations in supporting that work. Other chapters in this volume tackle issues of selection and training of professionals, the institutional context of professional practice and the movement of professional employment from individual fee for service contracting to salaried employment in complex social organizations, and the unique role of universities in articulating and supporting professional practice. Taken together, the message is quite clear: professional responsibility requires support and political commitment as much as it requires technical skill and personal dedication. Beginning with the next chapter, the analysis turns from the underlying principles and structures of professional work to the study of professional responsibility in action by looking at specific issues in education and medical care that illuminate the practical stresses and strains that enable (or frustrate) responsible practice.

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Part IV
Exploring Professional Responsibility in Action

Introduction

This part consists of seven chapters that delve deeply into various aspects of professional responsibility as it is encountered in concrete educational and medical settings. The chapters cover four distinctive strategies for developing and strengthening professional practice in real-life work settings. The first of these strategies involves establishing strong leadership to organize and deliver professional services within an "institutional niche" by either capturing part of a large-scale complex organization or establishing a "parallel" or "counter" organization capable of implementing a novel service delivery system. The projects described in Chaps. 12 (Powell) and 13 (Franco et al.) illustrate the strengths and challenges posed by this strategy for actualizing responsible professionalism in education and medical care. Ronald Powell is the director of a California regional Special Education Local Planning Area organization established to coordinate and monitor the delivery of special education services in public schools. His organization is quasi-independent with a substantial amount of latitude in defining and implementing services. Initially, his organization was predominantly concerned with the psychological assessment of special education needs and the development of educational services appropriate to those needs. He describes, however, the creation of a "transdisciplinary clinic" that includes medical, mental health, and education professionals as equal partners in designing interventions that link educational, mental, and physical health specialists to diagnose and address individual child needs. The important part of his story is not so much the unique blend of professional services that are provided, but the complex leadership challenges that had to be addressed in order to create this clinic. He examines the phenomenology of professional leadership and concludes that the fundamental building blocks of innovative professional service delivery are the values that an organization articulates and adheres to. As he puts it, "Not only do values guide organizational behaviors, they also serve as catalysts for reorganizing and sustaining organizational change."

In Chap. 13, Zeno Franco and his colleagues describe a very different kind of institutional niche service delivery strategy. Analyzing the development of a community-based organization, organized and run by and for veterans, this chapter describes the tensions and ethical dilemmas that arise when community activists try to cope with complex social organizations like the Veterans Administration and professional medical services like the Medical College of Wisconsin. Described in intensely personal terms, this chapter tells the story of "Dryhootch of America," a community-based veterans organization seeking to help returning veterans overcome the tensions and challenges of reentry into civilian life. This chapter makes an important contribution to the analysis of professional responsibility by showing the contradictions that arise because professionals in complex institutions like the VA rely on *deontological* (i.e., rule-based) ethical principles, while more independent direct service professionals, like the chapter's lead author, rely more on *consequentialist* ethics, and the community organization leaders insist on calling attention to the importance of Aristotelian *virtue* ethics. This makes the community leaders impatient with and sharply critical of professionals who insist on interpreting procedural rules, laws, or standards of professional practice – they want to work with professionals who put relationships ahead of rules and mutual respect ahead of procedural norms. Thus, this chapter provides a provocative analysis of at least one reason why some people depart from established institutions and recognized practices in an effort to insist on the establishment of authentic relationships.

Chapters 14, 15, and 16 look at real-life professionalism from a very different perspective. These chapters examine the relationships between the universities where neophyte professionals are trained and the service delivery institutions within which they practice. These chapters provide concrete instantiation of some of the insights presented in Part III by O'Connor and Beach (Chap. 8) and Wilkes (Chap. 9). From the perspectives on professional responsibility developed in the chapters in this part, educational institutions (and by analogy medical clinics and hospitals) are materially strengthened when they rely on the university as a "Base of Operations" to guide and support professional practice. In Chap. 14 (Blacher et al.), the role of the university in supporting the ability of schools to understand and respond appropriately to the widespread incidence of autism among children is carefully delineated. This affliction, whose cause remains mystifying, challenges school systems that are under intense pressure to raise test scores and prepare students for economic success. What Blacher and her colleagues make clear is that the university role in conducting research and disseminating best practices requires that universities attend to schools just as much as schools need to attend to the universities as sources of both theoretical and practical knowledge.

In Chap. 15, Anne Jones examines the tension between politics and professional practice when it comes to addressing the educational needs of English language learners. She notes that the political system is preoccupied with reinforcing the civic culture where English language fluency is an important criterion for legitimacy, while the professional community is concerned with maximizing cognitive learning which research indicates is best supported by relying on bilingual instructional strategies. This chapter makes it clear that professional responsibility, at least in the

domain of language learning, requires accepting political as well as technical responsibility for educational program designs.

Chapter 16 by Mike Vanderwood and his colleagues offers yet another perspective on the relationship between the university and the institutions where professional practice takes place. These authors highlight two aspects of the relationship between university training and professional practice that deserve careful consideration by would-be reformers. First, they note that university-trained professionals (at least in the area of school psychology) cannot easily redefine the standards of practice once they leave the university and take up jobs in the public school system. Public schools have a long history of defining the roles for school psychologists and of hiring professionals to fill those roles. Nevertheless, and this is the second important observation, university training programs are designed to follow the norms of training and definitions of school psychologist roles that are indicated by research findings and the national organization of professionals in the American Psychological Association. This tension underscores the need for close collaboration between universities and school systems, especially when new and more effective modes of psychological intervention are identified, as the schools may not understand their utility and newly trained psychologists may lack the legitimacy or self-confidence to bring them to bear in daily practice.

A third illustration of the nature of professional responsibility is elaborated in Chap. 17 by Robert Ream and his colleagues. This example involves the creation of "Inter-occupational Agents of Change" who can interpret and support the professional tasks needed to ensure that educational and medical services are delivered in integrated and responsible ways. The authors of this chapter begin with the premise that children come to the school system with both educational and medical needs and that their needs are best addressed in an integrated system that maintains the integrity of both medical and educational professional standards. Their chapter "challenges the prevailing skepticism about whether the human improvement professions (e.g., primary care medicine, public health, social welfare, and education) . . . can . . . [act] in conjunction to effectively advance the wellbeing of all children." The strategy set forth is to embrace collaborative civic professionalism and utilize research findings from earlier work on institutional change agents to guide the formation of institutional entrepreneurs who possess the skill and will to execute intersectoral reforms, assuring that medical and educational needs are met in an integrated way.

The fourth discussion of a strategy for reinforcing professional responsibility is presented in Chap. 18 by Paul Adler and his colleagues. In the introduction to this chapter, the authors underscore a point emphasized by Brint in Chap. 6, namely, that bureaucratization and market forces have undercut the classical guild form of professionalism. They quickly move on, however, to argue that "Neither a return to the guild form of professionalism nor further bureaucratization or marketization will enable professionals to meet the challenges we and they face today." Rather, this chapter makes an extended argument for, and documents the existence of, professional workers forming "Collaborative Communities" that replace autonomous individual professionals who have been seeking but failing to develop independent control over their work. The essential point made by these authors is that the development of

agreed-upon professional task standards, and the establishment of standardized work routines to ensure compliance with these standards, enables professional workers who give up their traditional pursuit of independent individualistic control over their work. Through a collaborative development of practice standards, professional communities can secure professional control which is otherwise overrun by organizational management, governmental regulation, and market incentive structures.

Chapter 12
Supporting Educator's Professional Responsibility for Intervention in Family Health Issues

Ronald J. Powell

For more than a century, public education has incorporated public health issues within its broad responsibility to the welfare of society. By promoting the common good of a healthy and well-educated citizenry, the integration of public health concerns into the standard curriculum has bolstered the esteem and autonomy accorded to professional education by the community. For the most part, though, health issues append to the standard curriculum and have little impact on the professional responsibility of educators. Recent scientific advances, however, have demonstrated the strong association between family health risk factors and the cognitive and affective development of young children. Prenatal substance exposure, early life trauma, and environmental exposure to violence, abuse, and neglect directly impinge on the ability of the child to learn, thus rendering standard instructional practices ineffectual. With estimates of one in three children affected, these risk factors are associated with significantly increased incidence rates of serious mental health disorders, academic failure, and poor life outcomes. The complex relationships between family health factors and neurodevelopment provide a context for an examination of the implications for professional education in an environment where specialized knowledge assumptions about student behavior and theories of learning are inadequate and public confidence becomes shaken. Against this backdrop, we examine professional responsibility through the lens of complex adaptive systems theory, positing that organizations must continuously adapt to external threats through a dynamic process involving three domains: identity, information, and relationships. We discuss the implications for the profession in light of current threats to these conditions and make recommendations for the future.

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Since the United States Congress passed the Individuals with Disabilities Education Act in 1975, school districts across the nation have been tasked with the responsibility to provide a free, appropriate public education (FAPE) to students with disabilities. At the time of this landmark legislation, Congress estimated that less than half of all students with disabilities received an appropriate education and 12 % of children with disabilities were excluded entirely from public education (Education for All Handicapped Children Act of 1975). Nationally, over the course of the succeeding 38 years, the population of students with disabilities has continued to grow as a proportion of all students in public schools. Similarly, the cost associated with the provision of special education services has also grown (Moore et al. 1988; Parrish and Wolman 1999). Recognizing that average school districts are often too small to provide for the full range of services that may be required for students with severe disabilities, California conferred oversight responsibility for the provision of special education services on consortiums of school districts organized within an administrative structure called a Special Education Local Plan Area (SELPA). The SELPA is governed by a locally developed plan that ensures that all students, regardless of the nature and severity of their disability or their geographic location within the region will receive FAPE.

The Desert/Mountain SELPA (D/M SELPA) is one of over 100 SELPAs in California. Over 100,000 students are enrolled in public schools within the D/M SELPA region including over 11,000 students with disabilities. Extending from the San Gabriel Mountains to the border of Arizona in San Bernardino County, the Desert/Mountain SELPA is the largest SELPA in the state covering nearly 20,000 square miles (larger than most New England states) and comprised of 27 local education agencies (LEAs). Due to a history of unequal distribution of government services, the geographic isolation of the Desert/Mountain SELPA has proven to be an important catalyst to the development of innovative service delivery models to serve students within the SELPA region. This, together with the small rural nature of many of the area communities, has resulted in an unique ethos of independence from "big city" services and has fostered a utilitarian recognition that collective effort is necessary to meet local needs. As a result, local school districts, adopting an "all for one, one for all" mentality, frequently pool resources in support of innovative solutions to meet the needs of all students.

Demographically, school districts within the D/M SELPA face many challenges in their attempt to fulfill their educational mission. In 2012, 70 % of students in the region were children of poverty compared to 58 % statewide. English learners made up 13 % of the student population (California Department of Education 2014). The Child Maltreatment Rate in the region is comparable to the statewide rate with 7.5 per 1,000 children reported to the Department of Children's Services for suspected abuse and neglect and 3.2 children per 1,000 were placed in foster care compared to 9.4 and 3.2 per 1,000, respectively in California (Needell et al. 2012). Of the approximately 30,000 births in the county each year, 7 % are of low birth weight and 12 % are to teenage moms between the ages of 15 and 18 years old. In addition, based on self-report, 29.3 % of women acknowledged that they had used alcohol, tobacco, and/or drugs at some time during their pregnancy compared to national

estimates of 16–35 % (Children's Network 2006; Chasnoff 2010). As reported by Fullan (2003), Keating and Hertzman (1999) note that large differences in socioeconomic status among school districts, communities, or societies are frequently correlated with poorer developmental health outcomes. These developmental health outcomes are defined as poorer physical and mental health, competence, and coping skills that bode poorly for personal success in an economy that is heavily dependent upon the successful utilization of knowledge and information.

The impact of poor developmental health on students within the SELPA is evident along multiple indicators. While student proficiency in English/Language Arts has shown steady improvement over the last decade, only 53 % of general education students and 33 % of special education students scored at a level of proficient or advanced on the California Standards Test in 2011; a rate well below the state benchmark of 68 %. In addition, suspension rates expressed as a proportion of enrollment for special education (17 %) as well as general education (14 %) remain well above average suspension rates in the state (11 %) (California Department of Education 2012).

Moreover, the region has also witnessed a dramatic shift in the proportion of students with disabilities. Successful early interventions for students with mild learning disabilities and speech impairments resulted in fewer students identified in need of special education services. However, students identified on the autism spectrum as well as students identified as "Other Health Impaired" due to an identified attention deficit disorder increased by magnitudes of 912.5 and 361.4 %, respectively over a decade. The difficulty that districts face because of this shift in the constituency of the special education population is primarily financial. Students with more severe disabilities are more expensive due to the increased number of additional services that are required to enable them to benefit from their special education. As a result, between 2006 and 2010, while the overall enrollment of students with disabilities in the county remained relatively stable, the costs for the provision of special education services increased by ten million dollars.

It was within this context that school districts within the SELPA began to press for answers. Districts felt confident that they possessed sufficient technical expertise to address the challenge of differentiating instruction for a broad gradient of academic skills in the classroom. They expressed much less confidence, however, in their ability to address the increasing level of severity of behaviors that children were exhibiting. Persistently high suspension and expulsion rates together with a high school completion rate of 82 % were sufficient indicators that more needed to be done. Moreover, the community was also raising concerns about youth violence which placed additional pressure on school districts to respond. Law enforcement reported that the juvenile arrest rate was 150 % ahead of the state average and gang activity in the county was ranked third in the nation behind Los Angeles and Chicago (Children's Network 2006). As a result of these concerns, school districts turned to the D/M SELPA for answers.

Research indicates that severe behavior patterns are evident very early in a child's development and if identified early on, there is hope for successful intervention. Friedman (1996, 1999, 2002) estimated that 9–13 % of American children and

adolescents between the ages of 9 and 17 have serious diagnosable emotional or behavioral health disorders that result in substantial to extreme impairment. However, these problems appear much earlier (Lavigne et al. 1996). Campbell (1995), for example, estimated that 10–15 % of preschool children exhibit chronic mild-to-moderate levels of behavior problems and among children of poverty, this prevalence rate is estimated to be twice as high (Qi and Kaiser 2003). The severity of these behavior problems is of such significance that preschool children are three times more likely to be expelled than children in elementary and secondary schools (Gilliam 2005). Moreover, children who are identified as hard to manage at ages 3 and 4 have a 50 % chance of continuing to have difficulties into adolescence (Campbell and Ewing 1990; Campbell 1991, 1997; Egeland et al. 1990). In fact, so persistent is an early pattern of aggression that the correlation between preschool-age aggression and aggression at age 10 is higher than that for IQ (Kazdin 1995). Moreover, Dodge (1993) noted that when aggressive and antisocial behavior has persisted to age 9, further intervention has a poor chance of success. This is particularly troubling given that early appearing aggressive behaviors are the best predictor of juvenile gang membership and violence (Reid 1993).

Taken together, these facts paint a vivid picture of the problems faced by teachers in terms of classroom control. Regardless of how skillful a teacher may be in conferring academic content, severe disruptive behaviors significantly impair the ability of the teacher to fulfill their essential responsibility of educating an informed citizenry capable of being successful in today's knowledge economy and equipped to be good citizens that contribute to society as well. Nevertheless, faculty in higher education early childhood programs report that their graduates are least likely to be prepared to work with children with persistently challenging behaviors (Hemmeter et al. 2008). Moreover, in spite of the evidence of the prevalence of significant behavior and mental health disorders among our youth, fewer than one in ten children will receive services for these difficulties (Kataoka et al. 2002). Taken together, these findings suggest that in a typical kindergarten class of 30 children, 6 children will manifest significant behaviors that adversely affect their ability to learn; but only 1 child out of every two classes will receive mental health treatment. Moreover, 4 of those children will continue to exhibit aggressive behaviors at age 10 with little chance at that point for successful intervention. Fortunately, however, there are evidence-based strategies that are effective in changing this trajectory. The problem rests in ensuring access to these interventions and supports in a timely and intensive manner sufficient to address the complexity of each child's needs.

"Alan has a behavior," his mother, Beth, explained. "He hits himself and he hits other children." Alan's mother spoke confidently, anxious to tell her story. There was a marked difference between her affect now compared with 10 months earlier when 3-year-old Alan was referred to our clinic. At that time, Alan's behavior was "out of control" in spite of a year of intensive special services. The stress that his special needs had placed on the family was significant and in response, Beth had reached out to us. "He wasn't talking very good," she recalls. "Instead of him trying to use his words, he would attack you to get what he wanted."

Beth's story, like the stories of many families of children with special needs, chronicle her efforts to navigate the fragmented systems of multiple agencies with shared and overlapping responsibilities. Beth's efforts highlight one of the current challenges to professional work. Colby and Sullivan (2008) contend that one of the defining characteristics of professions is the commitment to serve clients and the broader welfare of society. To the extent that professionals serve clients well in service to the common good, professionals enjoy greater autonomy and public esteem. But to the extent that the public views professional services as ineffective or that the professional is acting out of self-interest or blatant disregard for the individual needs of the client, then not only is the individual reputation of the professional impugned, but also the public perception of the profession is sullied as well. In that sense, then, a profession cannot survive if the ethical commitment to the common good of society is not evident to the public that they serve. Certainly, technical expertise and a proficient grasp of highly specialized knowledge will not redeem a profession that is broadly regarded as being out of touch with the key values and expectations of the community and the ethical code of the profession. But when an individual's personal values and beliefs come into alignment with both the ethical commitment of the profession as well as community expectations, then such an alignment produces a culture in which professional autonomy, public trust, and a personal sense of purpose flourish resulting in conditions that foster professional fulfillment and high morale (Sullivan 2004).

Within this framework, then, institutional as well as environmental conditions serve to undermine the ability of the professional to fulfill their commitment to the community with moral integrity and ethical behavior. Conditions such as economic concerns, external regulation, and the inevitable fragmentation of care that results from a cloistered institutional focus tend to degrade the profession by weakening morale and compromising the sense of purpose that undergird professional efforts. Moreover, silos of technical knowledge buttressed by narrow self-interest or guild protection restrict communication among agencies involved with the child and constrict the available choice of interventions to those that are within the technical expertise of the lead agency. These institutional barriers confront the profession of education as well.

For over three decades, the education profession has been challenged by a public perception of calloused, uncaring educators who pass along an increasingly illiterate population of children from grade to grade (National Commission on Excellence in Education 1983). These tensions became evident as Beth sought help for her son. Like many families of children with special needs, Beth recognized Alan's behavior and language needs early on. Her efforts to secure help to address her son's emerging delays, however, led to only partial answers. Although Alan's early development was unremarkable, Beth was mystified by his repeated ear infections. Alan's pediatrician successfully treated the infections with antibiotics 15 times in his first 2 years, but offered no explanation for their recurrence. Alan spoke his first words at 10–12 months and continued to add to his expressive vocabulary until somewhere around his second year when language suddenly stopped and his aggressive behaviors, especially toward his mother, began to escalate. Alarmed by the deterioration

in his behavior, Alan's pediatrician referred him to the Regional Center (the lead agency for children with disabilities under the age of 3) for an evaluation. At the Regional Center, Alan's poor impulse control and aggression toward others together with limited language resulted in a diagnosis of autism spectrum disorder at the age of 2½. As a result, Regional Center authorized in-home behavioral services using principles of applied behavior analysis (Hagopian et al. 2000) to address the escalating pattern of tantrums and screaming. Six months later, the primary responsibility for treatment shifted from the Regional Center to the public schools and special education services were added to the daily in-home regimen of behavioral therapy. Alan attended school daily and received specialized academic instruction in a special center for preschool children who fall on the autism spectrum. In addition to his daily educational experience, supplemental speech and occupational therapy services were provided weekly. In spite of the diversity of these services, however, progress was minimal and the severity of the behavior continued to increase projecting a grave prognosis for Alan's successful integration into public school. Faced with this urgency, Beth referred Alan to the Desert/Mountain Children's Center.

The Desert/Mountain Children's Center (DMCC) is a unique hybrid between public schools and the Department of Behavioral Health. As an extension of the Desert/Mountain SELPA, it operates under the administrative umbrella of the County Superintendent of Schools. As a mental health clinic, however, the DMCC is funded primarily through Medicaid funds as a community-based mental health organization under contract with the County Department of Behavioral Health to provide school-based mental health services to children from birth through age 21. Clinic-based services for children under the age of 6 are patterned after the transdisciplinary model of the Screening, Assessment, Referral and Treatment (SART) centers pioneered by Dr. Ira Chasnoff of the Children's Research Triangle in Chicago, Illinois.

The DMCC SART clinic provides a focal point for assessment and treatment of children under the age of 6 who have been exposed to toxic levels of stress or trauma or who have been prenatally exposed to alcohol or substances of abuse. Substantial research in the fields of medicine and neuroscience document that early exposure to toxins such as illicit drugs (Thompson et al. 2009), alcohol (O'Malley 2000; Riley et al. 2005; Streissguth 1997), and tobacco (Herrmann et al. 2008) or early experiences of trauma and/or neglect result in neurological damage that adversely affects the developing brain in ways that significantly impair cognition as well as the regulation of emotional states (Kaufman et al. 2000; Perry 1997; Putnam 2006; Szalavitz and Perry 2010). These exposures are extensively implicated in the presence of mental health and physical health problems throughout the lifespan (Anda et al. 2006; Felitti et al. 1998). In schools, these early life exposures often result in such impairments as a limited ability to learn, attention deficits, and a variety of challenging behavior problems that include severe temper tantrums, episodes of rage, aggression, or internalized behavior disorders such as withdrawal, or depression. Left untreated, these behaviors manifest themselves as social anxiety disorders, or violent and aggressive behaviors in adolescence. As a transdisciplinary assessment center, Alan's referral to the DMCC SART brought him into contact with a broad base

of medical, psychological, and therapeutic professionals. Working together, these professionals pool their expertise in a case-centered approach that focuses on the unique needs of the child in an effort to identify child and family strengths and needs that impinge on the child's normal cognitive and affective development.

Obviously, in Alan's case his behaviors were not typical of normal developmental milestones. And while many of his behaviors (e.g., the sudden halt in normal language development, the rage and tantrum behaviors, poor impulse control, and aggression toward adults and peers) were characteristic of the behaviors often exhibited by children who fall on the autism spectrum, other more specific explanations for the behaviors also seemed plausible. For example, delays in language development are common among children with frequent ear infections—Alan had 15. Moreover, children exposed to tobacco smoke in the home are susceptible to recurrent ear infections and children exposed to tobacco in utero have a significantly higher rate of attention deficit, hyperactivity disorder (ADHD). Alan's maternal as well as paternal history indicated that Alan was exposed to tobacco in his prenatal and perinatal developmental period.

Beth also indicated that she drank alcohol socially, but stopped once she found out that she was pregnant—6 weeks into Alan's neonatal development. This early exposure to alcohol occurred at a critical time in neurodevelopment—the formation of the corpus callosum and the limbic system. The corpus callosum is located in the midline of the brain and allows the sharing of information between the brain's right and left hemispheres. As a part of the limbic system, the corpus callosum plays a major role in the way in which sensory information from the environment is received and processed by the brain. When the limbic system is structurally damaged as a result of prenatal alcohol exposure, the brain is unable to use previously stored information to guide behavior. Under these conditions, a child may be able to articulate the rules germane to a particular environment, but appears to be unable to use them to regulate behavior. As a result, damage to the limbic system that occurs from drinking in the first trimester results in many of the functional deficits that are often described as hyperactive, impulsive, disobedient, oppositional, and defiant behaviors (Chasnoff 2010; Kaufman et al. 2000; Olney 2004; Rasmussen 2005; Streissguth and O'Malley 2001). Stitched together, these elements presented a more complete understanding of the relationship between Alan's early environmental experience and health history and the cognitive and behavioral challenges that he was exhibiting.

Working together from the perspective of their various disciplines, the transdisciplinary team posed a new hypothesis for the root cause of Alan's behavior and suggested a fresh path for treatment recommendations. Based upon the history of prenatal exposure to tobacco and alcohol, the team assumed neurological damage to the limbic system. This would result in an impaired ability to organize sensory information from the environment and process it in a nonthreatening way. The team also assumed that the frequent ear infections had resulted in a disruption in auditory input during a developmentally critical period resulting in a severe language delay. The aggressive behaviors, then, were viewed as having a communicative intent. As a result of these assumptions, the team recommended an intensive 10-week clinical

assessment program that included daily speech and language therapy and sensory integration therapy. These treatments were nested within a developmentally appropriate environment characterized by abundant music, movement, and healthy touch. To reinforce appropriate behavior, the environment was structured to provide consistency and predictability. Finally, to broaden the generalizability of the regimen beyond the 4-h day, Beth participated in Parent Child Interaction Therapy (PCIT) (Bell and Eyberg 2002; Eyberg 1988). PCIT is a relationship-based therapeutic model in which the parent works directly with their child while being observed electronically by a therapist in another room. The therapist surreptitiously guides and coaches the parent in their interaction with the child through an ear bud in the parent's ear.

The challenges represented by Alan's case can be seen as a microcosm of the challenges faced by professional work. It was not for lack of will that treatment for Alan's behaviors had been unsuccessful. While Alan had received timely attention from multiple professionals, their individual efforts were insufficient to address the complexity of the problems that he presented. In fact, all of the professionals who were involved in Alan's care had acted diligently and responsibly within the scope of their knowledge and expertise. However, the fact that no single profession possessed enough technical expertise to address the problem speaks to one of the key challenges faced in professional work. To address this issue, most professional institutions have created opportunities for professionals to work collaboratively together toward a common goal. Nevertheless, it is novel for such collaborative arrangements to exist across professional fields and in fact, it is here that we can best see how institutional structures, patterns, and processes mitigate against the collaborative ethic that must characterize a new view of professional work in order to maintain a place of trust within the community.

In Alan's case, individual professionals performed their duties well through early identification and the provision of multiple services from competent and experienced medical and educational professionals. His pediatrician effectively treated his multiple ear infections; an early diagnosis of autism resulted in the provision of evidence-based behavioral therapy; and the schools stepped in at the appropriate time and added speech, occupational therapy and specialized instruction to his routine. However, the problem remained that the level of services available lacked sufficient intensity to address the behaviors of concern because the function of the services had been misunderstood. Confronted with his lack of progress, the educational professionals began to doubt their effectiveness in dealing with a child with such significant special needs. Moreover, the educators felt constrained by limited resources from offering a greater frequency or intensity of service. The educators were also concerned that if services were intensified for one student, other families might expect the same consideration. The apprehension over limited resources became juxtaposed to the professional's judgment concerning the nature of the services that might be necessary for a specific child.

The subsequent loss of a sense of efficacy in dealing with the needs of children like Alan represents a threat to the professional identity of the adults entrusted with the responsibility to provide educational benefit to the child. Colby and Sullivan (2008)

posit that professional identity is nested in the acquisition and practice of specialized knowledge and skills. However, an individual's sense of whether or not their specialized knowledge is sufficient is dependent upon evidence that the strategies that are employed are working. The ethical commitment of professionals, then, to continuously hone their skills and sharpen their professional knowledge through lifelong learning becomes integrally linked to notions of professional identity and personal significance that are dependent upon salient indicators of effectiveness. Consequently, a strong sense of professional identity that is grounded in expertise alone is subject to the inevitable loss of morale that accompanies a growing cynicism regarding the capacity of a profession to achieve its essential purpose.

So what is the answer? Colby and Sullivan (2008) posit that professionalism can be fostered through professional education that enables students to find intrinsic meaning in their chosen profession through a solid grounding in the moral purpose that underlies the standards essential to quality work. They suggest that this goal is best accomplished by integrating the core values of the profession throughout the process of the acquisition and practice of professional knowledge and skill. In this sense then, the moral concepts of the profession become both the foundation and the glue for the knowledge and skill of the profession.

The essential role of core values as a foundational element that underpins professional work is a long observed characteristic of human nature. John Locke (1690), for example, observed over 300 years ago, "I have always thought the actions of men the best interpreters of their thoughts" (*An essay concerning human understanding*, Book 1, Chap. 3, Sect. 3). In fact, correlates of this principle are found not only in philosophy but also in psychology and organizational theory. In an examination of the factors that underlie the administrative decisions of school principals, Powell (1992) demonstrated that principal decisions emerge from core belief systems that undergird a sense of personal identity rather than from a specialized repertoire of administrative skills. Rather than selecting from various rational courses of action in response to an environmental circumstance, Powell noted that specific actions and administrative behaviors are employed precisely because they are in consonance with the core values and moral principles that form the individual's sense of self. Cascading from the general to more specific, the set of moral principles that form the personal identity of the principal are insulated from the impingement of environmental contingencies. Principals subsequently hold to those values and make decisions that are in harmony with their deeply held beliefs.

The significance of this view lies in the central importance of moral purpose to our conception of professional responsibility. Within this frame, it can be seen that the specialized knowledge and technical skill of professional work is interpreted and applied based upon the lens of the moral purpose that is an integral part of individual identity. As a result, when individual, professional, and community purposes are aligned, individual professional autonomy, morale, and satisfaction are strongest.

It makes sense, then, that if individuals make decisions in this way, that institutions, as social enterprises, would mirror this existential human behavior. At the corporate level, common identity is embodied in the corporate culture (Deal and Kennedy 2000). Corporate culture includes the values and principles of the organization that

are reinforced by the traditions, symbols, and rituals of institutional life. In this regard, both formal and informal rules, symbols, and traditions carry communicative intent. For example, open door policies and flat organizational hierarchies communicate egalitarian views of communication, whereas the use of formal titles and designated parking spaces assigned by position within the organization clearly convey a different message. One sets a tone that is more inviting to the interchange of information across all levels of the organization, whereas the other creates barriers to communication and conveys a message that information as a tool of power must be vetted and brokered to be seen of value to the organization.

Not only do values guide organizational behaviors, but they also serve as catalysts for reorganizing and sustaining organizational change. In an examination of the essentials of organizational reform, Fullan (2003) identifies the central importance played by the interaction between three fundamental elements identified as (1) moral purpose, (2) quality relationships, and (3) quality knowledge. All three domains are regarded as necessary to change the context of the organization in such a way that it creates an environment in which positive change can be formulated, inspired, and sustained. Moral purpose is intrinsically motivating and as such causes individuals to sustain their endeavor in the face of difficulty precisely because their efforts are motivated by a purpose beyond themselves. However, moral purpose alone is not sufficient. The selfless expression of moral purpose lies in the close bonds that exist within strong interpersonal relationships through which purpose is expressed and finds shared meaning. In the same way, organizations cannot thrive unless there is a way of coalescing individual identities behind a common moral purpose that resonates with the most noble aspirations of each individual and in that way binds them to one another toward a common commitment to the greater good.

The theoretical foundation for Fullan's work is found in an extension of chaos theory (Gleick 1987) known as complex adaptive systems theory or complexity theory (Marion 1999; Marion and Uhl-Bien 2001; Schneider and Somers 2006; Wheatley 1994). The central notion of complexity theory is that organizations of all types are more like living organisms than they are like machines. Machines are engineered to accomplish a specific purpose and when a variable is injected for which the system was not designed, it disrupts the mechanism's operation. When viewed through the metaphorical lens of a living organism, however, organizations are constantly adapting to change in the environment through "redesign," "retooling," and system modifications. As a "living system" the organization has the capacity to continuously reorganize and assume different forms. Similar to the work of Fullan on organizational reform, Wheatley and Kellner-Rogers (1996) have identified that the ability of an organization to self-organize in response to threats from the environment is dependent upon the interrelationship among three essential domains: identity, information, and relationships.

Most organizations only tinker around the edges in seeking reform. Policy makers will change the formal structures of the organization by reorganizing departments, shifting priorities or responsibilities. They may change the patterns of the organization by altering the ways that they interact with their core constituents or directing the behaviors of staff. Alternatively, they may change the processes of the organization

by instituting new rules and policies in an attempt to make the organization more efficient, to insulate the organization from threats, or to reinforce core messages. However, for the most part, organizations are resistant to change. This is because individuals within the organization have adopted a "sense of self" that is employed in the continuous process of making sense of the world around them. They interpret information in terms of "What does this mean for me?" and rarely think beyond that. In the same way, organizational identity is comprised of its values and mission, as well as the symbols, rituals, and traditions that make up the corporate culture. It includes the history and the stories of the organization as well as its future aspirations for what it can accomplish through the affiliation of its members. As such, the identity of the organization embodies the corporate "self" that continually engages in the process of construing the phenomenological world in alignment with its interpretation of itself. Unless the organization, then, is intentional about creating an alignment between the identity of the organization and people's shared sense of identity, then efforts to move the organization in a different direction will be ineffective (Wheatley and Kellner-Rogers 1996).

As living systems, organizations are in a continuous process of gathering information from the environment, matching that information with experience and generating a response that is in alignment with the core values of the organization. Dynamic organizations perform this task enthusiastically recognizing that new meaning is often created in that serendipitous moment when old patterns are perceived in a new light and thus given new significance. The medium in which dynamic organizations thrive is rich, deep information, ubiquitous throughout the organization and proffered with an expectation that people within the organization will construct new meaning from the information in alignment with the shared intentions of the organizational self. The synergy of ideas that is created when information belongs to everybody enables the organization to shift quickly in a coordinated response to changing needs.

Wheatley and Kellner-Rogers view relationships as the vehicle through which new information is shared and knowledge is created. Through social interaction, ideas build upon one another, inspiration fosters creative approaches, and encouragement sustains the effort. The connections established through social interaction broaden the base of ideas in support of the work. The broader the base, the more stakeholders are included and the more points of view are taken into consideration. Relationships also broaden perspectives and the tolerance for new ideas. Through social interaction, empathic understanding of individual differences is fostered and loyalty to each other as well as to the organization is engendered.

The three domains of identity, information, and relationships act in concert with one another to energize the reformation of the organization from within. Unlike the mechanistic approach to reorganization that focuses on changes to the structure, patterns of behavior, or processes of the organization, complex adaptive systems theory looks to the power of the individuals within the organization to devise solutions that are in alignment with their common understanding of the mission of the organization. Empowered with an understanding of the deepest intentions of the organization, in concert with colleagues who share this sense of mission, and given

access to the information and connections with others who share this common purpose, the organization is capable of devising and implementing innovative solutions that are inconceivable in a mechanistically constituted organization. From this perspective, we now turn to an examination of how complexity theory can be used to better understand the professional responsibility of educators for intervention in family health issues.

When area superintendents directed the SELPA to develop a program to address the significant behavioral and mental health disorders of children in area schools, the request fits comfortably within the established identity of the SELPA. The mission of the SELPA ("the relentless pursuit of whatever works in the life of a child") conveyed the shared understanding of the obligation of the organization to continually seek ways of meeting child needs. The alignment of staff behind this intention created an eager expectation that the new direction articulated by leadership was possible and generated an infectious enthusiasm among individuals across the organization. Issues of funding, developing community partnerships, and building staff capacity needed to be resolved. Necessary processes and procedures to support such an endeavor were unknown. Legal and liability hurdles needed to be cleared and barriers endemic to transdisciplinary service delivery models needed to be overcome. However, the novelty of the notion that we were attempting to do something that had never been done before, together with the strength drawn from a deeply held conviction that success in this endeavor would deliver immense benefits to children in our region, propelled and sustained the efforts necessary to move forward. Information and ideas multiplied rapidly through collaborative teams and each successful resolution fostered increasing perceptions of competence, which in turn served as an additional catalyst to press on. Throughout the process of development, staff remained committed to the project with unwavering faith that success in this endeavor would provide a valuable service to children and families within the community and school districts that we serve.

As a result of these efforts, a transdisciplinary clinic was established that included medical, mental health, and education professionals as equal partners in designing interventions to address individual child needs. Today, the clinic employs nearly 150 medical and therapeutic professionals providing clinical and school-based mental health services to over 4,000 children annually from birth to 22 years of age. Transdisciplinary assessment including pediatric, psychotherapeutic, speech and language, occupational therapy, and clinical neuropsychological evaluations inform intensive therapy and clinical treatment, as needed, for children under the age of 6 and their caregivers. As specialized knowledge with this population grew, so did expanded opportunities for service that included services to children like Alan.

"Like I said before," Beth repeated. "He's wonderful! He's amazing! Family and friends are noticing a change and they're like 'Did you put him on drugs?', and I'm like 'No! He's not on any medication.'"

Beth laughed and then continued. "He is doing so great and it's because of [the clinic] and I want to thank all of the ladies that was a part of that. I just want to say 'Thank You!' Because without you I don't even know my son would be in a regular classroom, let alone at the Academy (a competitive magnet school). He is writing

his name, he knows his phone number, he gets his self dressed, he brushes his teeth, he is just amazing! Like his report card; he's there. He met all the requirements for kindergarten. So I couldn't be more amazed."

We are often asked, "Why?" As an education agency, why would we want to go into the mental health business or take on the complexity of medical liability? Certainly Beth's story is compelling and causes us to be encouraged by Alan's dramatic success. In 10 weeks, he progressed from functioning at a 14-month level to age appropriate levels in receptive and expressive language, behavior, and concepts of school readiness. And while Alan's progress is exceptional, it is not an outlier. Over 60 children have matriculated through the 10-week intensive clinical program since its inception 2 years ago and most children make similarly impressive gains.

The fact is that we did not engage in this work willingly. Our first response, based upon the research, was to fill the gap of early identification. We initiated the service with the intention that we would only conduct the transdisciplinary assessments for children under the age of 5 who were referred through the child welfare system. Our intention, then, was to refer identified children to community-based mental health clinics to provide the services. However, at a community forum to which over 100 service providers were invited, the question was posed, "How many of you have expertise in providing mental health services to children under the age of 5?" Fewer than ten hands were raised.

"And how many of you have capacity to receive additional referrals if we find children who are eligible for services," we asked. One hand remained.

Rising to her feet, the dear lady exclaimed, "We can take two."

Immediately, it became obvious that we could not assess 400 children annually if there was no capacity in the community to serve. Therefore, prodded by the obvious community need, we accepted the responsibility to provide services as well—the relentless pursuit of whatever works.

Philosopher John Dewey was once confronted by a young physician with a low opinion of philosophy, "What's the good of such claptrap?" he asked, "Where does it lead you?"

To which Dewey responded, "The good of it is that you climb mountains."

"Climb mountains?" the young man replied, "And what's the use of doing that?"

"You see other mountains to climb," was the reply, "You come down, climb the next mountain, and see still others to climb. When you are no longer interested in climbing mountains to see other mountains to climb, life is over" (Tan 1979).

And so it is with professional work. The continuous improvement in carrying out professional responsibility, guided by an ethos that is committed to employing the specialized knowledge and skill of the profession in service to the common good of the community, draws upon relationships and connections with others to create new knowledge and shared meanings that are employed to provide services in response to human need. The benefit to the organization is that the regenerative process energizes the professionals within it. And from the vantage point of additional knowledge, experience, and skills, new needs are identified that require fresh ideas and creative thinking in a continual cycle of innovation and renewal.

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Chapter 13
Professional Ethics and Virtue Ethics in Community-Engaged Healthcare Training

Zeno E. Franco, Mark Flower, Jeff Whittle, and Marie Sandy

Introduction

Community engagement is one key to improving the relevance and uptake of scientifically supported health interventions. Health researchers widely agree that healthcare organizations must organize and resource community engagement processes to generate meaningful engagement in order to improve population level health outcomes (Ahmed et al. 2004; Ahmed and Palermo 2010; Minkler and Wallerstein 2010; Simonds et al. 2013; Wallerstein and Duran 2006). We argue that explicit attention to the ethical complexities of Community-Based Participatory Research and practice (CBPR) is similarly vital. This is particularly evident when

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new CBPR practitioners move from traditional care and trainee supervision models in clinical work environments to community engagement settings.

One important aspect of this transition is encountering differences between the ethics of professionally trained service providers and the conceptions of ethical responsibility held by community partners. These complex trade-offs arise most clearly when clinical practitioners transition from closely supervised training within healthcare settings to assuming professional practice roles in community settings. In the community, trainees must negotiate novel uncertainties and discontinuities with limited supervisory input. While there are some systematic efforts to improve the pipeline of health professionals trained to perform CBPR, most do not attend to the ethical, as opposed to knowledge- or skill-based challenges that are encountered in the field. In order to illustrate these considerations, we describe in some detail a community–academic partnership for military veteran health located in Milwaukee, Wisconsin. The four authors of this chapter each play a role in the complex social dynamics of this case study. Hence, we begin with a brief introduction to the authors and how they have participated in the evolution of this dialogue.

Zeno Franco—a prelicensure clinical psychologist, primarily trained in evidence-based treatment for combat trauma in the VA Healthcare System. During the time period this case study describes, Dr. Franco transitioned from providing traditional one-on-one outpatient psychotherapy for veterans in the VA Healthcare system to a Health Research Service Administration (HRSA) supported postdoctoral fellowship in primary care and community health research housed at a civilian hospital. During this transition, Dr. Franco joined a community–academic partnership run by a small veteran nonprofit organization—Dryhootch of America—in collaboration with faculty from the Zablocki VA Medical Center and the Medical College of Wisconsin in order to focus on population level interventions for veterans.

Mark Flower—a veteran peer mentor employed by Dryhootch. Mr. Flower provides direct, community-based recovery support to veterans struggling to reintegrate into civilian life. Most of his clients suffer from drug or alcohol addictions or other challenges to their mental health. Mr. Flower served as a liaison between Dryhootch and the community–academic partnership.

Jeff Whittle—an internal medicine physician at the Zablocki VA Medical Center. Dr. Whittle was one of the founding members of the Dryhootch community–academic partnership and a senior research mentor to Dr. Franco in this setting.

Marie Sandy—an assistant professor of community studies at University of Wisconsin, Milwaukee. Dr. Sandy's work focuses on socially just approaches to community engagement, and the application of practical philosophy to discourse in community–academic partnerships. For this project, Dr. Sandy offered avenues for the other authors to reflect on the partnership process and to formalize the ethical critiques offered by the community partner in order to put those arguments on more equal footing with the views offered by the professional partners.

The narrative presented below represents, in part, Dr. Franco's personal reflections on the partnership process and his struggles with selecting the appropriate set of ethical precepts to apply in this context. These reflections are interspersed with ideas drawn from *practical philosophy*[1] to facilitate a deeper understanding of the discourse between the community and academia (Sandy 2011). In particular, we focus on the philosopher Hans-Georg Gadamer's interpretation of the Aristotelian ethics of *friendship*, *practical beauty* (i.e., the aesthetics of partnership) and *fortitude*, elements in the broader ideal of *virtue* (i.e., attending to fundamental values that drive individuals and groups toward moral excellence) in order to link the views held by Mark Flower, the community partner representative, with those of Dryhootch's academic partners. The language of virtue ethics gives voice to what Mark and the community organization see as a flexible approach to ensuring access to health services for individuals and communities most at risk of "falling through the cracks." Comparing the ethical precepts of academic partners with those of the community partners is challenging, but informs us regarding why some of the chosen courses of action of the academics are at times in tension with the community. Further, comparing these precepts serve to better balance divergent ethical perspectives within the partnership, while remaining faithful to the ethical standards of professional service provision.

Most of the concepts offered in the CBPR curricula proposed by (CBPR; Israel et al. 2005) are fairly straightforward. However, the ethics of CBPR are not as clear, particularly when community–academic partnerships are focused on improving health (Buchanan et al. 2007; Flicker et al. 2007; Whittle et al. 2010). In part, the ethical dilemmas encountered within these partnerships stem from divergent views of what foundational ethical framework should be applied. Clinical providers generally embrace a set of ethical guidelines advanced by professional organizations (e.g., AMA 2001; APA 2003). These guidelines attempt to balance "deontological" with "consequentialist" ethical responsibilities. That is, clinicians see ethics in terms of institutional rules on the one hand and professional duties to prevent undesirable consequences on the other (e.g., the duty to report, etc.). In contrast with these concerns, communities members tend rely on a very different framework, appropriately described "virtue ethics"[2]—action evaluation criteria that deemphasizes prescriptive rules or attendance to immediate consequences of actions, but instead emphasize the common good and human flourishing as goals that must, at times, trump deontological or consequentialist concerns. They use these shared understandings to set standards for judging the appropriateness of their own and

[1] Elsewhere, Sandy argues that the practical philosophy approach of Hans-Georg Gadamer describes how each of us is responsible for exercising wisdom in our personal lives and that we are all charged with determining the common good for society. By extension, this approach assists in understanding and orienting the work of service-learning and community engagement (Sandy 2011).

[2] Aristotle described the "common sense" ethics that point human beings toward living a good life, both individually and collectively. The concepts in this chapter are drawn from Nicomachean Ethics, particularly Book VI.

clinicians' actions. Thus, in some cases, a rule that a hospital might view as taken for granted (ranging from fairly simple things like requiring overly long intake forms, to much more complex issues such as calling security to respond when a patient is upset during intake rather than having a mental health specialist intervene and defuse the situation, etc.) might be seen as a fundamental barrier to access by community members. Thus, community representatives may view these rules as addressing institutional concerns *at the expense of* human flourishing.

These are complex waters to navigate for seasoned health and mental health professionals and are even choppier for trainees in these disciplines. An important area for training in professionalism is learning to recognize and accommodate discontinuities among the ethical assumptions of various communities, healthcare systems, and regulatory bodies engaged in collaborative activity. The trainee must take care to honor each approach while simultaneously balancing very real risk considerations. Our discussion of CBPR considers the perspective of early career clinicians and of how mature professionals supervise novices in community settings. We also describe how academics come to understand the social norms and service expectations of the communities they seek to serve. Finally, we hope to develop avenues for institutions to more fruitfully encounter "the other" (Olson 1998) with greater sensitivity to the ethical views and priorities of community partners.

To accomplish these goals and ground the discussion in actual community-engaged practice, we trace the difficult initial development and gradual transformation of a community–academic health research partnership between Dryhootch of America (the community-based veteran outreach group), the Clement J Zablocki VA Medical Center (ZVAMC), and the Medical College of Wisconsin (MCW), all located in Milwaukee, Wisconsin. Discussion of ethical dilemmas that emerged in this community–academic partnership is our primary focus. We tell the story from the perspective of a personal and prolonged encounter between this chapter's senior author, Zeno Franco (the MCW postdoc) and Mark Flower (veteran peer mentor) of the Dryhootch community organization. We demonstrate that the ability to enter into meaningful *discourse* is a fundamental aspect of professionalism in the development of community–academic partnerships (Mezirow 2003). Drawing on a practical philosophy framework for deepening discourse with the community partner about conflicting ethical assumptions, we explore three elements found in virtue ethics: *friendship*, *practical beauty*, and *fortitude* (Sandy 2011; Franco et al. 2011). These ideals offer a formalized language that encapsulates important features of the Dryhootch community partner's counterarguments to the largely deontological views of the MCW and VA partners. The running discussion between representatives of the partnering agencies regarding how ethical decision making impacts the common good gradually changed the ethical perspectives of both the institutional professionals and the community agency. This process has practical implications for training early career professionals, considerations for clinical supervisors, and developing future CBPR curricula that more deeply address the varying ethical assumptions encountered in partnership.

A Case Study of Community Partnership in Health Services Delivery

Although postcombat health and mental health problems have been recognized since the Civil War, they affect a particularly large proportion of veterans returning from the wars in Afghanistan and Iraq. The importance of addressing these issues through community-based, population health approaches is increasingly recognized as VA hospitals are not always the first place where veterans seek care (Hinojosa et al. 2010; Kudler et al. 2011); they frequently prefer remaining outside these institutions.

Dryhootch is based in Milwaukee, Wisconsin's bustling East Side business district. The agency provides peer-to-peer mentoring, recovery programs, and informal social support for veterans. "Hootch" was the term for a hut or other safe place to sleep commonly used in the Vietnam combat theater and is also a play on the word's association with alcohol—one of the major problems for veterans of all eras. The term "dry" denotes the organization's mission to provide a social gathering place for that is free of alcohol. Thus, the concept behind "Dryhootch" was a desire to establish a coffee house or café like environment that is dedicated to "helping veterans who survived the war, survive the peace." While Dryhootch is a small organization, it has grown from being a dream held by a number of veterans who were in conversation with the Milwaukee VA in 2007, to owning a building and providing veteran social support programming in 2010, to expanding to several satellite locations throughout the state in 2012–2013. Since its inception, Dryhootch has been in partnership with ZVAMC and MCW.

Partnership Challenges

Difficulties within community–academic partnerships are quite common given the complexity of articulating and negotiating between the cultures, objectives, and styles represented in the collaborating organizations (Minkler and Wallerstein 2010). The Dryhootch/VA/MCW partnership is no exception; however, some typical partnership difficulties are magnified by factors unique to the veteran population and by the mental health focus of this effort. These magnified problems fall into three interrelated categories (1) a history of miscommunication and mistrust between some veterans and the local and national VA; (2) very different perspectives among partners regarding the type of mental health services a community-based nonprofit should provide to veterans and the types of risks that should be tolerated; and (3) difficulties in identifying and advancing a mutually beneficial research agenda. Details about the struggles and later successes within the partnership are offered elsewhere (Franco et al. 2014); the focus here is on the mission and risk tolerance discussion and how these elements relate to professionalism training for early career community health professionals.

Mission and Risk Management

At its inception, the partnership jointly agreed that Dryhootch's primary mission was to provide *peer-led* support for veterans' practical and mental health problems, based loosely on the Vet-to-Vet model (Resnick et al. 2004; Resnick and Rosenheck (2008). However, Dryhootch later accepted the volunteer services of a clinician from outside the partnership who was interested in providing one-on-one psychological counseling, therapeutic retreats, and practicums for student clinicians at the Dryhootch location. The medical and mental health providers from the partnership were uncomfortable with this direction because Dryhootch did not have the basic infrastructure needed to run a mental health clinic. Some of the clinical and ethical issues observed by health providers in the partnership when visiting Dryhootch are listed in Table 13.1. Additionally, the academic side of the partnership was aware of several situations that were (at least from a clinical perspective) questionably handled at Dryhootch during this time period. Over several months, the academic partners repeatedly advised Dryhootch senior staff about issues that included the legal and financial risks to Dryhootch, potential negative press that might adversely impact all partners, and the potential disservice done to veterans who might receive inadequate care. Dryhootch staff saw this as an example of the partnership being used inappropriately to influence the day-to-day operations of their organization so that it would conform to the wishes and views of the VA.

This disagreement about the provision of clinical counseling was contemporaneous with a large grant submission; some academic members of the partnership felt this change in mission represented a serious enough risk to warrant abandoning the

Table 13.1 Clinical and ethical problems observed at community partner location

Overstatement of credentials	Dual relationships between supervisee and clients (student clinicians socializing with those seen in individual therapy)
Unsafe supervision arrangement for masters mental health practicum students	Lack of clinic infrastructure
Clinical supervisor not accessible to supervisee	Insufficient record keeping for clinical practice
Inappropriate advice about a *Tarasoff* situation	Substantial liability issues for community partner
Individual counseling being provided without clinic infrastructure (record keeping, etc.)	Press releases described individual counseling as an available service, despite clear communication from academic and healthcare partners about the inappropriateness of these claims
Confidentiality not observed	
Web-based interventions without identifying role, nor specifying limits of confidentiality	
Peer mentors visiting with clients in crisis unit at VA without identifying as an outside provider	

Table 13.2 Exploring alignment and tensions between professional codes and CBPR principles

APA ethics code excerpts (APA 2003)	CBPR principles (Israel et al. 2005)
Psychologists cooperate and consult with other professionals to best serve their client	Principle 2—CBPR builds on strengths and resources within the community
Are concerned about the ethical compliance of their colleagues' scientific and professional conduct	Principle 3—CBPR facilitates collaborative, equitable partnerships in all phases of the research
Do not make false, deceptive, or fraudulent statements about their training, experience, or competence	Principle 4—CBPR promotes colearning and capacity building among all partners
In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm	Principle 7—CBPR involves systems development through a cyclical and iterative process
	Principle 9—CBPR involves a long-term process and commitment

grant writing effort. When this sentiment was expressed to Dryhootch, it was again viewed as a pressure tactic that had the potential to disassemble the partnership rather than as a genuine expression of concern.

The mental health providers identified a number of specific situations that warranted corrective responses according to the American Psychological Association (APA) ethical code. These ranged from the failure to correct veterans' misconceptions about credentialing level of the volunteer mental health provider to mental health trainees on practicum assignments at Dryhootch without on-site supervision or immediate emergency telephone access to fully trained clinicians as appropriate for their training level. The initial impulse of the partnership's mental health providers was to take immediate action to address these issues.

This impulse to act on APA ethical code standards was tempered, however, by the principles of CBPR. The CBPR principles are shown alongside the APA code elements in Table 13.2. A close look at the CBPR principles shows that they urge professionals to take a longer-term view, emphasizing the maintenance of partnerships as well as serving the needs of individual clients. Given that the community partners expressed deep discontent with what they saw as "meddling" in their internal, operational decisions, the academic clinical partners felt that immediate action, though supported by the APA code, might create an irreconcilable break in the partnership, and that this would likely diminish the partnership's ability to support important outcomes at Dryhootch. In light of this, consultation was sought from a psychologist outside of the partnership with more experience in community psychology. This outside consultant brought a new perspective. Rather than viewing the individual veterans seeking services at Dryhootch as "the clients" of the mental health clinicians in the partnership, the consultant articulated the view that the academic partners should take an organizational psychology perspective and the client was really Dryhootch, *itself*, taken as an entire organizational unit.

From this vantage, the academic partners reconceptualized their role as consultative to the organization with the intent of improving Dryhootch's overall capacity to provide safe and effective services rather than working at the level of individuals receiving these services. From this stance, they felt they had discharged their duty by clearly expressing concerns directly to Dryhootch's executive director and to Mark Flower. At this point, the only reasonable option seemed to be to temporarily suspend direct clinical involvement with the peer-to-peer mentorship activities at Dryhootch, but take no direct actions beyond this. This uncomfortable compromise helped to satisfy the academic professionals' need to highlight "red flags" from the perspective of the APA ethics code, reduced institutional risk, and emphasized areas where the academic partners thought Dryhootch needed to build capacity for appropriate service provision. At the same time, it left the door open to future collaboration. Some months later, the community-based clinician volunteering for Dryhootch departed, in part because of disagreements arising from Dryhootch management's increasing discomfort with the turn toward professional clinical services at the expense of their own stated goals of providing paraprofessional social support. Subsequently, Dryhootch changed course back toward its originally stated mission of providing nonclinical peer-to-peer services for veterans, and the activities of the partnership resumed.

Many of the issues encountered at this stage in the partnership were gradually resolved through intensive "shuttle diplomacy," with Zeno Franco and Mark Flower meeting informally at a coffee house a few blocks from Dryhootch to discuss differences in views and to try to establish areas of common ground. Differences across a wide range of topics, including basic ethical premises, views of risk, privacy, clinical, and peer mentor boundary setting, and even topics like perceived "institutional abandonment" were discussed. These conversations and events from this period are memorable; their meanings continue to be contested within the partnership. For example, what the academics saw as "pulling back to make a point" and reorient relationships among the partners, the leadership at Dryhootch interpreted as evidence of a what they saw as a familiar governmental pattern of intimating support for an idea (i.e., the veteran-led social support program) only to abandon the effort when "the going got tough." While those concerns have relaxed to some degree, they still color some conversations several years later. The academic clinical mental health providers in the partnership view their actions as not very direct and possibly risked being "too soft." Meanwhile, the partners from Dryhootch expressed the view that the academics focus on the risks of providing formal clinical care at Dryhootch and resulting "threats" to dissolve the partnership were profoundly uncomfortable because, "it felt like a hammer was being brought down" on them. From Dryhootch's perspective, the academics were willing to discard several years of work just to make a point, that the academics were trying to "teach to them" about what was best for veterans, but that the academics were not willing to learn from the community perspective and know-how about what types of service are effective in reaching veterans who are marginalized and most at risk.

Exploring Divergent Views of the Meaning of Health and Professional Ethics

It was not until an automobile trip that two of the partners (Franco from the academic side and Flowers from the community side) took to another city for the purpose of presenting the partnership process to another organization, that fundamental philosophical differences in the professional ethics and community ethics considerations came into focus and began to be explored in an open way. In part, it was because over the course of an hour long drive some of the more subtle processes of partnership to surface. There was a loosening of "expert" roles and some engagement in social rituals (such as eating breakfast together, on the road and in the middle of an intense snowstorm). The result was a deeper and more open encounter.

During the conversation during this long trip, Zeno Franco challenged Mark Flower about problems he saw with the intervention model employed by Dryhootch—specifically around areas of confidentiality and boundary setting, noting, for example that poor boundaries and psychological enmeshment between a peer mentor and a veteran might cause a peer mentor in drug or alcohol recovery to relapse. Mark Flower insisted that the ability of the peer mentor to *reach* an otherwise unreachable, high-risk individual required, in part, dissolving unnecessary boundaries or the "rules" that might create an unproductive, reactive response in a drug-addicted veteran. These are fundamental, often seemingly intractable problems with traditional psychological care. Psychotherapy is quite effective for those who remain in treatment, but many of those most in need of care react negatively to the actual or perceived authority of the therapist, structure of therapy or just entering a clinic, and simply drop out of treatment (Baekeland and Lundwall 1975; Beutler et al. 2005; Brorson et al. 2013). Moreover, Mark Flower's point was also about the role of mercy, providing a way back for those "too far gone" to be served by institutions and unable to work within the confines of professional care, offering a bridge for these individuals back to a place where they might eventually be open to considering the value of reentering society and engaging with professional healthcare and recovery programs.

Although the fundamental ideas resonated, after almost a decade of traditional training and adopting the mantle of professional responsibility offered by the guild of clinical psychology (e.g., the APA ethics code, state law for mental health professionals, etc.), this was the first time that Zeno Franco deeply encountered this alternative set of ethics, based not on external consequences (what might happen to his professional standing or his clinical supervisor's license) or deontological (rule/principle) based ideas—but instead an virtue ethics, guided by the ideal of human flourishing.

As a mental health provider this now required Franco to negotiate the discontinuities between very concrete guidelines for professional responsibility and an aspirational view of what ethical healthcare service delivery to marginalized populations *might be*. In several respects, this process also required internal restructuring of Franco's role as a provider—transitioning from thinking about treating individuals

to influencing services to a population through his interaction with Dryhootch as an agency. This transition involved more deeply examining the community partner's positions revolving around virtue ethics and interrogating the differences between this perspective and the framework taken for granted by clinical psychology. Moreover, this engagement with the ethical views and priorities held by the leadership of Dryhootch forced a Franco to attend in a much more meaningful way to some of the nuances of the CBPR process itself.

Virtue Ethics and Professional Practice in Partnership

The concept of virtue ethics is one method for creating a shared theoretical framework in community–academic partnerships, and here we apply the ideas derived from this work—using the ideals of *friendship*, *practical beauty*, and *fortitude* as ways to capture the ethical worldview of community partners to the Dryhootch partnership in particular. Aristotelian virtue ethics were inspired by the question about how to live a good life, both individually and collectively, and these ethics applied equally to everyone in society. From this perspective, the art of living well is considered to include both our individual and collective or public lives. Incorporating Aristotelian ethics to guide action in community–campus partnerships is appealing because it highlights the knowledge we use in everyday life to make decisions and work collaboratively with others and distinguishes this form of knowledge from scientific and theoretical knowledge traditionally valued experts or professionals in the academy. The turn toward Aristotelian practical wisdom, as described by Hans-Georg Gadamer, provides an epistemological framework that celebrates *learning by doing for the common good*. In particular, Gadamer emphasized practical wisdom in most of his later work, what Sandy (2011) described as practical beauty, and highlighted friendship and openness to the "other" as the process through which this occurs. The virtue of fortitude, or 'hanging in there' in partnerships, even when things are not running smoothly, are opportunities, according to Gadamer, to reflect on what we might be getting wrong, to understand what the partner or situation has to teach us.

An ongoing discussion about these ideals between the academic and community partners helps to formulate a formal view of ethical obligations described by the community partner that can be considered alongside the consequential and deontological professional ethics of academic clinicians and links them both to the procedural ethics of CBPR.

Friendship

One of the principles of community engagement is development of interpersonal relationships. Yet, this probably does not accurately reflect the depth of these relationships as they mature and does not acknowledge the fact that for true engagement

to occur, a form of friendship[3] may be needed. Sandy (2011, p. 271) discusses friendship within the context of community partnership in the following manner:

> Working to transform conditions for social change also requires a different approach in the Gadamerian tradition, one in which we connect more intimately with those we wish to 'serve'. He wrote that in the interests of 'service to what is considered valid' (Gadamer, 1960/1975, p. 278), one can help solve a problem of another only if they are a friend, and willing to "think along" with another person as if they too were affected, rather than knowing or judging as someone who stands apart. Friendships require attending to many aspects of a relationship, including caring for the other, and remaining open to the truth of our friend's experiences (Sandy 2011, p. 271).

In this sense, the journey that Mark Flower and Zeno Franco took gave them the opportunity to get to know one another better and to enter into the spaces the other occupies more fully. Until this time in the partnership, despite training, openness to the CBPR process, and intensive discussions with the other authors about the ins-and-outs of community engagement, there was a subtle sense in Franco that "we (the medical complex, psychologists, etc.) know best." But in part because Flower and Franco have a mutual interest in reaching the most difficult to reach veterans, they began to think together about the types of services or combinations of services that would be best able to provide paths to recovery for these veterans.

> In this process, Franco and Flower both had to acknowledge the relative strengths and weaknesses of the veteran peer mentor process and the traditional medical/mental health treatment models, and in a very specific sense, examine the differences in roles and boundaries for providers in both of these settings. Through developing a better understanding of the professional environment that each occupies, it felt for the first time possible to mutually imagine a better system of care, and to take steps toward this vision.

Sandy (2013) goes on to note that:

> Gadamer (1979) stressed that participation itself can form the core of an epistemology for the humanities and social science disciplines because they are based on our participation in, rather than our objective distance from, the traditions in which they find themselves… He wrote:
>
> [T]he ideal of objective knowledge which dominates our concepts of knowledge, science and truth, needs to be supplemented with the ideal of sharing in something, of participating in something…this possible participation is the true criterion for the wealth or the poverty of what we produce in our humanities and social sciences (Gadamer 2001: 41).

The role of friendship in participatory process can be understood as part of the virtue ethics that is fundamental and foundational for community engagement because of the relationship between friendship and a commitment to the common good. For example, Doyle and Smith (2002), drawing on Bellah et al. (1996) interpretation of Aristotle, offer that the classical ideal of friendship consists of three aspects:

> Friends must enjoy each other's company, they must be useful to one another, and they must share a common commitment to 'the good'. In contemporary western societies, it is suggested, we tend to define friendship in terms of the first component, and find the notion of utility difficult to place within friendship.

[3] "Friendship" here is intended to be understood in terms of Aristotelian virtue ethics, not merely the modern conception of pleasurable affiliation.

> What we least understand is the third component, shared commitment to the good, which seems to us quite extraneous to the idea of friendship. In a culture dominated by expressive and utilitarian individualism, it is easy for us to understand the components of pleasure and usefulness, but we have difficulty seeing the point of considering friendship in terms of common moral commitments.

Moreover, Aristotle points out that:

> That such friendships are rare is natural, because men of this kind are few. And in addition they need time and intimacy; for as the saying goes, you cannot get to know each other until you have eaten the proverbial quantity of salt together. Nor can one man accept another, or the two become friends, until each has proved to the other that he is worthy of love, and so won his trust. Those who are quick to make friendly advances to each other have the desire to be friends, but they are not unless they are worthy of love and know it. The wish for friendship develops rapidly, but friendship does not (Aristotle, Trans. Ross and Brown 2009).

Further, Mark Flower sees friendship and the lowering of psychological boundaries that the process of developing friendships creates as central to peer mentorship for veterans. He rejects what he sees as overly clinical, professionalized models of peer mentorship precisely because he perceives their attention to rules as often getting in the way of rather than facilitating, mental health recovery. Where Franco might complain to Flower about boundaries that are too loose (e.g., a dual relationship Mark had with a veteran—working with him as an Alcoholics Anonymous sponsor and also employing him for odd jobs),[4] Flower argued that this more psychologically enmeshed stance allowed him greater insight into the recovery problems his mentee faced, offering real-world situations to work through in relation to this mentee, and that the financial incentive offered by work (and the difficult conversations sometimes created in financial transactions) were critically important to navigating the difficult phases of early recovery. Mark Flower consistently asserted that the only hard and fast rule he works from is reporting potential for immediate harm to self or others. Save for these situations, he views rules as having just as much potential to harm as to help, and that the role of a peer mentor should be "to do what works" to reach each individual on their own terms.

While the rules and duties of a professional mental health provider are necessarily more formal, Flower's view forces academic clinicians to reflect on aspects of clinical psychology that are critical to reaching those patients who are the most reactive and least likely to remain in treatment. While the impact of *relationship* (unconditional positive regard, genuineness, therapeutic frame, etc.) is a historical pillar of clinical psychology and empirical evidence for the importance of the relational, not just procedural, skills is mounting (Norcross 2002), our focus as a

[4] Notably in a recent discussion with Mark Flower about these types of psychological boundary considerations, Mr. Flower said that he is increasingly careful about identifying and avoiding dual relationships as a Dryhootch veteran peer mentor in part because of the agency's need to satisfy institutional requirements for state certified peer mentors; however, he continues to see value in fluid boundaries in other settings such as in his role as an Alcoholics Anonymous sponsor. This change may in part reflect the mutuality of partnership, with the Mark also gradually recognizing the value of the views and rules of professionalism held by the academic members of the partnership.

profession seems to increasingly be on the performance of specific, often routinized interventions. Further, while the emphasis of academic clinicians is often on individual therapy and the strictures around confidentiality that it entails, other models involving milieu and employment-based intervention are effective and require providers in these environments to slightly relax standards around self-disclosure, confidentiality, and duality of relationships precisely to have the desired impacts (e.g., Ridley and Hartley 2013). The progression toward a pragmatic friendship with Mark required also forced Zeno to consider Mark's view of friendship as an ethical ideal in recovery intervention much more seriously.

Practical Beauty

We rarely consider aesthetics, or *what is beautiful* as a component of professional responsibility. Sandy (2011) notes, however, that:

> Gadamer' s treatment of phronesis emphasizes the openness of conversation, ongoing participation that may lead to friendship, and process of deliberating on the common good. These are aesthetic talents, in the Gadamerian sense, because they involve "the art of thinking beautifully" (Gadamer, 1977/1986, p.17) and cannot solely be understood in conceptual terms. These talents involve certain "finesses of mind that include: playfulness, responsiveness, and the capacity for improvisation" – what MacIntyre Latta (2000) described as delayed intentionality; self-understanding or self-recognition, which involves putting into question our historical consciousness through the use of our individual and collective memory, and using our sense of humor; and participation together in *festivals* where we might experience community together…or enacting celebrations of the partnerships themselves (Sandy 2011, p. 275).

In part, the classical ideas of beauty involve ideas of symmetry and proportion, and those offer important ways to talk about the interpersonal and friendship aspects of community–academic partnership. As Mark and Zeno became friends, the barriers between the professional and personal became blurred, resulting in a deepening of mutual positive regard. But more importantly, Zeno began to view Mark as a professional colleague, increasingly taking his comments for what they were, not just off handed remarks from a rough-hewn veteran and former addict, but insights from a seasoned recovery specialist who spent thousands of hours working with people most profoundly impacted by addiction and mental health difficulties. In this sense, this friendship assisted in the development of professional roles that became increasingly symmetric within the context of the partnership. In the process, these partners evolved a habit of "thinking beautifully," i.e., conceptualizing together a future health system that is more equitable and accessible for veterans.

One arena where Mark envisions a more holistic approach to veteran care is in what he terms "warm and fuzzy hand-offs" between community organizations serving veterans and the VA healthcare system. In practice, a number of concerns about creating tighter relationships between the VA and nonprofits arise, including concerns about ensuring confidentiality for patients, verifying what types of supportive services offered by community agencies are appropriate and effective, the VA's

desire to not favor one community agency over another, and ensuring that, for example, informal peer mentors understand the limits of their roles when working with a veteran who is also in treatment at a VA medical center. Care transitions are complex even among professional providers and healthcare institutions, involving layers of regulation and rules. Yet, as Mark frequently points out, navigating and obtaining services, benefits, and obtaining supporting documentation needed to make claims is often a daunting task for those veterans who are most marginalized. He sees improving the ability of nonprofits, the Court system, colleges, the VA, and civilian healthcare providers to share meaningful information on a just-in-time basis as a more symmetric, respectful position that does not privilege the expertise of the larger institutions. From his perspective, smaller organizations also have extensive knowledge and know how that must be leveraged effectively to ensure that veterans do not "slip through the cracks."

Fortitude

Courage, the ability to encounter complex, potentially risky situations, and not remove oneself or back down from an important position is not something classically discussed as part of the overt curriculum for health professionals. Yet, real change in the way systems of care encounter and engage with community will, necessarily, involve difficult moments. At times, there will be intense debate, threatening the ability to stand with the communities being served and engaging in long-term discussions that sometimes produce intense friction. Aristotle suggests that to achieve our most humane state and to encourage human flourishing, an excess of virtue is required, noting that "to brutishness it would be most fitting to oppose superhuman virtue, a heroic and divine kind of virtue" (Aristotle, Trans. Ross and Brown 2009). Aristotle goes on to suggest that:

> Though courage is concerned with feelings of confidence and of fear, it is not concerned with both alike, but more with the things that inspire fear; for he who is undisturbed in face of these and bears himself as he should towards these is more truly brave than the man who does so towards the things that inspire confidence. It is for facing what is painful, then, as has been said, that men are called brave. Hence also courage involves pain, and is justly praised; for it is harder to face what is painful than to abstain from what is pleasant.

Ultimately, trainees working in the context of community engagement are asked to make decisions that emphasize (or at least take into account) the idea of human flourishing (in Aristotle's language, *eudaemonia*) implicitly embodied in the ethics of the community partners. For trainees this ethical principle of virtue is in tension with traditional deontological and consequentialist ethics. Although often unspoken, the procedural ethics of CBPR is very much aimed at the enhancement of human flourishing, as the approach "….facilitates a collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities" (Israel et al. 2005, p. 7).

Part of the role of a community-engaged practitioner is to rectify power imbalances, to create compromise with groups that have very different vested interests, and to achieve superordinate goals that are the vision of a partnership—often without the support of the intrainstitutional incentives. In fact, the goals of such adhocracies typically run afoul of intrainstitutional rules and assumptions at least in beginning phases until the pay-offs can be seen by all parties and investment in the goals of the partnership gradually becomes institutionalized. Spearheading such efforts is often not a comfortable role even for seasoned professionals, and yet as we move toward community driven health research and delivery models, we will be asking a larger proportion of young professionals to take on this mantle.

Sandy (2011) suggests that this community engagement requires a transinstitutional role and associates this role with the same skills as those involved in formal diplomatic positions. Further, because this transinstitutional role involves introducing novel approaches and views to all sides in partnership, those occupying this role are, at times, placed in awkward or even risky positions:

> In itself, being a border crosser does not imply trickiness any more that switching from speaking English to Chinese does, but there is usually creativity involved with helping to re-imagine the house rules of higher education, and to redefine what counts as legitimate, that is rigorous, academic teaching, learning, and research. If we truly are to be about the business of generating a "shift in the educational paradigm" (Liu, p. 11, 1999) for the *greater good*…it indeed may be necessary to disrupt the status quo on our campuses or to break the rules sometimes, and this always entails risk. Some may even feel compelled to "kill the messenger" (p. 265–6. Emphasis added).

Community engagement requires long-term commitment to an iterative process and will inevitably involve many moments of difficulty in bringing parties together in conversation to achieve its goals. In that way a deeper understanding of the various components of the virtue of courage in the face of these constraints is important. Fortitude or what has been termed "passive courage" is the ability to *endure* in the face of risks over a long period of time, and in this sense it achieves the mean between rashness (intrepidity) and cowardess (inaction) (Franco et al. 2011). Fortitude also suggests another of the cardinal virtues *temperance* and the practical wisdom of waiting to act "until the time is right."

Because fortitude necessarily less flamboyant than intrepidity, this ideal is also more conversational. It implies a very personal encounter with *all* parties in partnership ranging from the community partners to those most deeply involved in the administration of healthcare system. Maintaining an open stance with all stakeholders is critical if real change toward the goal of human flourishing is to occur. While professionals are trained to discharge ethical *duties* and move forward, this position calls for a long-term commitment to respect ethical *obligations* to one another in partnership. This requires a willingness to endure often long-term discomfort as divergent ethical views, assessments of risk, and priorities for impacting health are weighed and applied. In the context of the partnership with Dryhootch, the increasing willingness of the academic partners to be unsure, to manage difficulties within the partnership less formally and on a more personal basis, and to actively engage with the ethical worldview of community partners—even when it was very uncomfortable to do so—allowed the partnership itself to flourish.

Discussion

Within the partnership as a whole, and in terms of the interpersonal relationship between Mark Flower and Zeno Franco, the realization that they were ultimately, and very personally committed to the same goal—improving veteran health and well-being (that is to say, to the *flourishing* of the veteran community) led them to recognize not only the utilitarian nature of collaboration but also shared "moral commitment." When this finally occurred, after perhaps 4 years of often difficult partnership, they began to understand that the obstacles to partnership were not as important as originally supposed and that relationships were and would remain enduring (ongoing obstacles to partnership were faced with *fortitude*), thus removing the specter of dissolution of the partnership. When this occurred, and only when this occurred, was it possible to commence with the activity of partnership in its deepest sense. At a personal level, Mark and Zeno began to meet informally *as friends*, not just as partners in a coalition, because of the confluence of affinity, utility (shared work), and a common ultimate vision (at once *practical* in its goal of improving veteran outcomes and *beautiful* in its conception of what a flourishing veteran community might mean) that made individual or institutional differences in approach profoundly less problematic.

While this chapter revolves around a fairly theoretical discussion of the ethical problems encountered within a community–academic partnership for health and our efforts to formalize the ethical worldview of our community partner, the experience suggests several concrete steps that can be taken to strengthen training in professional degree granting programs that involve community engagement.

First, developing an approach for training early career professionals about alternative ethical views that may be held by community partners and how tensions between the priorities of these aspirational views and the strictures of professional practice may play out is an important area for curriculum development in CBPR as a whole. Second, offering trainees a framework for internally negotiating the potential discontinuities between what varying stakeholders would see as ethical, or even ethically relevant, is critical to ensuring that these professionals can operate effectively and independently in roles that require political acumen. Third, and conversely, while postdoctoral and early career clinical providers are valued in part because of their ability to act comparatively independently and without direct clinical supervision, it is vital that they develop a good sense of when to seek consultation within the partnership, as well as the freedom to seek independent counsel outside of normal supervision lines in order to cross check decisions and gain insight from a wide range of perspectives when needed. Fourth, for clinical supervisors working with early career professionals, recognizing the complexity of this work and the potential for trainees to get ethically "stuck" in relationships that they have not experienced in traditional one-on-one patient treatment is a key concern. For example, some of the early ethical problems experienced with Dryhootch revolved around the question, "who is the client?"—this is a complex discussion in organizational psychology consultative practice even for seasoned professionals

and warrants considerably more attention in doctoral and postdoctoral education (see, e.g., Fisher 2009). Finally, just at the moment an early career professional is consolidating around a professional identity and an expert role, community engagement paradoxically requires *letting go* of the professional mantle and accepting the input of community partners as having significant value. While CBPR textbooks offer this as an important ideal, it is a difficult lesson to learn without real-world experience, making advanced programs in CBPR education with direct, immersive engagement a key component of professionalism training for clinical providers in this arena.

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Chapter 14
The Role of Graduate Schools of Education in Training Autism Professionals to Work with Diverse Families

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Introduction

While better knowledge regarding the origins and consequences of various developmental and learning problems faced by schoolchildren does not always provide educators with adequate strategies for addressing them, increased knowledge does typically imply new dimensions of educator–professional responsibility. In this chapter, we address one area where expanded knowledge is focusing resources and attention on a prevalent learning difficulty: autism.

Autism is an equal-opportunity disorder. It occurs across the political spectrum; it affects all ethnicities and cultural groups, rich and poor alike. Recent statistics from the CDC place the rate at 1 in every 88 individuals—a truly high-incidence disorder and one that all general education teachers and most university faculty will encounter at some point. The most recent Diagnostic Statistical Manual of the American Psychological Association (DSM-5) now refers to autism spectrum disorder (ASD) rather than to autism. In this chapter, both terms are used interchangeably.

Autism is not just a problem requiring identification, treatment, and educational intervention. It is also an opportunity. Students in a professional graduate school of education training to be public school teachers or, ultimately, faculty themselves

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may have the opportunity to learn about this complex and baffling disorder, and to begin to understand the cultural context of autism. Too, university-level research on autism crosses the boundary between education and medicine, providing opportunities for collaborative work in areas such as genetics, psychology, and neuroscience.

Professional schools are responsible for training students in how to deliver high-quality services equitably to diverse families. This chapter describes the role of educational professionals in meeting the needs of diverse families who have children with autism and the training process needed to prepare them. We set the stage by presenting the context for the training of teachers and research professionals in autism. This includes an overview of the of the increasing Latino population in Inland southern California, concomitant with the increasing numbers of children on the autism spectrum and the dire need for teachers to work with them. In addition, there are growing numbers of individuals with autism graduating from high school and seeking postsecondary experiences, especially in colleges and universities. This chapter also provides the rationale for keeping university faculty abreast of autism as well.

Finally, the Family Autism Resource Center at UCR, known as SEARCH, will serve as an example of how basic doctoral research training can be merged with community outreach to secure more equitable and higher quality assistance to children with autism and their families. The chapter highlights one important area of research, student–teacher relationships, and their importance for transitioning young children with autism spectrum disorders into early schooling. Implications of work on autism for emerging professional roles across the disciplines of special and medical education will be proffered.

Overview of Autism Spectrum Disorder

The term "autism" refers to a neurodevelopmental disorder associated with genetic risk (Dawson et al. 2009). The well-known features of autism are (1) impaired social interaction and the failure to develop social relationships; (2) impaired language and communication; (3) restrictive, stereotyped, or repetitive behaviors. Between 2000 and 2013, the term, autism, included autistic disorder, Asperger syndrome (AS), and pervasive developmental disorder—not otherwise specified (American Psychiatric Association 2000). Asperger syndrome and high functioning autism referred to individuals on the autism spectrum who had little or no cognitive impairment. Currently, the DSM-5 (2013) refers to all individuals as having Autism Spectrum Disorder (ASD), rather than autism, reflecting the heterogeneity of this group of individuals.

Prevalence rates now categorize autism as a common disorder, with CDC now reporting that an average of 1 in every 88 children born in the USA will

have an ASD (Centers for Disease Control and Prevention 2012). In the DSM-5, ASD refers to a group of developmental disabilities characterized by deficits in social interaction and communication and restricted and/or repetitive behaviors. While Asperger syndrome has previously referred to high functioning autism or individuals on the autism spectrum with typical intelligence, the newest clinical definition in the DSM-5 no longer makes such distinctions (American Psychiatric Association 2013). So far as we can tell, there is no one cause of autism; it is best thought of as multiply determined, with several pathways of influence leading to the same common set of behaviors, or equifinality (Cicchetti and Rogosch 1996).

California alone has had a 12-fold increase in ASD rates, particularly among culturally diverse children (California Department of Developmental Services 2008). For example, as compared to other states with high percentages of immigrant Latinos (e.g., Texas, Puerto Rico, Nevada, and Florida) even without accounting for the under assessing of minority populations, California has the highest rates of Latino children diagnosed with autism. In 2011, of the 71,595 children ages 3–21 diagnosed with autism in California, 37.3 % were Latino and 36.6 % were White (IDEA Data 2011).

Unfortunately, disparities in diagnosis and access to educational intervention are also evident in the institutions that are responsible for providing care to children and youth with ASD. These disparities most negatively affect diverse families. For example, numerous studies suggest that Latino and Black children gain access to autism diagnosis at a significantly later age—if ever—which impedes their ability to make significant cognitive and social gains early and ameliorate their symptoms. For Latino children, well-documented underdiagnosis and poor quality treatment impede their access to proper educational intervention, mental health services, and medical interventions (Begeer et al. 2009; Kreps 2006; Mandell et al. 2002; Mandell and Novak 2005). Finally, there is evidence that families of Latino children disproportionately utilize treatments that are not evidence based (Mandell and Novak 2005; Levy et al. 2003; Liptak et al. 2008). In California, as in the rest of the nation, autism is not a low incidence disability (Ludlow et al. 2005; Smith et al. 2008). *It is no longer a question of whether a teacher will encounter a child with autism in her/his class, but when and how often.*

Furthermore, increasing numbers of individuals with autism who are high functioning (i.e., with IQ's in the normal range or higher) are graduating from high school and becoming eligible for college and work—in short, for a life as close as possible to that of their typical peers (e.g., living independently, going to college, acquiring and maintaining employment, and finding a partner (Attwood 2007; Howlin and Charman 2011). However, while many of these individuals qualify for, and ultimately attend, campuses of the University of California system, as well as other colleges and universities, faculty are rarely prepared to accommodate them.

Meeting the Need for Special Education Faculty Leadership in ASD

With this rise in children with ASD, of course, comes the need for qualified personnel to teach them—teachers who are trained in evidence-based and promising research methods, who are consumers of current research, and who benefit from highly qualified teacher educators and researchers as their professors. It is imperative that graduate schools of education produce highly qualified teacher educators and scholarly researchers in the field of autism who can address the unique needs and improve outcomes for culturally and ethnically diverse children with autism, a state and regional need as demonstrated by the data cited above.

Across the nation, there is a critical shortage of qualified professionals to meet higher education's demand for Special Education faculty (Smith et al. 2010). Since 1992, the proportion of Special Education doctoral graduates who take academic positions has declined (Pion et al. 2003). A recent article in USA Today (2011) reported that "too few doctoral graduates are produced while the demand for new faculty remains high." The results of the 2011 Special Education Faculty Needs Assessment (SEFNA) confirmed the supply–demand imbalance of Special Education faculty (Robb et al. 2012). For example, faculty retirements across Special Education programs are predicted to increase by 21 % per year between 2012 and 2017 (Montrosse and Young 2012). Therefore, special education programs are at a substantial risk of being even further understaffed in the upcoming years (Smith and Montrosse 2012).

Lack of Use of Evidence-Based Practices by Educators

Nationwide surveys of special educators report their use of teaching strategies supported with research and large effect sizes with equal frequency to those that do not have an evidence base (Burns and Ysseldyke 2009). In one survey of educators working with children with ASD, teachers in Virginia reported a lack of knowledge about effective practices to address communication, social skills, and sensory motor issues, and effective teaching practices, when implemented, were at low levels (Hendricks 2011). In Georgia, fewer than 10 % of the teaching strategies that educators used were supported by research evidence (Hess et al. 2008). In Southern California, focus groups of early childhood special educators identified six intervention techniques that were reportedly used by participants in all focus groups (Stahmer et al. 2005). Some of the strategies were supported by research evidence and others were not (National Research Council 2001; Simpson 2005). Participants believed that all strategies they used were evidence based. These studies confirm that better preparation of special educators, particularly autism educators, is imperative. It is critical that doctoral programs in graduate schools of education recruit, retain, mentor, support, provide rigorous coursework, research, and teaching opportunities for

doctoral students studying in the area of autism. Furthermore, these graduate students should be able to teach others to critically evaluate and implement evidence-based research practices and engage in scholarly research that advances the field of autism for culturally and ethnically diverse children with ASD (Reichow and Volkmar 2010; Doehring and Winterling 2011).

Over the past decade, autism researchers have made great strides in developing comprehensive assessments and empirically sound treatments that target the needs of children with ASD; yet, the critical shortage of autism leadership personnel, both nationally and locally, prevents these empirically sound treatments from being transferred to the classroom and faithfully implemented (Odom et al. 2013; Yell et al. 2003; Wong et al. 2013). In fact, according to the National Research Council, "personnel preparation remains one of the weakest elements of effective programming for children with autistic spectrum disorders and their families" (NRC 2001, p. 225). Additionally, these assessments and treatments are not widely used and empirically tested on culturally and economically diverse children (Begeer et al. 2009; Levy et al. 2003; Valicenti-McDermott et al. 2012). Although the Department of Education (OSEP 2013) requires a highly qualified special educator to meet the state standards for special education certification, these general special education certification requirements often do not contain coursework or practicum experiences for educators to gain the expertise to effectively educate children with ASD.

There is a dearth of formal data that allows even cursory evaluation of the state of personnel preparation in autism. For example, according to the National Research Council (NRC 2001), no data exist regarding the number of autism specialists who are trained annually, how many autism programs exist, which professional disciplines are involved in autism training, and what comprises standard requirements of an autism personnel preparation program (Scheuermann et al. 2003). Even a decade later, in the most recent data files from the Data Accountability Center of IDEA (http://www.ed.gov/open/plan/ideadata-org), there are still no data specifically identifying the number of "highly qualified" autism educators in each state. At the national level, we have yet to acknowledge the unique expertise required to effectively educate a child with ASD, let alone a Latino child with ASD.

In California, however, state agencies and government officials are acknowledging the need for trained autism educators that can implement empirically sound interventions for ethnically and culturally diverse children with ASD. The California Commission on Teacher Credentialing recently instituted an autism authorization requirement, where universities might offer coursework in assessments and educational practices related to effective teaching practices for children with ASD (California Commission on Teacher Credentialing 2010). Also, in April 2012, Senator Darrell Steinberg, the Chair of the California State Senate Select Committee on Autism and Related Disorders, held a legislative hearing entitled: "Ensuring Fair & Equal Access to Regional Center Services for Autism Spectrum Disorders." The hearing served to acknowledge the systemic disparities that exist in minority and poor families' access to ASD interventions and to determine how to eliminate these disparities.

Proposed Solutions for Meeting the Need

In response to the increasing need for high-quality autism education leaders well versed in the needs of culturally and ethnically diverse children with ASD, universities can expand their efforts to prepare doctoral level autism education leaders to meet the needs of these children and their families through mechanisms such as the following objectives:

1. Recruit, prepare, and retain high-quality doctoral level autism education leaders trained to work in institutions of higher education (IHEs) preparing autism educators to work with culturally and economically diverse children with ASD.
2. Prepare faculty who can train teaching credential candidates to work directly with culturally and economically diverse children with autism.
3. Prepare doctoral level autism education leaders to conduct scholarly research in high need community settings that contributes to empirically sound autism interventions and leads to changes in educational policy and practices.
4. Prepare doctoral level autism education leaders who contribute to the field through active engagement in community and professional organizations that support individuals with autism and their families.

High-quality leaders are needed to train doctoral students to evaluate and integrate knowledge as it is generated and to demonstrate competency in the acquisition of that knowledge. Particularly with respect to ASD, they must also be able to critically evaluate the rapidly growing knowledge base, to generate and disseminate new knowledge and advance the field, and to understand and adapt efficacious interventions for culturally and economically diverse children with ASD and their families (Cook et al. 2013.) There is no reason why this type of training could not also include medical students preparing for community engagement.

How Does Autism Affect the Community?

The Rising Tide

California alone has had a 12-fold increase in ASD rates according to the Department of Developmental Services (DDS 2008), and those statistics do not include children at the milder end of the autism spectrum who are served (or not) by the public schools. Naturally, the rise of autism has been accompanied by a surge in service needs, and a challenge to schools of education. Nationally, the U.S. Department of Education reported an increase of total enrollment in public school special education programs of children with autism from 4 % in 2004–2005 to 8 % in 2009–2010 (U.S. Department of Education 2012). These figures do not include the higher functioning children who are typically in general education programs. Thus, the question is no longer *whether* public school teachers will encounter a child with autism, but *what they will do* when this inevitably occurs.

Litigation and Lack of Services in Schools

Specifically, between 1993 and 2005, court cases pertaining to appropriate educational placement and programming [FAPE/LRE] were over 10 times more likely to concern a child with autism than the proportion of these children in the special education population (Zirkel 2011). The disproportionate growth of autism litigation is likely due in part to the school system's limited success in effectively addressing this complex disability. The obvious implication is that teachers need to pay particular attention to providing effective research-based programs for children with autism. Special education faculty are now faced with the challenge of equipping teachers with evidenced-based practices, research-based programs, and scientifically based instructional strategies for children with autism.

There are other things for us to be worried about with respect to teacher preparation and training to respond to this virtual tsunami of children in the public school system with some kind of ASD.

Importance of ASD Knowledge for Autism Education Leaders and Future Teachers

Poor Student–Teacher Relationships

The entry into elementary school is a nearly universal experience for children in the USA. It reflects a qualitative change in the context of children's development and brings with it a host of new academic, social, emotional, and behavioral challenges and demands (Rimm-Kaufman and Pianta 2000; Pianta et al. 1999). Children with ASD encounter heightened challenges as they enter school and are at risk for poor school adjustment, including academic underachievement (Basil and Reyes 2003; McConnell 2002), disruptive behavior, emotion dysregulation, and social rejection (Chamberlain et al. 2007). Whereas many factors influence children's adjustment in the early school years, the quality of the early student–teacher relationship has emerged as an important predictor of children's concurrent and long-term adjustment in the classroom (Howell et al. 2013).

Unfortunately, we have a shortage of teachers trained to deal with the challenging behaviors of children with autism, and a surplus of teachers who resent having such kids in their classroom. Children with ASD are likely to be less successful in building positive relationships with their teachers than typically developing children (Blacher et al. 2014). Yet, these relationships may be particularly important as compensatory resources for children with ASD and may protect them against school adjustment problems over time (Meehan et al. 2003).

Lack of Teacher Efficacy and Confidence with Respect to Child Behavior Problems

In addition, we know that teachers view children with behavior problems as more challenging to work with than children with any other type of disability (Gebbie et al. 2011). Children with intellectual disabilities have more than three times the incidence of behavior problems in comparison to their typically developing peers (Baker et al. 2002, 2003; Hemmeter et al. 2006). This ratio appears to be the same for children with autism. Thus, teachers who have not received training to deal with such children may experience a lack of personal teaching efficacy—a belief that they can affect change in students despite challenging circumstances (Allinder 1994). On the other hand, teachers with high self (personal)-efficacy are found to employ more positive and less aversive interventions to manage students behavioral challenges (Gebbie et al. 2011). Clearly, then, appropriate training for handling child behavior problems for all teachers has the potential benefit of (a) improving their self-efficacy with regard to children with autism, (b) increasing their positive feelings toward these children, as demonstrated by their student–teacher relationship, and (c) increasing their effectiveness in the classroom.

As further evidence of the importance of the student–teacher relationship, Bob Pianta, the Dean of the University of Virginia's Curry School of Education was featured recently in an article in the New Yorker for his research with typically developing schoolchildren on student–teacher relationships. He has developed a system for evaluating various competencies relating to student–teacher interaction, including "regard for student perspective," one of 11 dimensions assessing the teacher's emotional and instructional aspects of the classroom. With regard to K-12 education of students on the autism spectrum, teacher preparation is imperative to ensure positive evaluations of the student–teacher relationship using a system such as Pianta's. This requires the preparation of doctoral-level autism experts and (general and special education) teachers alike.

Importance of ASD Knowledge for University Faculty

The reality is that many youth with ASD have typical intelligence, and increasing numbers of them are pursuing postsecondary education in preparation for careers and productive employment—for lives as close as possible to those of their non-ASD peers (Attwood 2007; Howlin and Charman 2011). This begs the issue of who will teach them at the university level. University faculty, themselves, need further awareness of the growing numbers and traits of youth with ASD on college campuses. This "autism education," if you will, may also fall under the aegis of a graduate school of education.

The transition to adulthood can be challenging for these high functioning students, and university life poses its own additional set of issues. We assert here

that a focus on enhancing the environmental support for postsecondary students with ASD with average-to-well-above average intelligence will benefit both those youth on the spectrum and the faculty who teach them.

Research on Preparing Youth with ASD for Postsecondary Education

Using data from the National Longitudinal Transition Study-2 (NLTS-2), Shattuck and colleagues (2012) described postsecondary outcomes of individuals with ASD following high school. Twelve percent had attended a 4-year college, 28 % a 2-year college, and 9.3 % a vocational/technical school. Also from the NLTS-2, Chiang et al. (2012) identified significant predictors of participation in postsecondary education, including (1) type of high school (i.e., attending a regular high school was more predictive of participation than attending a special school); (2) high school academic performance (i.e., stronger academic performance was predictive of college attendance); (3) high family income, and (4) parental expectations their children would attend college. A higher proportion of postsecondary students with ASD majored in STEM programs when compared across disability categories (Wei et al. 2012). Results of research by Wei et al. (2012) are consistent with findings in a sample of 667 undergraduates attending a technological university, where the prevalence of high functioning autism was between 0.7 % and 1.9 % (White et al. 2011). Clearly, postsecondary education is a realistic goal for individuals with autism and typical intelligence, particularly in STEM majors.

Skills and Supports Needed for Success

Young adults with autism need supports to "survive" college (MacLeod and Green 2009). At the postsecondary level, most supports offered during the K-12 years are no longer available (Graetz and Spampinato 2008; Hewitt 2011), assuming essential life skills have been taught and learned (Hendricks and Wehman 2009; VanBergeijk et al. 2008). Living at home during college can ease the transition (Adreon and Durocher 2007), but this can compound difficulties students may have in making friends and developing skills necessary to navigate social situations. College is an ideal place for socializing, but most young adults with ASD have few friendships and face social communication challenges (Geller and Greenberg 2010; Howlin 2000; Orsmond et al. 2004). Zager and Alpern (2010) developed a program for college students with ASD, providing them with scripted responses for potentially confusing social situations. Students with ASD may also have difficulty in disciplines that require the study or interpretation of human social behavior (e.g., sociology and psychology) and/or incorporating the opinions of others into their writing or speaking assignments (e.g., political science; Davis 2011).

University Accommodations

Accommodations at many campuses present additional problems to students with ASD. The Americans with Disabilities Act (Americans with Disabilities Act 1990) provides support to college students with documented disabilities. Many campuses have a student disabilities center to provide support and to address challenges. However, disability centers are generally more informed about aiding students with physical or learning disabilities than those with ASD (Geller and Greenberg 2010), for whom social, communication, and organizational supports are needed as much as academic ones (Graetz and Spampinato 2008). These students may benefit from support groups of students who also have ASD (Smith 2007), and/or campus peer mentors (MacLeod and Green 2009). For example, the Center for Students with Disabilities at the University of Connecticut has developed a first year course specifically designed for students with ASD, involving social skills training, assistance in adapting to the college environment and connecting with other students (Wenzel and Rowley 2010). While commendable, this program is focused on educational interventions for students. However, educational intervention for university faculty of students with ASD may also prove useful.

Importance of University Faculty

Why focus on faculty? "It is also critical to engage with faculty members across campus, not only to educate them on how to best work with this population, but also to listen to their impression of working with these students and what behaviors if any need to be addressed" (Wenzel and Rowley 2010, p. 49). We found no studies of college student–faculty relationships, despite scores of studies that attest to the importance of the student–teacher relationships in K-12. Our own work, focused on student–teacher relationships (STRs) in the early school years, finds STRs of students with intellectual disabilities to be of a poorer quality—and marked by more conflict and less closeness—than those with students with typical cognitive development (Blacher et al. 2009; Eisenhower et al. 2007); other research has shown that those with ASD experienced *even poorer* STRs (Blacher et al. 2014). Researchers have identified middle and high school students' school engagement as a predictor of student success (Zyngier 2008). Although definitions of engagement vary, they typically include positive STRs, as well as positive feelings about school and enjoyment of learning (Aunola et al. 2000), positive classroom behaviors, and engagement and compliance with homework (DeBaryshe et al. 1993). Academic engagement is positively associated with academic achievement (Furrer and Skinner 2003; DeBaryshe et al. 1993) and negatively associated with interfering behavior problems characteristic of persons with ASD (Aunola et al. 2000). For these individuals, who are often socially immature or challenged, engagement with knowledgeable faculty may prove to make or break a successful college experience.

We expect that challenging faculty–student relationships in the case of college youth with ASD will be typical, and thus we advocate proactive faculty training or, at the very least, awareness. Students' college success can depend a great deal on their relationships with individual faculty members who may help them become academically engaged and successful (Freedman 2010). Yet, university faculty often lack knowledge and experience even with the tenets of the ADA (Dona and Edminster 2001; Cook et al. 2009; Wenzel and Rowley 2010). Furthermore, specifically for autism, how knowledgeable and experienced are faculty? We conducted a campus-wide survey at UC Riverside and asked students, faculty, and staff questions pertaining to general knowledge about autism. Although participants correctly responded that the prevalence of autism is on the rise (>70 %), most incorrectly attributed the increase to a debunked theory of vaccine exposure. Most importantly, our survey revealed that many faculty respondents had limited knowledge about autism (Tipton and Blacher 2013).

A Model for University Research and Community Outreach in ASD

The Graduate School of Education (GSOE) at UC Riverside has confronted the challenge of helping to meet the need for leadership in autism in several ways:

First, the GSOE established the SEARCH Family Autism Resource Center (Support, Education, Advocacy, Resources, Community, Hope). SEARCH provides a research and training context for graduate students, while at the same time serving the community. Initially funded by a local county initiative (First Five Riverside and First Five San Bernardino), SEARCH developed a screening clinic for autism, where we provide screening using "gold standard" instruments that require considerable training for clinical and research reliability. While we serve all families, our target is low-income and/or Latino families, with services in Spanish and English, and follow-up consultation. Researchers in the GSOE are not looking for the cause and cure for autism; rather, they are helping teachers and families deal with this disorder NOW and seeking best practices for doing so. In addition to screening activities, another SEARCH mission is to help parents differentiate empirically valid research from unsubstantiated approaches. SEARCH Fellows and their activities have already increased awareness of autism among Latino families and provided autism screening, follow-up, and parent groups.

Second, in tandem with the opening of the SEARCH Center, we have expanded the number of graduate students specializing in the area of autism. We have recently added the M.Ed. program in autism, in partnership with UCR Extension, specifically for regular and special education teachers already in the field who need to update their skills to better meet the needs of children on the spectrum in their classrooms.

Finally, merging training efforts of the Graduate School of Education with those of the new School of Medicine at UCR could prove to be a winning combination when it comes to educating the community about autism and best practices in educational treatment. Clearly there is more work to be done, and we cannot stop here. To quote Will Rogers: "Even if you're on the right track, you'll get run over if you just sit there."

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Chapter 15
Bilingual Education as a Professional Responsibility for Public Schools and Universities

Anne Jones

Introduction

The use of languages other than English in the instructional programs of America's public schools has proven to be a troublesome issue of both public policy and professional practice since the establishment of mass compulsory public education more than a century ago. As a nation populated primarily by immigrants from more than a hundred other nations, the United States has had to wrestle with two fundamental linguistic questions: (a) How can we balance the national need for integrating language and culture with the democratic political rights of citizens to opt for preserving their own diverse linguistic heritages, and (b) Does multilingual schooling enhance or inhibit the acquisition of the academic and social skills needed for social and economic success? The first question is primarily political and tends to be worked on through interest group organization, political action, legislation, regulation, and formal adjudication. Political systems at the local, state, and national levels have been vexed with this conflict, with each side claiming some victories and suffering some losses. The second question is primarily professional, and its answer rests on a combination of scientific evidence and professional judgment regarding when and how to help children meet the linguistic and academic goals set by the political resolution of the first question. Of course, resolving the primarily professional questions of appropriate language use in the classroom quickly turns professional judgment into a political force. Professionals accepting the responsibility for facilitating linguistic and academic competence for the nation's school children cannot help but formulate an answer to the question of what public policies most effectively support the learning processes that their professional judgment dictates as most effective for children whose first languages are not English.

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Hence, to meet their professional responsibility for instruction, education professionals must first develop a coherent perspective on the central political question. The primary objective in this chapter is to address the professional question of appropriate language usage in academic instruction, but we must first describe the evolution of political context and how that context circumscribes and facilitates or inhibits linguistic, academic, and social education.

A Brief History of the Social and Political Context for Bilingual Education

In the nineteenth century, social, political, and economic changes within many countries resulted in a large number of people leaving their birth countries and emigrating to the United States to pursue economic success and individual freedom. As they immigrate, families typically seek to live in settlements, sharing language and cultural traditions. Social structures, such as local schools, churches, stores, etc. are established using native languages in daily discourse. A sense of belonging grows as immigrants establish social identity groups in their new nation (Lessow-Hurley 2013).

Over time, xenophobia (fear of foreign things) emerges throughout the nation, leading to legislative restrictions on native language use. Restrictive policies curtailed the flow of immigration, mandated English language use, and undermined immigrants' new-found freedom. During World War I, legislation forced closure of native language settlement schools. By contrast, during World War II, when communication with foreign allies was necessary, there was a positive shift in attitude toward bilingualism, with the military leading the way (Lessow-Hurley 2013).

In 1965, the Immigration and Nationality Act legislatively changed immigration policy, removing the national origin quota system, encouraging immigration from diverse groups. By the 1980s, legislative focus shifted toward undocumented immigrants seeking alternatively to create paths to citizenship or prevention of border crossing. As a result, many recent immigrants became legal citizens (Lessow-Hurley 2013).

As part of the "War on Poverty," Title VII of the Elementary and Secondary Education Act of 1965 (ESEA) and the Bilingual Education Act of 1968 assisted local education agencies to serve children from families with annual incomes under $3,000 (Lessow-Hurley 2013) and who are disadvantaged by an "inability to speak English" (Faltis and Arias 1993, pp. 6–29). Title VII offered monetary grants to education agencies to: a) develop and run bilingual programs for low-income, non–English speaking students; (b) make efforts to attract and retain bilingual teachers; and (c) establish communication between home and school (Faltis and Arias 1993). Schools were not required to use students' primary languages or to apply specific instructional approaches. Money was provided for research to develop theory and methodology. In 1974, the Bilingual Education Act was reauthorized and expanded to reach an increased number of English learners by removing the annual income cap (Lessow-Hurley 2013).

In 1974, the reauthorization of the Bilingual Education Act of 1968 provided critical leverage for proponents of bilingual education. The reauthorization was heavily influenced by the Lau v. Nichols decision (1974), in which the US Supreme Court held that Chinese American students in San Francisco, California were being denied their right to an equal educational opportunity under Title VI of the Civil Rights Act of 1964. Specifically, the Supreme Court found that these students were being denied their rights based on their ethnicity, and more significantly for the proponents of bilingual education, that language is inextricably linked to an individual's nation of origin; ethnic discrimination and language discrimination are interconnected. As a result of this ruling and stronger reauthorization language, schools were now forced "to provide equal access to children who could not function in English," strengthening an aspect of the Civil Rights Act of 1964 (Lessow-Hurley 2013, p. 141). This reauthorization included specific guidelines for addressing language minority (LM) students' needs, and a timetable for doing so was established. These remedies rejected the sole use of English as a second language (ESL) for teaching limited English proficient (LEP) students, implying that bilingual education programs were preferable in many cases. With the Lau v. Nichols decision in place, the Office of Civil Rights "embarked on a campaign of aggressive enforcement" (Crawford 1989, p. 37). While educational agencies were not given specific directives within the written law regarding how to address the equality court order with the Lau v. Nichols decision, the Federal government's Department of Health, Education, and Welfare, and the Office of Civil Rights took the lead and designed a document that gave guidance to districts in order for them to implement programs which would bring them into legal compliance. The guidelines included standards for: (1) identifying limited English speaking students, (2) assessing language fluency, and (3) ways to meet their needs. These standards were the impetus for a state mandate to begin compliance review process, making review a condition of continued federal funding. The guidelines did not mandate dual language instruction, but school districts realized that this approach would help meet the requirements imposed upon them, and several states, including California, began to prioritize the development of dual language programs.

Because elections determine who controls the policymaking process, maintaining policy coherence is difficult (Cuban 1990; Fuhrman 1993; Tyack and Cuban 1995). In California, new public school curriculum frameworks were developed between 1987 and 1994. These frameworks reflected policy shifts in two ways. First, they urged substantial changes in curricular content, and second, they emphasized challenging academic outcomes while simultaneously providing less prescriptive guidance regarding how to achieve them. Fuhrman (1993) argued that these frameworks provide an essential foundation for systemic reform. They presented a new philosophy and approach to teaching and learning that, if enacted, would change power and authority relationships in the schools and classrooms. The framework developers sought to encourage teachers to move from teacher-centered to student-centered classrooms and from academic subject segregation to interdisciplinary learning activities that engage students in constructing knowledge through hands-on, cooperative, and active learning processes (Lucas et al. 1990).

In 1980, the Carter administration sought to impose more prescriptive guidelines, mandating bilingual education in schools with a sufficient number of limited English proficient (LEP) students. On transition to the Reagan administration in 1981, however, these guidelines were dropped and policy returned to emphasizing approaches that used only English. With the 1984 reauthorization of ESEA, some federal funds were offered for an instructional program called Special Alternative Instructional Programs (SAIPs) (Crawford 1989, p. 36). SAIPs provided instruction in English, placed greater emphasis on preparing students in academic skills and content areas, and made Title VII less compensatory in nature. While most Title VII funding went to programs using students' native languages, the addition of SAIPs allowed districts to deemphasize bilingual instruction in favor of English-only instruction. The rationale for SAIPs was that (a) bilingual programs are not feasible in districts with students of many different language backgrounds and (b) qualified bilingual teachers were not available in large enough numbers to staff bilingual programs (Lucas and Katz 1994).

In 1995, the California Legislature commissioned a study of test data, reclassification rates and program exit rates, comparing the effectiveness of different language development programs (Lopez and McEneaney 2012). A California businessman, Ronald Unz, used this study to argue that bilingual programs allowed by the California Department of Education were weak. In 1998, he sponsored Proposition 227—a referendum aimed at severely restricting the use of primary language for instructional purposes (Gandara 2000). The proposition passed despite opposition from language education researchers. As enacted, Proposition 227 mandates that all instruction in California public schools be conducted in English, with teachers specifically trained to address English language development (ELD). The proposition does allow parents or guardians to waive this requirement if they can show that the child already knows English or would learn English faster through alternative instructional techniques. It also provides that children not fluent in English may be given initial, short-term placements of 1 year or less in intensive sheltered English immersion programs (Garner 2012, League of Women Voters, 1998).

State guidelines were established, requiring schools to offer identified English learners. English Language Development (ELD) instructional services targeted their English proficiency level in one of three settings:

Structured English Immersion (SEI) – A classroom setting where nearly all classroom instructions are in English but with curricula and presentation formats designed for children who are learning the language.

English Language Mainstream (ELM) – A classroom setting for English learners who have acquired reasonable fluency in English and continue to receive additional educational services in order to recoup any academic deficits that may have been incurred as a result of language barriers.

Alternative Program (Alt) – With parental approval, a language acquisition process in which English learners receive ELD instruction targeted to their English proficiency level, while academic subjects are taught in the primary language. (http://www.cde.ca.gov/ds/sd/cb/cefelfacts.asp).

These guidelines also created legal sanctions threatening educators and school officials who failed to comply (Mora 2002). Districts were given the responsibility of establishing the number of students with waivers per grade level needed for establishing an Alternative Program. Teachers, administrators, and school board members are held personally liable for fees and damages by the child's parents and guardians for improper implementation. These provisions, taken together, are the most restrictive in the nation (García and Curry-Rodríguez, online: 22 Nov 2010).

There was an immediate impact on the then-current bilingual teachers, and many were compelled to leave the bilingual settings and embrace the English-only (EO) model. Administrators sent back bilingual materials; new textbooks adopted for the Spanish language instruction were returned unused to the publishing companies. Many school boards withheld teachers' bilingual stipends as a result of Proposition 227, causing a change in the teachers' annual salaries. Teachers' unions held emergency meetings to assist their colleagues with guidelines that were not clearly defined. Parent meetings were held to explain the new educational settings established by this legislation. Parental rights were addressed regarding the Alt option, with local bilingual advocates and teachers encouraging the choice of language waivers to re-establish bilingual instruction within the classrooms. As with the general electorate, opinion was divided on the issue; many in the educational community supported the changes brought by Proposition 227. However, the impact on the pro-bilingual education community was powerful. Teachers felt devalued as Spanish bilingual educators, even though they had the ability to continue teaching in bilingual education settings (Alamillo 2000). Confusion and feelings of abandonment were prevalent, especially in communities with a high number of English learners.

Bilingual education in California has faced persistent political resistance and recurring regulatory challenges. Even under the restrictive environment created by Proposition 227 and its regulatory enforcement, California schools have not been able to find a sufficient number of qualified bilingual teachers. Monolingual classroom teachers are challenged to find appropriate methods for teaching non–English speaking students.

The highly visible political controversy surrounding bilingual instruction has tended to obscure professional responsibility aspects of the issue. Professionally, educators are responsible for the well-being of the children assigned to their care and keeping. This requires more than just understanding the politically structured incentives and sanctions imposed on the schools and protecting children from the negative consequences of vitriolic political disagreements. Professional responsibility extends beyond simply managing political opportunities and constraints. Professional responsibility also encompasses understanding and managing the academic, technical, and social dimensions of language acquisition and usage. That is, educators are professionally responsible for understanding the interactions between language learning, academic subject mastery, and cognitive, social, and intellectual development by children as they navigate institutional life in schools and communities. Hence, we turn in the remainder of this chapter to an analysis of the complex dimensions of professional responsibility, giving special attention to the roles of university schools of education in nurturing and enabling the development of the educators who hold these professional responsibilities.

University Schools of Education and the Development of Professional Responsibility

Anti-bilingual political pressures following the passage of Proposition 227 significantly curtailed implementation of dual-language programs in the public schools. This led to sharply diminished interest in obtaining bilingual teaching certification by prospective teachers. This, in turn, reduced the ability of university schools of education to mount bilingual training programs.

Legislation and political pressure did not, however, stem the flow of non-English speakers into the nation's schools—particularly in California. And these pressures did not eliminate the substantial educational challenges facing English learner student populations. These political conditions, made even more damaging by budget cuts following the Great Recession of 2008, have produced a dramatic shortage of biliterate teachers and administrators. As a result, university education schools are now faced with the responsibility of expanding the size of the biliterate teaching force. As Santos et al. (2012, p. 3) note, this responsibility cannot be met by a few "boutique" programs serving a handful of schools. The public schools need scaled-up regular programs, preparing bilingual teachers for an increasing number of teaching jobs. Development of new programs is made even more urgent by the recent adoption of the Common Core State Standards (CCSS), which require dramatic changes in professional practice with substantial implications for the EL student population (Quezada and Alfaro 2012). Quezada and Alfaro (2012) present a compelling argument that access to the CCSS for English learners is best accomplished through literacy and biliteracy development. They argue that the new standards require the development of "culturally proficient biliteracy teachers" who enable students to use their first language cultural funds of knowledge to enhance learning (Quezada and Alfaro 2012; Crawford and Krashen 2007; Verplaetse and Migliacci 2008).

Recruitment of a Biliterate Teaching Workforce

Enrollment in teacher preparation programs in California has declined steadily over the past 5 years (California Commission on Teacher Credentialing 2012). In some regions, however, as the English learner population has grown, so has the proportion of candidates entering the teaching profession whose first language is not English. This fact alone, however, has not facilitated recruitment of a bilingual teaching workforce. Recruitment efforts—particularly for elementary and middle school teacher candidates—have shifted from traditional liberal studies programs to ethnic studies and Spanish language majors, who have selected college careers that capitalize on their cultural and linguistic assets. Biliterate teachers' cultural funds of knowledge are necessary to effectively engage students and their students' families. They must develop sophisticated academic language skills and content pedagogy in both languages.

Curriculum Reform

Curriculum reform in teacher education requires both the emotional will needed to advance reform efforts and a clearly articulated direction. In response to the emerging demographic shifts in California, as well as the activism of professional groups such as the California Association for Bilingual Education (CABE) and the California Association for Bilingual Teacher Education (CABTE), the California Commission on Teacher Education (CTC) recently adopted a comprehensive new set of standards for preparation of biliterate/bilingual teachers. The new standards are aimed at shaping the way university education school programs think about curriculum and design preservice teacher candidate experiences (California Commission on Teacher Credentialing 2009). One significant aspect of the new standards is an option allowing experienced teachers to earn their bilingual certification through added coursework while they continue to teach; previously, teachers could only earn their bilingual certification at the preservice level, or through the passage of a state-mandated examination. This professional coursework option increases the pool of certified bilingual teachers available to both teach students and mentor novice bilingual educators.

With the newly adopted preparation standards as a guide, university education school curricula for the bilingual authorization programs have generally been examined and revised. At the University of California, Riverside, the content for the student teaching seminars—the backbone of the preservice experience—was revised to include more opportunities for students to develop biliterate skills in parent communication and culturally relevant planning for instruction. Seminars throughout the program are conducted in two languages. Specific support for academic language acquisition in both native and target languages is infused across the curriculum and emphasized in a unique course for content literacy in a second language. At UC, Riverside, content methodologies for mathematics and science courses are now taught primarily in Spanish, the dominant non-English language in the region. Finally, candidates spend the entire year of practicum in dual immersion (DI) classrooms, under the supervision and mentorship of teachers that hold a bilingual authorization and have extensive teaching experience in bilingual settings.

Across the State, university schools of education have implemented similar programs and are giving renewed attention to the preparation of biliterate teachers. There is some evidence that an ideological shift toward relying on the public school system to help develop multilingual society is beginning to gain traction (Lara 2014). Local educational leaders report that enthusiasm for dual immersion programs is increasing in both the EL and English-only (EO) populations.[1] In response, some districts are expanding dual language programs; others are initiating programs for the first time. As a result, demand for credentialed bilingual teachers is rising. As the value of biliteracy is increasingly recognized in the education community,

[1] As reported in surveys and interviews with the superintendents and principals in Riverside and San Bernardino Counties during the period from 2009 to 2012.

the demand for teachers with bilingual certification has increased even in English-only schools and classes. School leaders report that in the current environment of workforce reduction for elementary school teachers, job security for teachers with bilingual certification is enhanced. All of this suggests that there is a perception of increased value for students when their teachers are biliterate.

Student Achievement and Biliteracy: Professional Responsibility for Outcomes

Once trained and certified, bilingual teachers have a professional responsibility to assure that students assigned to them are provided with instructional programs that, at a minimum, conform to the Hippocratic Oath to "do no harm," either academically or socially. Discharging this responsibility requires that teachers be able to clearly conceptualize program designs and consistently implement them as designed. Additionally, it is essential that alternative programs be competently and reliably evaluated for both adequacy of implementation and their intellectual and psychological impacts on students. For all their limitations, standardized academic achievement testing programs remain the basic tool of program evaluation in most public school settings. Hence, while it is important to keep pressing university schools of education, achievement test manufacturers, and education policymakers to produce more appropriate measures, for the foreseeable future, it is important for all teachers to develop a solid understanding of the programs they are expected to implement and be able to interpret the standardized achievement testing programs used to assess them.

Conceptually, there are five distinct approaches to language development being implemented with varying degrees of success in California public schools. Available data indicate that the academic efficacy varies dramatically across these approaches. The following is a brief description of the five major models of bilingual education:

1. *Early-Exit Bilingual Education*
   This program was designed to assist students learn English while they continue to learn academics in their primary language. However, it is also designed to have students' transition into all English by the end of third or fourth grade. Thus, development of bilingualism is limited, and students are still expected to leave their primary language behind and continue in English only.
2. *Late-Exit Bilingual Program*
   This program was designed to teach English as well as to continue teaching in the students' primary language up through the sixth grade. According to Thomas and Collier (2000), this program has been shown to be very effective in the education of English Learners.

3. *Immersion*
   In an immersion program, students are instructed in one language for the entire school day. For English learners, this program works on models similar to those originally designed to teach native English speakers a foreign language.
4. *Three-Language System*
   In this program, students are first taught in the official language of the state, a second language officially recognized by the state is introduced after approximately 2 years, and a third language is added several years later (Queen, Robin, "Spanish Speakers in the US").
5. *Dual Immersion*
   The program that has consistently been demonstrated to be a successful program for all language learners is the dual immersion (DI) program (Thomas and Collier 2003). Linguistically, this is a program based on an additive, rather than an interference perspective. Students are not asked to leave behind his/her culture or language; all languages and cultures are accepted and valued. Students study and learn the same academic content as other students at their grade level, but they also become bilingual, biliterate, and bicultural. The other great advantage of this type of bilingual program is that it is designed for both English learners and native speakers of English. It gives the opportunity of bilingualism to all.

In 1997, Thomas and Collier published a seminal study (Thomas and Collier 1997), which compared several models for bilingual education—including the early-exit, late-exit, and dual immersion models described above—assessing student achievement in English reading. They concluded that two-way bilingual immersion programs (dual immersion) and late-exit bilingual programs with content presented in English as a second language were the only programs where English learners reached the 50th percentile in English reading and maintained this level through 12th grade; the dual immersion programs produced the highest test score results. Their subsequent work (Thomas and Collier 2003; Collier and Thomas 2004) continued to demonstrate the efficacy of dual immersion bilingual education programs.

This evidence, along with the work of others (e.g., Cummins 2005; Crawford and Krashen 2007), has been compelling to some school districts serving high populations of English learners. There are currently 201 schools in 30 California counties offering dual immersion programs.[2] Administrators in one of the districts sponsoring several dual immersion programs believe that this model is the optimal program to ensure the academic success for English learners. The program was also chosen because it offers an opportunity for English monolingual students to become bilingual. The administrators believe this inclusive program has proven to be beneficial to all; education professionals in this district acknowledge the responsibility to offer the best education possible to students and to the community.

[2] Most recently available data (2012) from the California Department of Education (CDE) at http://www.cde.ca.gov/sp/el/ip/ap/directory.aspx

Benefits of Bilingual Authorization for Professional Educators

Bilingualism also benefits education professionals. Prior to the passage of Proposition 227, bilingual teachers received a stipend. Though these funds are now gone, teachers are still receiving benefits for their bilingual skills as they have been omitted from the reduction in force groups (i.e., laid off teachers) in some districts (Zehr 2008). As an example, in the Jurupa Unified School District, there has been an agreement with the district and the union each year that teachers with bilingual authorization have received specialized training and have special certification to teach in this program, and therefore are exempt from the reduction in force process.

Recent survey results from San Diego, Riverside, and San Bernardino counties regarding workforce benefits for bilingual educators provide further evidence for the advantage of biliteracy in the teaching workforce. Of 25 responding districts, 15 indicated that teachers received some type of benefit for biliteracy skills or certification. Benefits included a stipend, job security over others who do not have a bilingual certification, or both. Responses indicated that some districts recognize these skills as indispensible. These districts exempted the authorized bilingual teachers from layoffs, irrespective of whether they were in a dual language class or not. This reflects a commitment to ensure that bilingual teachers are working with EL students, regardless of the availability of dual immersion programs. In addition, at a time when very few teachers are being hired because of the current climate of economic distress, bilingual teachers with the special certification (BCLAD, which certifies their bilingualism) have a better chance of being hired over their monolingual counterparts.[3] Many positions open at elementary schools in this region specify, "Must be BCLAD certified."

Student Achievement and Biliteracy: Lasting Benefits

Dual immersion programs provide multiple benefits to both native English speakers and English learners. Most dual immersion programs reflect the language of their communities; in California, this is predominantly English and Spanish. Long-term exposure is especially helpful in meeting three Dual Immersion program goals:

1. Developing high ability levels in both first and second languages,
2. Grade-level academic performance, and
3. Positive cross-cultural attitudes (Howard 2002).

Linguistic proficiency, the most obvious linguistic benefit, is that students participating in dual immersion programs over time become bilingual. Students acquire

[3] As reported in surveys and interviews with superintendents and principals in Riverside and San Bernardino counties during the period from 2009 to 2012.

their second language at no risk of losing their primary language (English or Spanish), and they are able to maintain their first language while adding a second language. Thonis (2005) supports the proposition that mastery of the first language supports the acquisition of the second language and allows for the transferability of skills from one language to another. Native speakers of English who learn the content in Spanish (the target language) and English learners who learn the content in English (the official language of the nation) become bilingual and contribute to the linguistic resources of this nation.

It is important to distinguish between bilingualism and biliteracy. Students in DI programs learn to speak two languages (become bilingual), and within their classroom contexts, they also learn how to read and write in both languages (become biliterate). The instructional day is planned to introduce literacy skills in the target language for both groups, native speakers of English and English learners. A common Spanish–English DI model begins with a 90/10 instructional time allocation in kindergarten, that is, 90 % of the instruction is in Spanish and 10 % is in English. Importantly, literacy skills are introduced in Spanish. Native speakers of English learn to speak Spanish while concurrently developing their literacy skills in this language. As the grade levels progress, the proportion of time shifts by 10 % each year (i.e., in first grade, the instructional time is 80 % Spanish and 20 % English), until the instructional time is evenly split, at which point the students are considered fluently bilingual.

The important differences between learning to read English as a first and as a second language are described by August and Shanahan (2010). They note that strong literacy skills in the first language facilitate the acquisition of literacy skills in the second language. Receiving literacy instruction in the first language sets the stage for "cross-language" influences (Lindholm-Leary and Genesee 2010). These cross-language influences are observable as students rely on their first language literacy skills and gradually transfer them to attain biliteracy. Lindholm-Leary reports that "successful English learner readers/writers view reading and writing in English and the home language as similar activities with language specific differences" (Lindholm-Leary and Genesee 2010, p. 343).

Some scholars have argued that continued use of students' native languages helps develop English proficiency (Collier and Thomas 2004; Cummins 2005; Crawford and Krashen 2007). Moreover, it is asserted, developing and maintaining one's native language does not interfere with second language development. Clearly, many people become fully bilingual and multilingual without suffering interference of a first language in learning another (see, e.g., Baker 2011). Research suggests that proficiency in one's native language is a strong predictor of second language proficiency. Cummins' linguistic interdependence principle (2005) argues that this phenomenon results from a common underlying linguistic proficiency, allowing cognitive/academic and literacy-related skills to transfer across languages (Phillips and Crowell 1994).

Dual language programs also support academic success. In the last decade, Kathryn Lindholm-Leary (2001), Thomas and Collier (2002), and Lindholm-Leary and Block (2010) looked at the academic achievement of students placed in DI programs.

Lindholm-Leary (2001) collected data from 16 two-way programs, divided equally between 90/10 and 50/50 models for Spanish- and English-speaking children. She documented that both English- and Spanish-speaking students scored high in oral and academic skills in their respective native languages. Lindholm-Leary found that students in the 90/10 model performed better in Spanish skills, but all Spanish speakers (regardless of the model) became equally proficient in English. In general terms, she found that "across the grade levels, as students became more proficient in both languages, the correlation between reading achievement in English and Spanish increased" (Crawford 2004a, b, p. 304).

Collier and Thomas (2004) compared the English-reading achievement in three types of bilingual programs in the Houston Independent School District during the period of 1996–2000. The data, reported in percentile ranks, indicate that students in two-way bilingual programs outranked their peers in transitional bilingual education and those in developmental bilingual education. Lindholm-Leary and Block also examined the achievement level of 659 Hispanic students in a DI program (90/10 model). They reported that though these students came from low SES homes, they still scored comparably or better than their peers who received their instruction only in English. Native speakers of English in DI programs also scored higher than their peers in regular mainstream programs in both reading and math (Lindholm-Leary and Block 2010).

These researchers concur that students who participate in two-way immersion programs in both models perform very well in comparison to the students in other programs. The students in DI programs, both English learners and native speakers of English, obtain scores at the same level or higher than their peers in transitional bilingual and English mainstream classrooms (Thomas and Collier 2003). Lindholm-Leary asserts that time spent in Spanish instruction positively impacts achievement in Spanish and has no negative effect on achievement measured in English. Confirming the results posted by Thomas and Collier, Lindholm-Leary states that English learners in dual language programs "appear more likely to close the achievement gap by late elementary or middle school than their English learner peers in English mainstream programs" (Lindholm-Leary 2010, p. 352). These outcomes identify higher achievement as a benefit for students in two-way immersion programs. These benefits are also received by native speakers of English in DI programs. These students have consistently posted higher academic gains as compared with their peers in mainstream classrooms. The benefits of adding a second language to English are a welcome addition that will prove advantageous in the years to come (Thomas and Collier 2003).

Cross-cultural attitudes improve along with academic achievement and biliterate language skills in DI programs. This culture competence is the third goal of DI programs. The bilingual classroom environment and the integration of multicultural curriculum content help students to effectively function in two cultures. A modified and culturally differentiated curriculum gives students skills needed to participate in a global society. In these classrooms, student-to-student interactions help to develop

cross-cultural understanding. Teachers and students come to value the cultures represented in their classroom in very direct and concrete ways. Positive attitudes toward school and college are fostered.

Lindholm-Leary and Borsato (2001) researched these questions and concluded that former students in two-way immersion programs developed positive attitudes toward school and high levels of satisfaction with participation in these programs. The research, which included 142 high school students who were enrolled in two-way immersion programs, grouped students into three categories. The comparison group consisted of Hispanic students who had not participated in two-way bilingual programs.

All students completed a questionnaire that consisted of 147 questions. These questions probed issues of identity and motivation, attitudes toward schooling, current schooling path and college ambition, attitudes toward bilingualism and the two-way bilingual program, parental involvement, and school environment. The results showed that most of the students attained high academic competencies and developed motivation to do well in school. The researchers analyzed the data and indicated that in the areas of college preparation, students had a positive attitude, and they participated in activities that ensure academic success at the college level. In high school, they were enrolled in higher level math courses, were receiving good grades, and reported that they intended to stay in school and attend college. This encouraging report has implications for educators in the elementary level and sends the message that the DI program's success has ripple effects on high school students and may motivate students to attend college. The reported benefits of two-way programs for Hispanic Spanish speakers were, in the words of Lindholm-Leary, impressive: "almost half of these students believed that the program kept them from dropping out of school." She felt confident that these students would want to go to college right after high school graduation. Lindholm-Leary implies that the amount of information these students receive in elementary and middle school may give them more detailed and accurate information about what courses to take in high school and help them meet college admission requirements. So, in addition to developing high levels of academic competence and motivation, these high school students also developed pride on being bilingual, had positive self-concept, and saw themselves as successful students in high school and college (Lindholm-Leary and Borsato 2001, pp. 19–21).

Participation in DI programs offers multiple, long-term benefits to both native speakers of English and English language learners. Research shows that students who are schooled in DI programs reap collateral benefits in the area of bilingualism, biliteracy, and academic achievement. In addition, research shows that these students develop cross-cultural skills and a persistently positive attitude toward school. These attitudes may help to ameliorate the academic achievement gap and reduce the high school dropout rate. The evidence supports our assertion that expanding access to DI programs for students and preparing a highly qualified biliterate teaching force are essential responsibilities for the education profession.

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Chapter 16
Policy, Structural, Role, and Knowledge Barriers to Best Practice in School Psychology

Mike L. Vanderwood, Cathleen Geraghty-Jenkinson, and Richard Kong

School psychology, like many professions, is continuing to evolve and create a clear vision and scope of practice, and relatedly, a definition of "professionalism" for the field. The process of developing guidance for what professional practice in school psychology could be includes the active professional standards setting stakeholder groups of several organizations (e.g., National Association of School Psychologists (NASP), American Psychological Association (APA) Division 16 (School Psychology), Council of Directors of School Psychology Programs (CDSPP)), policy development of national organizations (e.g., National Council on Learning Disabilities (NCLD)), and several federally funded research programs. As in most professions, the definition of "professionalism" or professional behavior is significantly different today than it was two or three decades ago due to active examination and evaluation of the profession.

Yet, as detailed later in this chapter, very few of the recommendations for change in practice over the last two decades have made their way to full implementation in school settings. The reasons for the lack of change are quite complex; yet, an attempt is made to describe the historical and current contexts that are most likely the causes of the prevention of "best practice." The primary purposes of this chapter are to identify the barriers to change and provide recommendations that can be used to "problem-solve" these challenges and support the implementation of practices consistent with research and policy. The chapter starts with a brief description of the current status of the profession and the roles typically assumed by school psychologists. These are followed by an overview of current standards of practice. The chapter ends with an examination of the degree to which recommended professional practices are in place, the obstacles perceived to be preventing change, and a set of recommendations for training programs and practitioners.

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Origins of a Profession

Although there are many specialties (e.g., industrial–organizational, educational) in the field of psychology, school psychology is one of the only three American Psychological Association (APA)-designated applied psychology specialties. Although school psychology has many similarities to the other accredited applied psychology fields (i.e., counseling and clinical), there are tasks unique to practicing psychology in education settings that have led to the development of the field's own professional standards and competencies. The current standards are rooted in the initial practices of psychologists who worked in schools and clinics over a century ago (Fagan 1992).

The field of school psychology traces its origin back to the late nineteenth century (Fagan and Wise 2007). In what is considered the initial treatise of the profession, Lightner Witmer argued in a book titled the *Organization of Practical Work in Psychology* (1897) for the need to adapt instruction in psychology to support the "common" school teacher and psychological experts to address the difficult cases that resist the methods of the ordinary classroom. A few years earlier, the first psychological clinic for the evaluation of children's learning differences and behavioral difficulties was established at the University of Pennsylvania in 1892. This was followed in 1899 by the establishment of the first public school psychological clinic in Chicago (Fagan and Wise 2007).

As the diversity of students in public schools changed dramatically through the implementation of compulsory education, the need for professionals who could help identify students who needed additional assistance and provide recommendations to classroom teachers grew significantly (Tharinger et al. 2008). Although the term "school psychologist" was first used in the early 1900s, training programs did not exist until the mid-1920s (Fagan 1999). Some of the first school psychologists were teachers who received additional courses in testing, but the practice was completely unregulated, and many different terms were used to describe the profession. From the 1920s to the 1940s, several school psychology programs were created, including the first doctoral program at the Pennsylvania State University, and the first standards for certification were created in New York and Pennsylvania (Fagan 1986). Interestingly, even though APA often showed disinterest in applied psychology, for a brief time (i.e., 1921–1927), they offered their members a school psychology certification program (Sokal 1982).

The practice of school psychology in these early years was primarily dominated by psychological testing through a model best defined as "refer-test-report" that was primarily provided through clinics, including traveling clinics in rural areas (Fagan and Wise 2007). Two psychologists were particularly influential during this time: Lightner Witmer and G. Stanley Hall. Witmer's assessment process focused more on clinical acumen and experience than paper and pencil tests, and he wanted the science of psychology to be applicable to actual problems. He called for special training for psychologists working in school settings. Hall is credited with his focus on child student, both idiographic and nomothetic. Hall's child study methods did

not address special education, but instead sought to describe the "normal" child, which was more in line with the zeitgeist of the time. Some of Hall's work addressing school ecology, parents, teachers, etc. can be seen in the current ecobehavioral approach to school psychology (Fagan 1992). The more idiographic approach to address student problems is currently the most widely adopted, and has largely resulted in the "refer-test-place" practice of school psychology.

The need for school psychology had been established, but there was a lack of appropriate assessment tools and guidelines for practice, including professional behavior (Fagan 1992). National and state organizations that focused on school psychology did not exist during this period; yet, it appears that some of the approximately 500 school psychologists were affiliated with the American Association of Applied Psychologists (AAAP; Fagan 1993). One of the first signs of the creation of a professional identity for the field was the publication of the first textbook for the profession: *Psychological Service for School Problems* (Hildreth 1930).

Establishing the Identity of a Profession

As attendance in US public school grew substantially after World War II, the need for school psychologists also grew substantially, creating a need for professional organizations and the development of standards. The first national organization to support the development of the profession was Division 16 of APA, which was created when APA merged with AAAP in 1945. The creation of Division 16 is a milestone because of the recognition that the field was significantly different than educational psychology (Division 15) and clinical psychology (Division 12), and the role it played in helping develop credential and training standards that were used across the country (Fagan and Wise 2007).

One of the most significant events related to the development of the profession was the organization of the Thayer Conference in 1954. The Thayer Conference was held in part due to the significant outcomes obtained from the Boulder Conference (1949) that promoted the ideas of the scientist practitioner model for clinical psychology. At the time of the Thayer Conference, there were approximately 1,000 practicing school psychologists, using approximately 75 different professional titles. Several noteworthy conclusions were made at the conference that affected the development of the profession for the next several decades. First, the conference participants agreed that empirical research was a practical tool, and the school psychologists were morally obligated to use research to guide practice. Second, an agreement was made that a code of ethics for school psychologists should be developed and used to guide practice in school settings. Third, there was an agreement that schools should work to reduce the ratio of students to school psychologists to allow the profession to broaden its role beyond assessment and "gatekeeping" into special education. The fourth major contribution of the Thayer Conference was a definition of the profession that included the idea that school psychologists were psychologists with training and experience in education who

used their knowledge of assessment, learning, and interpersonal relationships to help school personnel enrich the education of students with special needs. This definition was meant to help encourage schools to broaden the role of school psychologists and use them for more than assessment purposes (Cutts 1955).

A recommendation that was made at the Thayer Conference and not widely embraced was to create two levels of certification: one for doctoral level and one for subdoctoral psychologists. It was suggested that the subdoctoral practitioner work under the supervision of a doctoral level school psychologist. This recommendation was not widely accepted, and currently most states credential at the subdoctoral level for school-based practice. Shortly after the Thayer Conference, the two-level credentialing system was thought to be defeating the end goal of broadening school psychological practice, and that it instead suggested that subdoctoral practitioners could only administer psychological assessments. Another area of contention at the conference regarding credentialing was related to whether or not school psychologists needed teaching experience. Most states viewed then, and continue to view, school psychologists primarily as psychologists whose primary background should be in psychology, although there are states that place more emphasis on a background in education similar to the experience of some of the first practitioners of the profession (Fagan and Wise 2007).

Growth of the Profession

Although the profession continued to steadily grow after the Thayer Conference, including the creation of the National Association of School Psychologists (NASP) in 1969, significant growth and the need for further development of the profession occurred after the implementation of the Education for All Handicapped Children Act (EAHCA) of 1975 that created the need for identifying students with special needs and supporting special education programs. This law, along with Section 504 of the Rehabilitation Act of 1973, played a substantial role in spurring the growth of the profession from about 5,000 practitioners in 1970 to over 20,000 by 1990 (Curtis et al. 2002).

The need for practitioners also spurred substantial growth in university programs and professional associations. At the doctoral level, accredited programs grew from 3 in 1972 to 20 by 1980, and exceeded 40 by 1990. At the nondoctoral level, the number of programs doubled from 100 in 1970 to over 200 just 15 years later. As another sign of professionalization of the field, several new organizations, including the Trainers of School Psychologists (TSP), Council of Directors of School Psychology Programs (CDSPP), Society for the Study of School Psychology (SSSP), and the American Board of School Psychology (ABSP), were created in the two decades after the landmark special education law was passed in 1975.

As the profession grew, one sign of an identity separate from other fields of psychology and education was the creation of a separate literature base focused on school psychology. The associations created their own outlets including the news-

letter *School Psychologist* and the journal *Professional School Psychology* (now *School Psychology Quarterly*) by APA Division 16, and several influential outlets by the NASP including the *School Psychology Review* journal and a few foundational texts (e.g., *Best Practices in School Psychology, Interventions for Academic and Behavior Problems*). As a true school psychology professoriat was starting to emerge to support the need for practitioners in the 1980s, several other journals were created including the *Journal of Psychoeducational Assessment, Special Services in the Schools and School Psychology International* (Fagan and Wise 2007). All of these outlets specifically targeted issues that were unique to the practice of school psychology, and had a significantly different focus than journals related to educational and clinical psychology, and special education.

To address the growth of school psychology at the university level, a significant amount of effort was placed into developing national accreditation and approval standards that also directly influenced state-level credentialing. NASP worked with NCATE to create a program approval process and standards for the training content, field placements, and program resources of school psychology programs, with a primary focus on nondoctoral-level programs (Batsche et al. 1989). The NASP program approval standards were revised five times from 1980 to 2010 and examined student as well as program outcomes. For example, the 2010 standards required a minimum of three faculty members with an additional requirement that the program director and at least one other of those members hold doctoral degrees in school psychology (NASP 2010a). APA created similar but different accrediting standards for its three applied fields (i.e., clinical, counseling, and school psychology) that were used to accredit doctoral programs. These standards emphasized the fact that all psychologists should have broad training in psychology as well as field-specific knowledge. Similar to the NASP approval standards, APA required that the faculty be role models for students and have degrees or a professional identity in the field (APA 2007). Although both APA and NASP provided expectations for training, most of the content of these standards were produced through a myriad of conferences and committees that met to define the everchanging "theoretical" role of the school psychologist.

Identifying the Professional Activities

One of the agreements from the Thayer Conference in 1954 was a commitment to create guidelines for practice, including ethics that could be used to inform training and professional development activities (Cutts 1955). Although there were other organizations that played a part in helping define the role of the school psychologist in school settings, the University of Minnesota's National School Psychology Inservice Training Network set the stage for two major conferences [i.e., Spring Hill (1980), Olympia (1981)] that led to a systematic examination of practice and the production of documents meant to broaden and enhance the field. An extension of the work from these conferences by one of the organizers titled *School Psychology:*

A Blueprint for Training and Practice, versions I to III (Ysseldyke et al. 2006; Ysseldyke et al. 1997; Ysseldyke et al. 1984), described the competencies needed by school psychologists in order to fulfill their roles. These Blueprints put a focus on broadening the role of school psychologists to include consultation and intervention activities. Specifically, with the release of each Blueprint, more and more emphasis was placed on the school psychologist's role as a consultant. For example, Ysseldyke et al. (2006) note that school psychologists should "use problem-solving and scientific methodology to create, evaluate, and apply appropriately empirically validated interventions at both an individual and systems level" (p. 14). They also suggested school psychologists should be transmitters of psychological knowledge and skills who help disseminate current research into the applied setting of the schools (Ysseldyke et al. 2006).

These Blueprints and the documents that followed were produced within a rapidly changing context within the broader fields of psychology and education. For example, in the 1990s, the field of clinical psychology started to place an emphasis on the use of empirically based treatments that were required to meet specific guidelines related to the quality of research used to evaluate the treatment. Leaders in school psychology, specifically members of APA Division 16, followed this direction and started producing guidelines for empirically based interventions (EBIs) to be used in school settings for academic and behavioral concerns (Kratochwill and Shernoff 2004). Although it is impossible to know the extent to which this work affected practices in schools, national legislation reflected the need to use empirically based practices and interventions. For example, research-based interventions are defined in the No Child Left Behind (NCLB) Act of 2001 (20 U.S.C. 6368), and included requirements for the use of rigorous empirical methods and data analyses that had not been previously required. This same legislation spurred the creation of an organization designed to improve the overall quality of education research (i.e., Institute of Education Sciences) and provide educators access to rigorous research about the quality of methods and interventions used in education. For school psychologists, who typically consult about interventions, the need to understand how to empirically evaluate interventions had to be added to the field's training at the university and in-service levels.

In addition to the changing context related to interventions, the *Standards for Educational and Psychological Measurement* (APA/AERA/NCME) were produced in 1999 and substantially changed how the field viewed assessment tools. Of significance for school psychologists, this document changed how the concept of the validity of assessment tools should be evaluated. Instead of focusing on the relationship between a test and other tests of the same concept, the *Test Standards* promoted the idea that tests should actually be used to help select or design interventions, and the process of testing should lead to positive consequences for the student or client (APA/AERA/NCME). As will be discussed later in this chapter, several authors challenged the notion that the tests most often used by school psychologists (i.e., measures of cognitive ability) could actually produce evidence of validity when judged against the new standards (see Braden and Niebling 2012).

With the aforementioned context in mind, NASP embarked on a major revision in 2010 to the professional standards used to guide the profession. Using the Blueprints as a starting point, NASP introduced a set of professional standards for four areas: Standards for Graduate Preparation in School Psychology, Standards for the Credentialing of School Psychologists, Principles for Professional Ethics, and the Model for Comprehensive and Integrated School Psychological Services (see Table 16.1). For the first time, the profession was provided with guidelines that integrated training, practice, and ethical standards by using a consistent framework and orientation to the science and practice of the field.

The goal of the NASP 2010 Standards is to support the comprehensive service delivery for academic, social, emotional, and behavioral issues through evidence-based practices (NASP 2010a, b, c). Although the other standards are important for the profession, the NASP 2010 Standards for Preparation in School Psychology address issues relevant for the focus of this chapter. Of critical importance in creating professional psychologists who practice in a consistent manner, the standards provide clear guidance on how school psychology training should be provided at the specialist and doctoral levels (NASP 2010c). The guidelines require programs to have a "comprehensive philosophy/mission, goals, objectives, program of study, and supervised practice" (p. 2) and that the program is "designed, delivered, and assessed by highly qualified faculty members who primarily are school psychologists" (p. 3). The requirements also recognize that students do not typically begin programs possessing the professional behaviors necessary for successful school psychology practice, and suggest a framework for providing developmentally appropriate feedback to students. The standards emphasize the importance of engaging in ongoing assessment and providing behavior-specific feedback as the primary method of shifting psychologists toward a competent model of practice (Roberts et al. 2005). The preparation standards also emphasize the need for school psychology faculty to be exemplary models of school psychology practice and to recognize their role in the ecological conceptualization of training (Forrest et al. 2008).

Current Status and Barriers to Professional Practice

As the previous section indicated, the profession of school psychology has followed a typical development process that included the creation of professional organizations, accreditation procedures, and standards of practice that are designed to help define the field. The profession has grown substantially over the last three decades and consists of an estimated 35,000 practitioners and over 200 training programs (Fagan and Wise 2007). Yet, as with most professions, evidence suggests an uneven application of the guidelines in practice due to a variety of factors. For example, there are data that suggest most school psychologists have not expanded their roles to be consistent with the NASP guidelines, and still spend a majority of their time

Table 16.1 NASP model for comprehensive and integrated school psychology

	Domains	Descriptions
All aspects of service delivery	Data-based decision-making and accountability	Use problem-solving framework
		Use data to understand problems, implement services, and identify eligibility
	Consultation and collaboration	Use problem-solving process for all consultative practices
Direct and indirect services	Student-level services	Assessment data to develop evidence-based strategies
	Academics	Address acceptability and fidelity of interventions
	Social and life skills	Design and deliver effective curricula for academics and behavior
	Systems-level services	Participate in creating and maintaining a multitiered continuum of support promote family, school, community partnerships advocate and support families
	School-wide practices to promote learning	
	Preventive and responsive services	
	Family–school collaboration services	
Foundations of school psychologists' service delivery	Diversity in development and learning	Provide culturally competent and effective practices
		Recognize own biases
		Promote social justice
	Research and program evaluation	Evaluate and utilize research findings to practices
	Legal, ethical, and professional practice	Keep consistent with ethical, professional, legal standards

conducting assessments that do not address factors that can be improved in the classroom (Reschly 2008).

One of the most disheartening aspects of current school psychology practice is the lack of application of the empirically supported strategies endorsed by the NASP standards and other organizations (e.g., What Works Clearinghouse, U.S. Department of Education 2014). In a recent paper, the authors pointed out the widespread beliefs about several strategies used in school settings and suggested that their continued use was a sign of the prevalence of "pseudoscience" in school psychology (Lilienfeld et al. 2011). As detailed earlier, at the policy and practice standards level, the profession endorsed the rigorous application of empirically based assessment and intervention strategies. Yet, unfortunately, it is still common for practicing school psychologists to endorse the use of what can best be described as incorrect assumptions about assessments and interventions. For example, in 1990, a seminal paper was published titled *Just Say No to Subtest Analysis* (McDermott et al. 1990), in which a coherent and strong rationale to stop making instructional recommendations based on the pattern of scores (i.e., subtest analysis) on the measures of cognitive ability was made. Yet, there is substantial evidence that subtest analysis is still routinely used because of a lack of understanding of the nature of the problems being evaluated (Reschly 2008). In addition, even though there is substantial evidence that supports the need for research-based tools, states have been slow to adopt more evidence-based methods for identifying students with learning disabilities (Fletcher et al. 2005).

The use of subtest analysis and lack of the use of research-based procedures are also related to another concern with current practice. As discussed previously, for most of the history of the profession, school psychologists have spent the majority of their time in school settings conducting assessments. Yet, over the last two decades, several authors and professional organizations have called for a "paradigm shift" from focusing on assessment to spending more time consulting and supporting intervention activities (Reschly and Ysseldyke 1995). Reschly (2008) suggests the call for a paradigm shift in school psychology to "(a) unresolved challenges in general, remedial, and special education; (b) research foundations for producing improved outcomes; (c) policy recommendations from prestigious national organizations; and (d) legal changes at the national, state, and local levels" (p. 14). This call to shift is based on evidence suggesting that school psychologists can have a significant impact on student performance when they engage in consultation activities (Sheridan et al. 1996). Although it is fairly clear consultation activities could have more impact than assessment on student performance, recent evidence suggests most school psychologists spend more than 50 % of their time conducting assessments (Fagan and Wise 2007).

The continued focus on assessment and use of practices that are not empirically supported would not be as problematic if there were not examples of how a paradigm shift can have a significant impact on student outcomes. There is evidence that goes beyond the theoretical rationale for why to change. The potential impact of the change was initially detailed in the earliest discussion on the "paradigm shift" (Reschly and Ysseldyke 1995), which demonstrates the positive impact consultation and prevention-oriented school psychology support can have on academic and

behavioral outcomes. For example, when Noell and colleagues (1997) used consultation and performance feedback with teachers, students' work accuracy increased. Additionally, the ongoing support provided by school psychologists aided in the maintenance of intervention implementation integrity, which is a common concern in school programs. By using evidence-based consultation practices, school psychologists meet the needs of more students (Sheridan et al. 1996).

Given the data that suggest a shift in the roles assumed by school psychologists can have positive impact, and the data that points out the shift has not occurred, a further examination of the factors that are obstacles to this shift is warranted. There are clear regional differences in the degree to which each of these obstacles may influence practice, including the degree to which the threat of legal action by parents and advocates impacts many of the factors described below.

Theoretical Disagreement

Although there is substantial agreement about the need for consultation and prevention activities, disagreement about the origin and nature of the most prevalent disability in school settings (i.e., specific learning disability [SLD]) has led some psychologists to argue against dropping some of the "traditional" assessment activities (Hale et al. 2007). It can easily be argued the theoretical disagreement about specific learning disability diagnosis is the primary factor preventing many psychologists from embracing the suggested "professional" behaviors mentioned earlier in this chapter. The most common approach to determining whether a student is eligible for SLD support is to determine whether a significant discrepancy exists between a student's cognitive ability and academic achievement. Despite the fact that numerous studies have suggested the flaws of the discrepancy model (Fletcher et al. 2005a, b; Kavale and Forness 2000), lack of treatment utility associated with the subtest analysis (McDermott et al. 1990), and overemphasizing processing (Kavale and Forness 2000; Vellutino et al. 1996), it is still common practice to administer assessments for the purpose of evaluating whether or not a student is demonstrating a significant discrepancy. Additionally, many practitioners continue to hold on to the idea of a visual perceptual deficit hypothesis of learning disabilities (Vellutino et al. 1997), which only supports the continued use of "pseudoscience."

As will be described more completely below, federal law was changed in 2004 to allow the use of alternative models of SLD identification (i.e., response to intervention) that more fully embraced the use of consultation and intervention activities. Yet, several authors suggested there was still a need for assessment of cognitive ability and cognitive processing in addition to the use of a response to intervention approach (Hale et al. 2007). But, if the guidelines from the APA/AERA "*Test Standards*" are applied to current cognitive measures, available tests fall far short of meeting psychometric standards (Braden and Niebling 2012). Additionally, there is a strong emphasis on the standards that the assessments used by school psy-

chologists have consequential validity. For example, this approach to evaluating the validity of assessments requires the user to consider what types of recommendations about the efforts to improve student performance might be necessary (e.g., reading interventions) and to only use assessment tools that have evidence to support those recommendations (i.e., consequences) (Kane 2013).

Learning disabilities are the most commonly used qualifying conditions for special education placement (U.S. Department of Education 1995). However, there has never been a consensus on how learning disabilities should be defined or identified. As a result, the development of early problem-solving models and valid and reliable curriculum-based measures were in part a response to the need to better monitor student progress, but were primarily developed in an effort to better identify students with learning disabilities. When learning disabilities did first appear in the federal regulations, P.L. 94–142 (1975), there was no consensus in the literature regarding the qualifying criteria. The resulting compromise was the discrepancy model. Since that time, defining the criteria and characteristics of learning disabilities has been the source of much controversy. For example, in 1990, Hammill identified 11 different definitions that have been used since the term learning disability was first coined. It is important to note that definitions and criteria for learning disabilities are often different.

The challenge for practitioners becomes determining what message should be followed. Most states now allow multiple methods to be used for determining SLD eligibility; yet, very few states have mandated a shift to an intervention-focused approach (Reschly 2008). Without a consistent message from the research literature, training programs and those who provide professional development to current practitioners will be constantly challenged by alternative models when presenting any approach to learning disability identification.

Policy Obstacles

As was mentioned earlier in the chapter, the implementation of the EAHCA law (1975) that required school districts to implement special education programs substantially spurred the growth of the school psychology profession (Fagan and Wise 2007). Although growth is typically viewed as a positive aspect for a profession, in this case, an argument can be made that the formalized connection between school psychologists and special education may have played a part in narrowing the role of school psychology. Surveys of practitioners during the 1970s and 1980s indicated a dissatisfaction with the refer-test-report model emphasized in the law and a desire to be more involved in providing consultation and mental health support (Fagan and Wise 2007). Recent data suggest that school psychologists still spend a majority of their time supporting the special education system with a primary focus on conducing assessments and reporting results (Castillo et al. 2012).

Efforts to change the law and support the broadening of the role of school psychologists have met with mixed results. For example, in 2004, the Individuals with

Disabilities Education Act (IDEA) created new criteria for identifying students with Specific Learning Disabilities (SLD) and created an option that would allow school psychologists to use and integrate intervention results into the assessment process instead of primarily focusing on determining whether a discrepancy existed between cognitive ability and achievement. Yet, the statute also allowed for continued use of the discrepancy model, even though there were research-based reasons to argue against the continued use of the model (Fletcher et al. 2002).

Structural Barriers

There has been a perceived shortage of school psychologists since the early stages of the profession (Fagan and Wise 2007). Currently, the mean ratio of students to school psychologist, as reported in a survey conducted in 2009–2010, is 1,383 students to 1 school psychologist (Curtis et al. 2010), which is well beyond the NASP recommendation of a ratio of 550–700 students to 1 psychologist (NASP 2010a, b, c). This is an improvement from previous estimates such as when Thomas (2000) estimated in 1999 that there are 1,816 students per school psychologist and Charvat (2005) estimated 1,621 students per school psychologist in 2004. Another survey by Sullivan and Long (2010) found that over 15 % of school psychologists were serving over 2,000 students. A large caseload typically forces school psychologists to prioritize their work toward assessments (Graden 2004).

With school psychologists being shared between several schools, it is typical that they serve the students with the highest needs, usually in the special education department. School psychologists are further tied to special education as they are often funded through special education for assessment instruments and professional development. Not only does this limit their interactions with general education personnel, but also limits them to the roles that special education administrators are familiar with, rather than the "broad" role of school psychologists favored by intervention strategies (Van Der Heyden et al. 2007).

Role Barriers

As school psychologists typically serve well over 1,000 students (Curtis et al. 2010), assessment and evaluation for special education students, of necessity, become the main priority. Currently, school psychologists are generally viewed as the gatekeepers to special education. Despite the three Blueprint documents that have called for broadening the role of school psychologists (Ysseldyke et al. 2009), assessment is still considered school psychologists' main area of expertise.

This "role barrier" can be seen in the schools as assessment is prioritized over other activities (e.g., consultation, prevention/intervention activities)—activities that may have more systemic impact (Graden 2004). School psychologists play a

limited role and involvement in addressing problems before they become serious. Often, the absence of school psychologists in mainstream education programs leads regular education teachers to request the service of school psychologists significantly less often than special education teachers. This is reflected in the reports by regular education teachers that they spend less time with school psychologists than special education teachers (Gilman and Medway 2007). One consequence of less time spent with regular education teachers is the perception that the school psychologist is not a resource for general education issues or systemic change.

Another barrier related to roles is the school psychologist's often limited ability to self-assess and problem-solve difficulties with consultation. Both NASP and APA include self-assessment as necessary competencies. Practitioners often cite barriers to being able to implement evidence-based practices, but are not able to reflect on how their own behavior may be inhibiting implementation. In order for school psychologists to effectively advocate new roles, they need to be able to consult with school personnel, specifically administrators. Ongoing self-assessment may be necessary in order for consultation to be successful.

Knowledge

For various reasons, school psychologists do not feel they have the knowledge necessary to practice in all aspects of the NASP-integrated model (Stoiber and Vanderwood 2008). In addition, Riley-Tillman et al. (2005) claim that there is a gap between researchers and school psychology practitioners, which limits the transference of research into practice. If the psychologist's school community does not value evidence-based practice, and/or still subscribes to antiquated views regarding learning disabilities and intervention, then there will be little motivation to seek professional development that counters the beliefs of the community. Some authors suggest many school psychologists do not have the skills to apply the scientific model to school problems (Kratochwill and Shernoff 2004). Furthermore, school psychology trainers in graduate programs may not be familiar with the current movement toward evidence-based practices, which limits effective practitioner development (Kratochwill 2007).

The new NASP Standards (2010) highlight the importance of being able to provide teachers' support for students with reading problems; yet, over 40 % of school psychologists felt that they had moderately low to low knowledge of early indicators of reading and of assessment tools for reading (Nelson and Machek 2007). It is also clear that some psychologists do not recognize providing support as an important part of being a school psychologist. In a recent survey, only 10 % of school psychologists rated reading monitoring/remediation as a priority for professional development (Stoiber and Vanderwood 2008). As a possible positive sign, traditional assessments were reported as the area of greatest competence, but consultation and prevention/intervention activities were rated as a more valued practice than traditional assessments (Stoiber and Vanderwood 2008). The reasons for this gap is

probably due to several circumstances such as mentioned in structural and role barriers, but it is likely that the knowledge needed to competently engage in consultation and prevention/intervention activities is also lacking.

Training

School psychology training programs are unique in that there are multiple governing boards, such as NASP, APA, and the state board of education. As previously mentioned, the APA recognizes the doctoral level of school psychology as a specialty within professional psychology. The majority of school psychology graduate programs offer training at the specialist level (e.g., 30 h past master's degree; Tharinger et al. 2008). This qualifies graduates for licensure or certification as a school psychologist by most state boards of education. However, state boards of psychology require doctoral-level training for consideration as a "licensed psychologist."

Perhaps due to the variety of accrediting agencies, there is a wide variety in the quality of training. At the very minimum, programs need to provide their students with the opportunity to be credentialed by the state; however, the guidelines differ by state, and sometimes, a practitioner can move to another state and not meet the minimum requirements despite having practiced for decades. Programs offering specialist level degrees may choose to become NASP accredited, but there is no national requirement that a program seek NASP accreditation. Doctoral programs are similar in that it is a program choice to seek accreditation from APA. Both accreditation processes require additional paperwork and oftentimes require significant changes to the program to meet accreditation requirements. The requirements are designed to ensure that training programs provide students with instructions and experiences to aid in the successful acquisition of school psychology competences. Given that training can be considered a prerequisite to the demonstration of professional behaviors, the field may consider requiring accreditation from the appropriate body in an effort to promote high-quality training opportunities. Those programs that are accredited have a formal review process and have more tenured faculty. They have been found to generate better student outcomes (Gaubatz and Vera 2006).

There has been a push by some to require doctoral-level training for entry into the profession with a title of "school psychologist" (Tharinger et al. 2008). In certain states, such as Texas, individuals with specialist-level training are not given the title of "school psychologist" but rather a title along the lines of "licensed specialist in school psychology" (Tharinger et al. 2008). According to Prus and Strein (2011), the growth of APA-accredited programs has been slower, with only 65 total programs accredited for school psychology or a similarly combined program. In comparison, there are 159 NASP-approved specialist programs, representing over 70 % of all school psychology programs (Prus and Strein 2011). An argument can be made that given the goal to broaden the role of school psychologists, more training may be necessary than what has typically been provided by nondoctoral programs. Yet, a review of the literature for articles examining this topic suggests it is a question that currently available research cannot answer.

One of the challenges for doctoral- and nondoctoral-level training programs is providing students opportunities to use the skills that broaden their capacity beyond the assessment role. Participation in a practicum is intended to serve as an opportunity for school psychology graduate students to obtain experiences in the field, completing activities that are consistent with the program and national standards. According to one survey, school psychology students spend a majority of their practicum time performing assessment-oriented tasks (Tarquin and Truscott 2006). It was also found in this survey that over 70 % of students spend less than 25 % of their practicum time engaging in consultation-oriented activities. The types of activities that school psychology students participate in during practicum mirror the practice choices of the school psychologist with whom they work (Tarquin and Truscott 2006).

Internships promise training similar to practica, but the field is facing a significant challenge, providing students appropriate internship opportunities. According to recent studies, very few high-quality school-based internships exist for school psychology students (Swerdlik and French 2000). At the doctoral level, the American Psychological Association (APA) has only accredited a limited number of school-based internships. Most accredited internships are housed in clinics, state hospitals, or medical centers (Swerdlik and French 2000). At the specialist level, a limited number of quality internship opportunities are available. For school psychology programs accredited by the National Association of School Psychologists (NASP), there are specific guidelines for internships and supervisors. Nevertheless, many internship sites still focus on traditional approaches to assessment and provide interns with minimal opportunities to engage in multitiered service delivery and evidence-based practices. Quality control in the form of supervisor competency is one of the current challenges in school psychology internships (Phelps and Swerdlik 2011). Inadequate intern supervision has been identified as an area of needed improvement by school psychology training programs (Harvey and Pearrow 2010).

A final obstacle related to training is the challenge to hire school psychology faculty members who can model the full range of appropriate practice behaviors. As mentioned earlier, the NASP modified their standards for school psychology faculty members by requiring that the individuals earn degrees in the profession, or have experiences that clearly identify them with the field (NASP 2010a, b, c). In settings that have a doctoral training focus, the focus on applied skills and prior applied experience could be at odds with a desire to hire individuals who can conduct high-quality research and receive external funding. To date, this potential obstacle has not been fully examined.

Recommendations to Support the Development of Professionalism

To this point, an attempt has been made to describe the development of a fairly new profession and to highlight how this profession developed a vision of the roles and responsibilities of those who practice. The difference between the vision of the

profession and current practices was also highlighted along with the obstacles that are perceived to be preventing complete implementation of a role for school psychologists that is broader than assessment. The rest of the chapter is dedicated to examining options for addressing the identified problems using systems-level problem-solving. The obstacles described above are viewed as "problems to solve," not excuses for limited professionalism. Although there is some overlap, the recommendations are roughly divided between those applicable to university settings and those for the field.

University Recommendations

Five core elements in university training can be used to overcome some of the most serious obstacles preventing school psychologists from embracing a role that is broader than assessment.

1. *Modeling.* It is critical that trainers model the appropriate professional behaviors for students. Recognizing this, both NASP and APA require that faculty engage in certain professional behaviors. While many faculty engage in these professional behaviors, their practices need to be made more overt. Put simply, faculty should consider their own behaviors as potential causes when addressing student competency problems (Forrest et al. 2008).
2. *Competency Assessment*. The field is currently moving toward a competency approach to train professional psychologists (Bradley-Johnson and Dean 2000; Elman et al. 2005; Rubin et al. 2007), which stresses developmentally appropriate training and experiences and ongoing assessment of those competencies. To reflect that emphasis, training programs need assessments, which determine whether students are developing essential competences and which provide feedback on progress that is routinely communicated to students. It is important that assessed competencies represent the professional behaviors of a successful school psychologist. Necessary and sufficient competencies are articulated by the NASP and the APA. Assessments should include performance data from multiple raters across various environments. Many programs require supervisor ratings, ratings that include faculty and consumer evaluations. Ratings should be developmental in nature and contain questions directly tied to core competencies (Forrest et al. 2008; Rubin et al. 2007).
3. *Self Assessment.* In addition to creating competency-based assessment and providing ongoing feedback from multiple raters, it is important that students engage in self-assessment, including personal goal setting (Rubin et al. 2007). Student, faculty, and supervisor ratings should be routinely compared and discrepant data thoroughly discussed, and actionable items identified. NASP and APA view self-assessment as a valuable lifelong habit.

Some students will require more intervention to develop professional behaviors. One way to reduce possible future problems and create a culture with clear and high expectations is to define professional behavioral expectations (see Table 16.2). The

Table 16.2 School psychology program—behavioral expectations

	Classroom	Field-Based (practicum/internship)	GSR/Grant	General (conferences, defenses, social)
Be collaborative	Listen when classmates are talking/ presenting	Collaborate with all school professionals, even if they have a different philosophy	Work collaboratively with colleagues	Demonstrate respect for faculty/ committee members
	Use appropriate body language	Appreciate diversity	Appreciate existing school norms	Communicate with faculty/ committee members in a timely manner
	Appreciate diversity	Appreciate your role at the school		
Be a problem-solver	Use a problem-solving framework to deal with school problems	Use a problem-solving framework when assessing students	Use a problem-solving framework when consulting	Use a problem-solving framework to resolve interpersonal conflict
		Use an ecobehavioral approach to problem-solving		
		Use a problem-solving framework to address problems		
Be professional	Use technology appropriately	Be a good consultant	Maintain confidentiality	Attend conference sessions of colleagues
	Remain on-task for the duration of class	Dress appropriately	Always arrive a few minutes early	Seek guidance on presentations
	Attend all classes	Always arrive a few minutes early	Dress professionally	Turn in manuscripts on time
	Arrive to class early, or on time	Use technology appropriately	Use technology appropriately	
	Dress professionally	Maintain confidentiality	Only count the hours you worked	
	Behave professionally with colleagues	Adhere to NASP and APA ethical guidelines	Follow through on obligations	
	Complete, and turn in, ONLY your own work	Demonstrate behaviors that correspond to NASP domains of competency		
	Complete all reading, assignments, materials prior to class	Do your best work		
	Pre-arrange when emergencies interfere with timely task completion	Advocate for the use of evidence-based practice		

idea of setting clear and high professional behavioral expectations is borrowed from the extensive literature on positive behavior support (PBS), which suggests that by defining and teaching expected behaviors, individuals will be more likely to demonstrate the desired behaviors (Peshak George et al. 2008). This can lead to a reduction in inappropriate behaviors and help prevent problems. It also allows for the program to provide concrete feedback to a student when there is a problem with professionalism. These expectations can be more specific than broad competencies, and can be used to give examples of appropriate and inappropriate behaviors.

4. *Practica*. In order for students to become professionally proficient, access to opportunities for practice and appropriate models. The primary vehicle for providing modeling and practice is typically through practica. In some cases, it may be necessary for university faculty to provide training and support to practica sites so that students observe professional behaviors, and their use of professional behaviors is encouraged. Some programs systematically choose practica sites, based on the philosophy of practice and the willingness of supervisors to engage in ongoing professional development (e.g., demonstrate professional behaviors). The practica experience should be viewed as a direct extension of the university training, and efforts should be made to promote the quality of the experience. The expectations presented in Table 16.2 can be used to help supervisors understand how to connect events in the field to training goals of the program.
5. *Internship*. The final educational experience for students in applied psychology programs is the 1,500 h internship, supervised by a doctoral level psychologist. The entire field of applied psychology is currently struggling to determine the most appropriate way to ensure this culminating experience has the desired effect on the trainee; yet, the challenges are different in each field. In clinical psychology, students must attend an APA-accredited internship site, which meets rigorous standards for training and creating diverse experiences for trainees. Yet, there is currently a significant imbalance in the number of accredited sites and the number of students who need to complete the internship. The field of school psychology on the other hand created less rigorous standards for internship that allowed school psychologists to complete internships in school settings (CDSPP 2012). The challenge with this approach is that the quality of training varies dramatically from site to site, and many sites are unable to provide supervision that meets current standards to obtain licensure. One of the biggest challenges for the profession in the next decade will be finding ways to create APA-accredited internships, with a focus on school psychology training.

Field Recommendations

Although university training programs can help broaden the role of school psychologists while they are undergoing training, there is a critical need to provide additional training for those already in the field. It appears that many school

psychologists value the concept of a broader role, but do not feel competent to perform a more interventionist or consultative practice (Stoiber and Vanderwood 2008). A review of the literature provides examples of the process used to help current psychologists broaden their competencies and, thus, their practices. The three most promising examples are as follows:

1. *University/Local Education Agency Collaboration*. One of the most obvious approaches to help school district personnel integrate consultation and intervention activities into their professional practice is to collaborate with a nationally accredited or approved school psychology program. There are numerous examples of this approach throughout the profession, including projects at Lehigh University, University of Minnesota, University of Oregon, and the University of Pittsburgh (see Shapiro et al. 2011). In these cases and others, a long-term relationship is created, including on-site professional development with extensive follow-up and immediate feedback about the success of the implementation process. A consistent theme throughout these projects is the joint problem-solving process that allowed schools to contemplate solutions that are not always obvious.
2. *State-Level Leadership*. Another approach to helping school districts support change is through the use of state-level initiatives, either supported by a state education agency or a state-level professional organization (e.g., California Association of School Psychologists). State-level initiatives have the advantage of pooling resources to allow for the development of additional resources that can be used to support the change process. This approach can also provide the extra support necessary to address some of the obstacles that cut across systems including concerns related to legislation and expected practice.
3. *Competency-Based Evaluation Systems*. Similar to the movement within doctoral level training, there is a clear rationale for creating an employee evaluation system that is based on the competencies that will enable school psychologists to broaden their roles. Through the use of an evaluation system, practitioners can receive feedback about the degree to which they are embracing the broader role and practicing in a manner consistent with suggested best practice. In addition to the evaluation system, it is important to create an environment that supports and rewards innovation (Shapiro et al. 2011).

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Chapter 17
Whither Collaboration? Integrating Professional Services to Close Reciprocal Gaps in Health and Education

Robert K. Ream, Alison K. Cohen, and Teresa Lloro-Bidart

When we try to pick out anything by itself, we find it hitched to everything else in the universe.

—John Muir, *My First Summer in the Sierra*

How are we to understand the compartmentalization of training regimes and work responsibilities that silo health and education professionals apart from one another even as inequality in health and education are inextricably linked? A voluminous body of research demonstrates, although all children are affected by physical and mental health issues impacting learning, children living in poverty and racial and linguistic minorities bear a substantially heavier burden (Chap. 17 Aud et al. 2010; Deaton and Paxson 2001; Hernandez et al. 2010; Price et al. 2011).[1] Not only are

[1] About one in five children now lives below the poverty line. Moreover, poverty rates continue to widen across racial/ethnic groups. At the end of the 1990s' economic boom, 23 % of Blacks had incomes below the poverty line. Within the span of a decade, however, Black and Hispanic poverty rates (38 and 32 %, respectively) had increased markedly, far exceeding the US average in 2010 (Lopez and Velasco 2011).

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minorities disproportionally uninsured due to soaring costs and barriers due to immigration and legal status (Ku and Matani 2001; Le Fanu 2002; RAND 2012), but especially those who are of low-income suffer disproportionally from disease and school failure, which, in a mutually reinforcing cycle, affect health consequences and life quality and expectancy across generations (Cohen and Schuchter 2013; Marmot 2002; Miller 1995; Olshansky et al. 2005; Ross and Wu 1995).

Without adequate health for lower income minority children and their families, there is little hope for closing the persistent gaps in educational performance that divide America (Currie 2005; Low et al. 2005; Rothstein 2004).[2] Yet, many administrators, parents, and concerned citizens remain unconvinced that intersectoral efforts at improving the health status of learners will pay dividends in enhanced educational and health-related outcomes (Symons et al. 1997). Thus, collaboration and bidirectional problem-solving between health and education systems and professionals does not routinely occur, despite growing evidence that it should (Bradley-Klug et al. 2010; Clay et al. 2004; Cutler and Lleras-Muney 2006; Roussos and Fawcett 2000; Shaw et al. 2011).

The Current Study

This chapter challenges the prevailing skepticism about whether the human improvement professions (e.g., primary care medicine, public health, social welfare, and education)[3] can reinvigorate the civically oriented purposes of professional life by acting in conjunction to effectively advance the well-being of all children. We are motivated by the potential for raising interprofessional collaboration to the status of a conscious social value simultaneously geared toward reducing disparities and increasing excellence in health and education. From this stance, we pursue the question of whether and how health and education professionals can formulate and implement, via university-sponsored consultation across disciplines, a metaprofessional culture and an integrated professional services system designed to

[2] Since the early 1970s, analyses of the nationally representative survey data have documented an enduring history of achievement differences, which reveal that whites enjoy relatively high-average student performance, while African Americans and some Hispanic and Southeast Asian subgroups experience relatively low-average student performance (Jencks and Phillips 1998). As early as kindergarten, racial achievement gaps already approximate 1 year of learning in both mathematics and reading (Fryer and Levitt 2004), and these gaps tend to increase as children continue through school (Alexander et al. 2007; Hanushek and Rivkin 2006). Moreover, children whose families are on the lower rungs of the social class ladder average far lower achievement levels than their wealthier counterparts (Duncan and Murnane 2011).

[3] We employ the terms "human improvement professions" as well as "human services professions" and "caring professions" interchangeably in reference to professionals who work directly with and on other humans in efforts to improve health, broaden understanding, and enrich human capabilities toward the ultimate goal of improving the well-being of society (Cohen 2011).

eliminate deep and persistent gaps in health and education, separating minority or poor students and otherwise socially enfranchised children.

A fundamental problem motivates our work: unhealthy children are academically challenged learners who must navigate systems of health and education that are interdependent, yet typically compartmentalized (Power et al. 2003; Rothstein 2004). We then identify prevailing market values that serve as the backdrop to ongoing reforms that are failing to produce excellent and equitable outcomes across both systems of care (Gawande 2012; Ravitch 2010). Then, we set forth a distinctly professional rationale for intersectoral collaboration,[4] presenting an integrated conceptual framework to inform the design and organization of mutually reinforcing work across the caring professions.

We note that amidst a hyperspecialized system of health and education and an increasingly compartmentalized workplace, finding common ground and dealing with critical social challenges in any organic and cooperative manner can be exceedingly difficult (Hessel and Morin 2012; Shaw 2003). Learning how to work together when health and education professionals are separately trained, are differently inducted into their respective occupations, and are taught to honor different legal and professional standards of practice, creates troublesome dilemmas that, to date, have been only partially addressed by research (Lechner and Stucky 2000; Nastasi 2000).

Accordingly, with an eye toward the American University's historic role as an incubator and common training ground for most of the professions (Gray 2012; Kerr 2001; Stevens et al. 2008; Sullivan 2005), we focus the second part of the chapter on university-sponsored adaptations and the university's promise for recruiting, training, and inducting a new corps of professional "change agents," who have both the capacity and the willingness to spur collaborative interdependence across medicine, health, social services, and education.

We start out by briefly reviewing research that illuminates the reciprocal nature of inequality in health and education.

Gaps in Health and Education Are Reciprocal and Ecologically Situated

Poverty and restricted access to health care services continue to exacerbate deep racial, social class and linguistic inequality in children's health, school readiness, and academic performance (Currie 2005; Duncan and Murnane 2011; Hernandez

[4] What makes this rationale distinctly professional, as we articulate more fully below, are the structure of the work tasks we set forth and the purposes to which these tasks are linked—purposes associated less with the pursuit of efficiencies on behalf of industry than with public purposes on behalf of human flourishing (Gardner et al. 2001; Mitchell and Kerchner 1983; Sullivan 2005).

et al. 2010; Jencks and Phillips 1998).[5] Compared with other industrialized nations, the United States continues to perform poorly on numerous indicators of health status and educational performance (Avendano et al. 2009; Fleischman et al. 2010).[6]

The three most prevalent physical health issues impacting academic achievement outcomes are vision problems, persistent asthma, and obesity (Basch 2010; Hernandez et al. 2010; Rothstein 2004). The three most prevalent mental health issues are attention deficit hyperactivity disorder, depression, and anxiety (Bhatia and Bhatia 2007; Fergusson and Woodward 2002; Loe and Feldman 2007). The incidence of each of these health challenges is elevated among historically underrepresented minority children from poor urban areas. While 20 % of all children suffer from vision impairments, for example, the rates are twice as high among urban Black and Hispanic youth who are substantially less likely to receive treatment (Ethan and Basch 2008; Olfson et al. 2003). Poor mental health also disproportionally affects student performance among low-income minorities who also have limited access to related services (DeSocio and Hootman 2004; Hernandez et al. 2010).

Each of these challenges, when considered separately, has only a small impact on the persistent gaps in educational achievement and attainment. In the aggregate, however, low-income and minority youth are cumulatively disadvantaged, which helps perpetuate the gaps across generations (Freudenberg and Ruglis 2007; Marmot 2002; Rothstein 2004). In a recent review of health disparities and gaps in school readiness, health economist Janet Currie (2005) estimates that racial differences in health conditions may account for as much as one quarter of the racial gaps in socio-emotional and cognitive abilities.[7]

Children are situated ecologically within families and reside in increasingly segregated neighborhoods and communities where schools are charged with their for-

[5] Concentrated poverty and compromised physical and mental health are not only associated with low test-score performance but also with school dropouts (Ross and Wu 1995). Blacks, Hispanics (especially immigrant Hispanics) and low-income students are much more likely to drop out of school and experience decreased health and occupational status than their White, East Asian, and high-income counterparts (Levin et al. 2007; Rumberger 2011). These findings prefigure problematic trends in educational attainment at the college level, where, between 1971 and 2009, the gap in bachelor's degree attainment between Blacks and Whites increased from 12 to 18 percentage points, while the gap between Hispanics and Whites grew even more, increasing from 14 to 25 percentage points (Chapman et al. 2013; Ream et al. 2012).

[6] The Patient Protection and Affordable Care Act of 2010, and the Supreme Court's recent decision to uphold the Act, should help reduce the number of uninsured Americans, but formidable challenges and health disparities will still remain. Disproportionate numbers of low-income minority children still lack access to health care due to rising poverty and rising costs (Hernandez et al. 2010). In 2009, 7.5 million US children under 18 had no health insurance. Compounding the effects, 16 % of these children were also living in poverty (Price et al. 2011). Under the Affordable Care Act, all families under 133 % of the federal poverty level will be eligible for Medicaid, and those under 400 % of the federal poverty level who are otherwise uninsured will be eligible for subsidized health insurance (Elmendorf 2010).

[7] Additionally, since educational attainment is a social determinant of future health outcomes, health problems in childhood that affect educational attainment can in turn cascade to affect health problems in adulthood (Case et al. 2005; Cohen and Syme 2013; Lê et al. 2013).

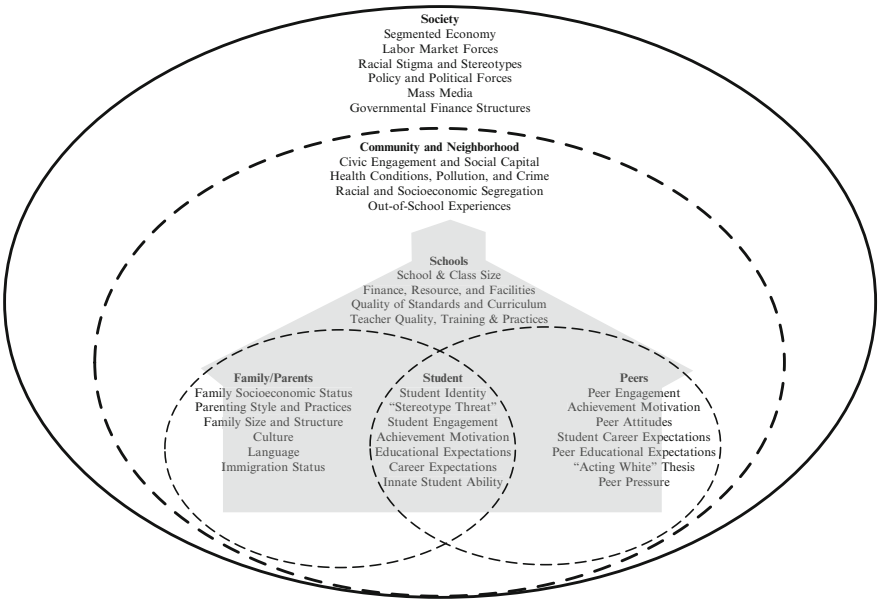

Fig. 17.1 Gaps in health and education are nested in overlapping settings (*Source*: Ream et al. 2008)

mal education, whether or not students are fortunate enough to breathe clean air, eat healthy food, and access adequate health services (Anyon 2005; Bronfenbrenner 1979, 1992; Ream et al. 2012). Each of these overlapping settings and networks conditions students' health and educational performance in ways that are entwined (see Fig. 17.1). We contend, therefore, that the entanglement of poverty, race, and inequality in health and education offers a rationale for collaboration across the professions and an ecological approach designed to disentangle the interwoven strands of this crisis.

Before we consider the challenges of university-sponsored coordination between systems, however, we pause to reflect on the common values that undergird ongoing and parallel reforms in health and education. Our brief focus on the backdrop and value logic of reform is important inasmuch as refortifying the human improvement professions depends on the core values and practices that can either legitimate or undermine collaboration amidst a crisis situation (Dimaggio 1988; Dacin et al. 2002).

The Gaps Are Often Framed as Market Inefficiencies

Physicians, public health officials, and patients as well as teachers, parents, and students have denounced the gaps in health and education as anathema to concern for patients and students and the professions' abiding commitment to accepting responsibility for the well-being of clients (Gardner 2007; Gawande 2011; Malina

2013; Rothstein 2004; Solomon 2007; Sullivan 2005). Contemporary discourse about inequitable and mediocre service delivery, however, seems most often to be framed not as a problem of collaboration across the professions but as a market problem of *inefficiency* in service to individual consumers (Cibulka 2001; Solomon 2007). Enhanced competition, better use of data, and greater accountability for physicians and teachers are often held up as the most efficient ways to bolster the professions if not also the means to separate trustworthy professionals from workers who are not.[8]

The prevailing efficiency narrative and accompanying free-market reforms are not without detractors, however. The same industries that have succeeded at leveraging size to improve efficiency have also tended to compartmentalize and devalue their employees (Gawande 2012; Solomon 2007). By creating hyperspecialization, individuation, and an overriding ambiguity over who is ultimately responsible for health and education outcomes, the imperatives of the market economy seem as likely to help perpetuate inequality as to mitigate the problem (Low et al. 2005; Ravitch 2010). Taken in the extreme, market-driven reform values may even undermine the work and integrity of the professions (Gardner 2007; Starr 1984; Sullivan 2005).

Thus, we articulate in the next section a decidedly *professional* rationale for interagency collaboration. Our rationale derives from the notion that professionals working toward the eradication of socially vexing problems—including reciprocal gaps in health and education—must bring together a diverse set of skills and wide-ranging expertise in order to decompartmentalize solutions. In keeping with the problem-oriented focus of our work, we reposition elimination of these gaps at the center of meaningful collaboration that undergirds "good work" among practitioners of human improvement.[9]

[8] At least since 1983, when the provocative *A Nation at Risk* report was delivered to Congress, the push toward standardized efficiency in education would appear to share with medicine a similar basis in market values. In the 1990s, for example, the emergence of hospital conglomerates and health maintenance organizations (HMOs) paralleled the emergence of public school management by private education management organizations (EMOs). In the *No Child Left Behind* (NCLB) era that followed, many reformers turned to tough business-accounting principles and data-driven efforts to produce higher test scores (Ravitch 2010). Fast forward a decade, and the Obama Administration's signal education reforms including charter schools, accountability, and value-added teacher models, continue to bare the imprint of market logic framed in the politics of education productivity (Cibulka 2001). Higher education is also increasingly designed for maximum measurability and market advantage. In competition for greater research funding and more competitive students, budget reforms and the allocation of resources are increasingly tied to metrics such as college graduation rates (Cummings and Finkelstein 2012; Gray 2012; Kirp 2009).

[9] The notion of "good work" derives from a problem-based professional ethos, whereby professionals' sense of their work as good is linked to the contributions they make to the well-being of society (Freidson 1994; Gardner et al. 2001). Elaborating on this point, William Sullivan (2005) argues that work that is good is often "undertaken within a context of peers who likewise seek to excel in doing such good work" (p. 14).

A Framework for Collaborative Civic Professionalism

We recognize the need to update the way we characterize problems of professional service delivery in health and education, and we think about this recharacterization in two parts. First, "civic professionals" have a fiduciary responsibility for working cooperatively to ensure knowledge creation and diffusion on behalf of their clients' well-being (Freidson 2001; Sullivan 2005). Second, a new form of "collaborative community" is essential for effectively integrating professional work designed to steer human improvers toward the eradication of the gaps (Adler and Heckscher 2006; Adler et al. 2008).

Regarding the first part, civic professionalism roots human improvement not only in the hard work and skill that underpin the so-called technical professional, but also in the ideals of functionally based service to society (Brint 1994; Tawney 1920). In effect, civic professionalism entails an idealized connection to professionalism as a public value geared toward humanizing modern work as work that is good not simply because it is financially rewarding but also because it is undertaken on behalf of all of society (Gardner et al. 2001; Sullivan 2005).

Regarding the second part, collaborative community derives from civic professionalism, but in the particular twenty-first century context of ascendant markets and technological expertise where professionals are sometimes pressured to act as the purveyors of expert services on behalf of industry rather than society (Adler et al. 2008). In the prevailing market economy, collaborative community is distinctive for its embrace of professionals who rely on collegial interdependence to assert their jurisdiction and expert judgment over customized service delivery on behalf of diverse clients (Freidson 2001; Montgomery and Schneller 2007; Parsons 1968).

The imprint of both civic professionalism and collaborative community is apparent in several emergent reforms and promising practices designed to foster student health in coordination with schools such as school-based health centers (SBHCs), full-service community schools, and the Obama Administration's Promise Neighborhoods program (Cohen and Schuchter 2013; Erbstein and Miller 2012; Kahne et al. 2001). Yet, the fragmented nature of partnership research and a lack of consistency in defining and operationalizing health–education partnerships as civic professionalism in praxis make it difficult to aggregate knowledge about how to make collaboration work toward the purpose of eliminating the gaps. Such fragmentation underscores the need for a unifying framework that can guide a more coherent agenda for the design of integrated health–education service delivery systems.

Our conceptual framework is informed by two sets of classic policy studies. The first is the RAND Corporation's well-known series of "Change Agent" studies, investigating the problem of education policy implementation in public institutions across levels of government (Berman and McLaughlin 1978; McLaughlin 2005). The second set derives from organizational theory and focuses especially on the hierarchical task structure entailed in professional work (Mitchell and Kerchner 1983; Rowan 1994). We link the second set of studies to the first set by

focusing on the task definition entailed in the change agent's professional work responsibilities.[10]

Illuminating the first set, the Change Agent studies revealed that it is exceedingly difficult for policy dictated from on high to change cooperative practice across diverse sectors in the workplace. This "implementation problem," discovered by policy analysts studying the Great Society's comprehensive intergovernmental initiatives (Pressman and Wildavsky 1973), found that the successful implementation of reforms demanding cooperation across systems ultimately depends on the professional characteristics of the agents of change at the end of the line (McLaughlin 2005). Accordingly, intersectoral reform has been consistently identified as a problem of the individual agent's technical *capacity* as well as the agent's *will* toward fulfilling the reform agenda (Berman and McLaughlin 1978; McLaughlin 2005). Capable and motivated individuals are the glue that links systems together (Power et al. 2003; Shaw et al. 2011).

Regarding the second set, the layered task structure of professional work (See Mitchell and Ream, Chap. 1, this volume) conceptualizes work responsibilities as a set of four interrelated types of tasks: (1) unskilled labor, (2) technical skill, (3) creative artistry, and (4) work geared toward fiduciary responsibility for client outcomes. The capacity of the change agent to fulfill the first two tasks—in this case, the diligent effort and skilled craftwork required to overcome barriers separating health and education systems—constitutes the performance-scaffolding upon which professional collaborators meet the basic requirements of the technical professional(Brint 1994).[11] Yet, beyond a set of precise technical skills, the civic professional must also possess the will to leverage creative judgment toward the goals of linking health and education in a more equitable and excellent service delivery system (Freidson 2001). Both skill at bridging disciplines *and* a desire to engage in intersectoral work emerge as critical components of the change agent's capacity to fulfill a professional calling in service to others.

In what follows, we build upon these findings to set forth ideas about the university-sponsored design and organization of interdisciplinary work that is good work because it aims to partner the professions for the explicit purpose of eliminating reciprocal gaps in health and education.

The University as Incubator of the Professions

Even amidst pervasive hyperspecialization and the siloing of professional domains of expertise, human improvers have persistently called for mutually reinforcing partnerships across the fields of health and education (APA 1995; Bradley-Klug

[10] To our knowledge, these two frameworks have not been combined for their value in guiding an agenda for targeted partnerships across the human improvement disciplines.

[11] By the term "technical professional," we mean to suggest the professional as purveyor of expert and individually marketable services—albeit not the broader obligation toward social responsibility entailed in higher order civically oriented notions of "social trustee" professionalism (Brint 1994).

et al. 2010; Cubic and Gatewood 2008; Shaw 2003).[12] Accordingly, pediatricians are encouraged to work with school psychologists on behalf of children with chronic illness (Bradley-Klug et al. 2010), school psychologists and nurses are encouraged to use both physicians' and educators' systems of diagnosis in the delivery of student services (Guttu et al. 2004; Nastasi 2000; Shaw et al. 2009), and teachers and school administrators are encouraged to develop strategies for identifying specific health factors that may be contributing to educational difficulties (Goldring and Sims 2005; Shaw et al. 2011). Yet, collaboration often lacks a basis in research (Sulkowski et al. 2009), is often conceived from within the discipline from which the particular recommendation is put forward (Clay et al. 2004; Goldring and Sims 2005; Power et al. 2003), and tends to play out in an ad hoc fashion (Dunsmuir et al. 2006; Power and Blom-Hoffman 2004; Schwab and Gelfman 2005; Shaw et al. 2011; Wodrich 2004). There remains substantial confusion about how to initiate and sustain partnership reform to solve pressing problems (DuPaul 2011; Erbstein and Miller 2012).[13]

Thus, we turn our sights to the research university as an institution that remains devoted to the pursuit of scientifically validated knowledge and the multidisciplinary development of professionals (Conant 1963; Flexner 1910; Kerr 2001). We are confident in the authority of the university to spur the independent professions to work *interdependently* toward eliminating gaps not only because of the university's traditional role as the chief port of entry for most of the professions, but also the historic context of American land grant universities' democratic responsibility for nurturing the establishment and growth of the professions on behalf of the broader American public (Gray 2012; Sullivan 2005).[14] Despite market imperatives that spur the increasing autonomy of the professional class, the university's institutional status and the overall legitimacy of the professions can be enhanced by working together toward solving critical social problems.[15]

There are few explicit guidelines, however, and no clear and widely shared understandings of what decisions reformers should develop with respect to encouraging

[12] Professional associations such as the Accreditation Council for Graduate Medical Education, the American Psychological Association, and the National Association of School Psychologists have consistently advocated policies and developed position statements endorsing positive interdependence across the caring professions (Dupaul 2011). The seven health professional education associations recently published a report envisioning how to educate health professionals in training, to be able to collaborate with others outside their discipline (IPEC 2011).

[13] We note that evidence from the Harlem Children's Zone (HCZ), one of the best studied examples of intersectoral collaboration in a single neighborhood area, is mixed. While the HCZ asthma program improved asthma diagnoses (Nicholas et al. 2005), and other programs appear promising (Northridge et al. 2002), these wraparound supports may not have an added benefit for educational outcomes above and beyond the schooling received in the HCZ Promise Academy Charter Schools (Dobbie and Fryer 2011; Dobbie and Fryer 2013).

[14] In this exercise, we are reminded not only of the German research model rooted in the pivotal founding of the University of Berlin, but also of the more contemporary and uniquely American "multiversity" aimed toward incubating the professions as instruments of social reform (Kerr 2001).

[15] By "legitimacy," we mean a condition in the transformation of institutions, "whereby other alternatives are seen as less appropriate, desirable, or viable" (Dacin et al. 2002, p. 47).The issue of legitimacy, as derived from institutional theory, seems crucial amidst substantial skepticism as to whether and how collaboration can add value across systems of care.

the university and the professions to cooperate more effectively in service delivery. In the absence of consensus, model programs and demonstration projects are often referenced instead (Shaw and Brown 2011). For example, the University of Geneva Faculty of Medicine sponsored a multidisciplinary series of dialogues that culminated in the design of an integrated medical curriculum, centered on problem-based learning via hands-on training in a Community Health Program (Chastonay et al. 1997; Chastonay et al. 2012).[16] Systematic reforms currently ongoing in health and education in the United States have spurred similar calls for universities to broaden the professional development of social welfare personnel and school psychologists (APA 1995; Shaw 2003; see Vanderwood et al., Chap. 16, this volume).[17] A recent special issue of the *Journal of Educational and Psychological Consultation* on new training approaches to medical and educational collaboration argued for a new "medical liaison" professional who could facilitate the implementation of multisystem collaboration as a "routine and expected part of both medical practice and educational service delivery" (Shaw and Brown 2011, p. 82).

Calls for the expansion of a new liaison profession may not immediately resonate within the structurally conservative modern research university. Yet, there are encouraging exceptions to the university as an inherently conservative institution with few rewards for innovation (Chastonay et al. 2012; Shaw 2003; Walker et al. 2008). And "Even if you're on the right track," as Will Rogers once said, "You'll get run over if you just sit there." We are intrigued by the role the university could play in sponsoring the formation of the intersectoral liaison as an agent of change, and optimistic that the university's *raison d'être* and the best interests of the professions and their clients align with this objective. In the next section, we venture some ideas about the design of a graduate program of study that could fortify the agent's capacity and will carry out multisystem collaboration.

The Formation of Change Agents Within "Incubator" Universities

We posit that graduate students would be the appropriate target population for this academic training. We would endeavor to recruit and invest in the formation of "mission-driven students" (see Allen, et al., Chap. 3, this volume) with relevant

[16] The cumulative findings from research on this program indicate high satisfaction among medical students, increased ties between the faculty of medicine and community health partners, and moderate improvements in the health of the communities served. The learning objectives and teaching modalities emerged from university-sponsored deliberation among primary care physicians, epidemiologists, public health and bioethics specialists, occupational health professionals, as well as lawyers and historians (Chastonay et al. 2012).

[17] Because educational systems are increasingly addressing health-related barriers to instructional outcomes via new school-based health centers, school psychologists are increasingly concerned about the space between their current training and the roles required in SBHC (APA 1995; Shaw 2003).Indeed, the reciprocal relationship between heath-care service delivery and school systems has led to newly energized plans for consultation and collaboration across both systems of care (DuPaul 2011; Erbstein and Miller 2012; Shaw and Brown 2011; Shaw et al. 2011).

undergraduate and applied work experience in diverse communities who could then work in high-level policy and management positions and/or serve clients directly (Walker et al. 2008).[18] This could happen in multiple formats with increasing levels of commitment: (1) a seminar-style course serving graduate students from multiple relevant degree programs (e.g., Medicine, Public Health, Public Policy, Social Welfare, and Education), (2) a certificate that reflected the completion of multiple courses and mastery of intersystem collaborative skills by graduate students drawn from relevant degree programs, and (3) a full-fledged graduate degree program. These different initiatives would all cover more or less the same breadth of topics, but would increase in depth accordingly.[19]

These programs would seek to train people in the laboring, technical, and creative skills (i.e., the first three layers in the task structure of professional work) required for multidisciplinary collaboration as well as the habits of mind and the social dispositions of professional work (i.e., the fourth layer in the task structure) needed to solve social problems such as the co-occurrence of health and academic disparities. We posit that people in the human improvement professions assume that consultation is good but are underprepared and infrequently incentivized to move toward meaningful collaboration. Thus, we consider programs that would be designed to train people in the knowledge, skills, and fiduciary dispositions required for intersystem collaboration, with an eye toward fostering a metaprofessional culture in which partnership across health and education sectors is expected, legitimate, and profitable.

At the conclusion of participation in these initiatives, students would be able to identify possible points for entry into collaboration in their own work, how to speak persuasively in a shared language—e.g., the ability to distinguish a disability diagnosis made by a physician utilizing ICD-9 (international classification of disease coding system) and the diagnosis of learning disability made by an educator following IDEA (Individuals with Disabilities Education Act)—and how to partner effectively across the human services professions. The cross-cultural communication skills entailed in this sort of work are immediately applicable since existing state requirements already incentivize hospitals, districts, and schools to involve community

[18] The focus on graduate study is common among some other interdisciplinary professional degrees—both public health and public policy training is more common at the graduate level than the undergraduate level (Gebbie et al. 2003).

[19] In particular, the certificate would be something that people could earn alongside of whatever professional degree they received. This would likely require around four courses, including the proposed seminar, and would provide a credential that participants could more formally list on their resume. However, to offer such a certificate, this would require getting the support of several different professional degree programs that all have their own requirements, which would require a great deal of intersectoral collaboration to establish. For this reason, an initial university-sponsored deliberative convening among stakeholders followed by the initial seminar course seems like a logical and measured first steps. Then, the next level of intensity would be to offer a separate and unique interdisciplinary degree program. Again, the initial convening and seminar course may be the desirable first steps to assess the extent to which there is a receptive enough culture at the university and among stakeholders, including potential employers, for people to recognize that this could be a useful degree to attain.

members in collaborative governance such as hospital foundation boards and school site councils (Erbstein and Miller 2012).

The university is a unique place in which both systems- and individual-level pre-professionals can learn together, before the hierarchical, compartmentalized bureaucracies that exist in professional realities (as alluded to here and in earlier chapters) materialize. We envision that the seminar, certificate, and degree programs would create a network of respected colleagues and an *esprit de corps* within the class setting that these students would be able to maintain as alums, with the goal of having highly skilled agents of change in a variety of settings, where they can work not only with other people in their immediate circles but with each other across sectors toward the fulfillment of a mutually recognized social purpose that aligns with the core values of their profession.

Any call for an ecumenical approach to the professional development of change agents may run counter to prevailing demands for efficiency and professional autonomy. Yet, we also suspect that the efficiency narrative limits the range of choices the university and the professions imagine as available to them, diverting their attention from the "low-intensity crisis of professionalism" (Sullivan 2005) this volume seeks to redress. Accordingly, we imagine the university's role in forming the skills and attitudes necessary for collaborative health–education reform, and we envision that these attributes would emerge from at least three facets of expertise: (1) academic science, analytic reason, and technical skills; (2) policy/politics, organizations, and collaborative leadership; and (3) people skills grounded in a humanistic understanding of intersectoral partnering and the values and social roles shared by civic professionals.[20]

Technical skills. In a political climate urging universities that receive significant amounts of public funding to become more accountable to the health–education crisis facing the nation, and in an era in which we are increasingly dependent on data, the ability to bring a wide range of research modalities to the practice of community-based work is essential (Gebbie et al. 2003). We identify three technical competencies (admittedly far from an exhaustive list) that may facilitate multidisciplinary scientific inquiry and praxis in partnership with local communities: (1) community-based participatory research (CBPR), (2) geographic information systems (GIS), and (3) cost–benefit analysis. CBPR is becoming increasingly desirable for its approach to developing and answering research questions in collaboration with community members (Minkler 2004; Minkler and Wallerstein 2008).[21] Geographic information systems (GIS) and cost–benefit analysis are two related

[20] Problem-based professional development and service learning are some pedagogical tools that may be useful in this setting insofar as students learn content, thinking strategies, and professional dispositions through solving complex real-world problems that render the techniques and understandings of single disciplines incomplete and inefficacious (Hmelo-Silver 2004; Sternberg 2008).

[21] The University of California Center for Collaborative Research for an Equitable California (CCREC), for example, is a multicampus initiative to advance the development of researchers and to fund multidisciplinary and intervention-oriented research done with community partners for community benefits (Minkler and Wallerstein 2008).

quantitative techniques, increasingly used in the policy and community spheres that could inform the improving of both systems. Yet, even though technical expertise in research methods is essential to intersectoral work, dwelling on the science of the health–education crisis without paying careful attention to the policy process, political dynamics, and leadership will not be enough.

Policy, politics, and creative leadership. Entrepreneurial agents of change cannot be fully effective without knowledge of policy, politics, and leadership. Understanding the role of multiple ecological contexts, perpetuating gaps in health and education, as per Fig. 17.1, only makes this skill more salient. Thus, we propose teaching the political history, implementation, and evaluation of major state and federal policies for education, public health and health care, social welfare, and housing and urban development. In addition, students would learn about bureaucracy and how it works, about how political interest groups strategically frame issues, and about values at the core of collaborative leadership (Cibulka 2001; Goldring and Greenfield 2002; Wilson 1989; Kirst and Wirt 2009). Organizational sociology could help students think systematically about stakeholders positioned within bureaucracies (see Montgomery, Chap. 5, this volume) and understand how institutional contexts shape professional realities within accountable care organizations, school district central offices, and schools (Fisher and Shortell 2010; Honig 2006). Still, although specialized knowledge of analytic methods and policy acumen may be essential, these skills also are essentially inadequate to do good work.

Humanistic understanding. At the third level of the professional task structure, where interpersonal engagement requires creative sensitivity, the change agent must also acquire the skill to read authority, ego, and social power processes that tend to impinge on collaborative endeavors and social capital (Erchul and Raven 1997). We encourage students to become trained in mindfulness, sociability, and empathy for both their work with diverse clients and their collaborative work with people from different training programs, informational systems, and organizational cultures (Lewis et al. 2012; Roeser et al. 2012; Tervalon and Murray-Garcia 1998). We also recommend students develop literacy skills in other languages, with the purpose of serving increasingly diverse linguistic communities.[22] Establishing and maintaining partnerships across systems of health and education requires grappling not only with professionals who honor different standards of practice, but also with challenging social dynamics around class, race, culture, and power (Erbstein and Miller 2012; Roussos and Fawcett 2000).

Finally, in order to align this admixture of technical skill, policy knowledge, and creative social intuition with the social norms associated with professional responsibility, we suggest training students in the history and evolution of the professions,

[22] Like "Medical Spanish" courses offered in some medical schools (e.g., Reuland et al. 2008), these courses may need to be developed with an eye toward the particular graduate student population, to be able to emphasize the vocabulary necessary for health, education, and social service needs. Such skills may be especially important in particular regions of the country such as California, where nearly 40 % of K-12 students have parents who do not speak English fluently (EPE Research Center 2011).

the university's role in developing esoteric knowledge and expertise, and the norms and civic identity that connect the professions to the larger society (Freidson 2001; Sullivan 2005). Situated at the fourth level of the professional task structure, this adds a uniquely integrative dimension to the structure of professional responsibility and a particular kind of responsiveness to others to whom the professional has special commitments because of the fiduciary nature of the work undertaken. It is via this apprenticeship that the agent's identity as a professional can be most broadly explored and developed.

However lofty the ideal of the systems change agent, we know that professional hierarchy can undermine authority even partially based in schools (Goepel 2009).[23] Whether agents would have the capacity to overcome barriers of this nature may depend partly on the rigor of the selection process, the stature of the programs where students are trained professionally, and whether there is general agreement across the professions regarding leverage points, where collaboration could add the most value. Of course, employers will need to concur that the agent's collaborative skills will be highly useful in the real-world setting. In other words, the agent's viability would hinge not only on capacity building, skill training, and symbolic legitimacy but also upon existing markets and organizational conditions that can either fortify or undermine intersectoral work. All of the changes that can be made to university-based preparation would amount to very little if agents graduate into an unreceptive professional environment. Accordingly, we must develop a framework of policies that facilitate partnership training across fields, promote the value of cooperative work in job descriptions across the human improvement professions, account for collaboration in workloads, and recognize and reward partnerships symbolically and monetarily (Erbstein and Miller 2012). "The question about professional responsibility today," as William Sullivan writes in this volume, "is how to realign the *conditions* of professional work so that they not only protect the interest of practitioners but also promote the enduring purposes of the professions as institutions of public purpose."

A Concluding Call for Disciplined Dialogue and Organizational Adaptation

This chapter sets forth a transdisciplinary response to an urgent problem: without improving the health of children most negatively affected by patterns of disparity, there is little hope for closing the racial and social class gaps in learning that

[23] While doctors are typically described as professionals with high status and specialist knowledge, school personnel have yet to fully recover from the post-1970 fall of public confidence in K-12 education (Gardner 2007; Sullivan 2005). In a recent field study in which pediatricians and teachers were interviewed in separate focus groups, Goepel (2009) found that while both doctors and teachers were concerned about gaining an awareness and understanding of each other's professional roles and responsibilities, school personnel often felt undermined by medical professionals who "did not recognize the difficulties of managing over 30 children at any one time" (p. 9).

continue to differentiate such a large group of people from mainstream society and its benefits. Yet, while official interest in the gaps may be at an all-time high, we have precious little to show for the past three decades of reform efforts professedly designed to tackle a reciprocal crisis that renders the perspectives and methods of siloed disciplines inefficacious (Jencks and Phillips 1998; Ream et al. 2012; Sternberg 2008). However honorable the impetus, there may be dire shortcomings to a system built upon values that fence off bodies of knowledge, in the name of efficiency, such that it becomes impossible for professionals to deal with the interconnected challenges of our lives in any organic manner (Hessel and Morin 2012).

Thus, we tapped a competing set of values based in collaborative civic professionalism, and from this stance, we referenced the RAND "Change Agent" studies and research on the task structure of professional work to imagine the formation of institutional entrepreneurs who possess the skill and will to execute intersectoral reforms designed to eliminate the gaps. We are optimistic about the change agent, particularly insofar as emergent calls for the formation of a new health–education liaison profession align with the expansion of the professions (Shaw and Brown 2011; Shaw et al. 2011). Yet, we are also aware of numerous barriers to multisystem collaboration and advise caution in moving forward too quickly. "The practical thing for a traveler who is uncertain of his path is not to proceed with the utmost rapidity in the wrong direction," cautioned Tawney, "It is to consider how to find the right one" (Tawney 1920, p. 2).

Thus, we conclude by advocating a university-sponsored deliberative forum marked by close scrutiny of relevant theoretical models (Borrell-Carrio et al. 2004; Bronfenbrenner 1979; Shaw et al. 2011), careful attention to exemplary intersectoral programs (Chastonay et al. 2012; Evans 1987), and rigorous inquiry of empirical evidence documenting collaboration (and barriers to collaboration) between health and education systems and professionals within these systems (Adler et al. 2008; Dobbie and Fryer 2013; Shaw and Brown 2011).

Deliberative dialogues— group processes that emphasize mutual understanding, transformative discussion, and alternative ways of thinking about a problem informed by research evidence—would need to be incentivized (Boyko et al. 2012). Relying on inadequate resources, generosity of spirit and heroic volunteers is unsustainable. We envision the support of philanthropic foundations as a catalyst for a series of dialogues, designed to enable stakeholders to think about and discuss:

- The most important questions to consider about how to link the professions for the purpose of eliminating the gaps in health and education;
- The backdrop in values and the meaning of concepts that are germane to key controversies about partnering toward elimination of the gaps;
- What we currently know from research about intersystem partnering and change agent entrepreneurs, what we do not know, and with what degree of confidence;
- Who is expected to employ trained agents of change;
- Possible implications of the above for the university-sponsored formation of entrepreneurial agents who are willing and able to spur collaborative interdependence across the human improvement professions.

Unwinding entangled gaps in health and education will require particularized knitting together of the civically oriented purposes of professional life and interdisciplinary knowledge of human improvement that are often sundered analytically in professional formation and practice.

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Chapter 18
The Mutations of Professional Responsibility: Toward Collaborative Community

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Introduction

There is a widespread sense that the professions are at a crossroads. At least in the USA and UK, the professions have for centuries stood apart from, and resistant to, the rationalizing forces of markets and bureaucracy, claiming to be driven not by self-interest but by a responsibility to higher social purposes, and asserting on that basis the right to autonomous occupational control. In the former, values aspect, the professions aspired to what Max Weber called a "value-rational" orientation (Weber 1978); however, in the latter, organizational aspect, they resembled traditionalistic craft guilds. The gap between aspiration and organization was often all too obvious in the professions' disdain for efficiency and external accountability.

Over the past half-century, a tide of instrumental rationalization has swept over both established professions and other occupations attempting to assert professional status. This rationalization has been driven by many factors, prominent among them being that aspiration–performance shortfall. Today, even the last bastions of professionalism

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are under siege: lawyers, physicians, and teachers—the most ancient and strongly institutionalized of the professions—are under intense pressure to redefine their professional responsibilities to conform to bureaucratic standards and market competition. Organizationally, the result has been to reduce many professionals to the status of experts in bureaucratic hierarchies or to small capitalist business owners. In terms of efficiency and external accountability, the results have been distressingly mediocre. Where efficiency has improved, it has often been at the expense of quality; and external accountability has been limited to the imposition of blunt and often counterproductive bureaucratic controls and financial incentives.

Our thesis can be stated succinctly. Neither a return to the guild form of professionalism nor further bureaucratization or marketization will enable professionals to meet the challenges we and they face today. The professions should resist these pressures. However, to resist successfully, the professions need to redeem their claims to higher responsibility, and this redemption requires the invention of a new organizational form that supports more adequately the professions' espoused value-rationality. This organizational form must enable a wider scope of collaboration within and across professions and a deeper dialogue with stakeholders outside the professions.

Our research suggests that recent decades have seen the emergence of a cluster of organizational innovations that allow us to see more clearly the contours of this new organizational form. We call this emergent form "collaborative community" (Heckscher and Adler 2006). These innovations buttress values and trust so as to improve teamwork both within the profession and in relations with other service providers, clients, and other stakeholders. They provide an organizational form that supports professionals' orientation to their common responsibility. In what follows, we offer some examples from healthcare and illustrate the impact of this form on performance with data from a school district.

The Professions: From Guild to Contract

Professional occupations can be characterized by three main attributes: (a) nonroutine tasks requiring expertise based on both abstract knowledge and practical apprenticeship; (b) occupational monopoly over this practice jurisdiction and individual autonomy within it; and (c) legal and ethical responsibility for this practice that is typically reflected in values of service. The third of these three attributes makes professionals distinctive in their "value-rational" action orientation: their daily work is oriented by their commitment to ultimate values such as justice, health, and education (Satow 1975). Such an action orientation contrasts with traditionalistic action, which is oriented to the means of action by attachment to habit or sacred tradition; it contrasts with affectual action, which is oriented to emotional goals; and it contrasts with instrumental-rational action which is oriented to the selection of the most efficient means for reaching taken-for-granted ends.

Weber doubted that value-rationality could form the basis of robust, large-scale, purposive organization because, in his view, it lacks a feature he saw as essential to such

endeavors, namely imperative command (Weber 1978: Vol. I, pp. 271–284; 289–292).[1] Indeed, under value-rationality, actors' behavior is coordinated, in the first instance, only by their common rational commitment to the shared end-value, and in such a collectivity, the scope for coordination by command is very limited. It is therefore a poor instrument for implementing the will of a master. Weber saw value-rationality as effective only in small, "collegial" organizations—advisory bodies without decision-making responsibilities, and the small leadership groups at the top of large organizations (Noble and Pym 1970)—not in larger-scale organizations under pressure to make "precise, clear, and above all, rapid decisions" (Weber 1978: Vol. I, p. 277).

In the face of this dilemma, how then have the professions organized themselves? When the professions first arose, they buttressed value-rationality with organizational structures based on traditionalism, borrowing the form of the craft guilds (Krause 1996; Light and Levine 1988). The professions thus long resembled guilds—largely traditionalistic, *Gemeinschaft*-type collectivities, reliant on fixed status hierarchies, and oriented to handing on distinctive traditions of expertise that were closely held against outsiders. Trust here was based on adherence to common traditions and embedded in rigid status structures. *Professional responsibility here meant loyalty—loyalty to one's professional peers, superiors, and traditions.*

The limitations of this form of professionalism are well known. Relative to collectivities based on the self-interested, contractual logic of markets or bureaucracies, traditionalistic guilds were slow to develop and diffuse radically new technologies; they were not effective in coordinating larger-scale undertakings requiring a complex division of labor; and they were resistant to meddling outsiders and foreign ideas. It is hardly surprising that pressures toward efficiency, quality, and accountability have driven many professions away from the guild form. These pressures are external, coming from clients, courts, and regulators (Scott et al. 2000); they are internal, due to competition from other practitioners (Gaynor and Haas-Wilson 1999); and they are interprofessional, as categories jostle over jurisdictions (Bechky 2003; Halpern 1992; Zetka 2001).

As a result, over the course of the last century, the organization of the established professions—most notably, medicine, law, and education—shifted toward the instrumental rationality of market and bureaucracy. And as new expert occupations arose—architects, scientists, engineering, accounting, social work, etc.—their claims to professional status encountered deep resistance (Layton 1971, for example, traces the failed attempt of engineers to develop a professional status in the face of forces driving them to subordination in corporate hierarchies). The guild ethos did not entirely disappear, but it was increasingly subordinated to the demands of market competition and bureaucratic controls. By the end of the twentieth century, the independent, self-employed, "liberal" professions represented but one small part

[1] Recall that Weber argued that while the traditionalistic and instrumental–rational types of social action can form robust organizations (in the latter case, as bureaucracy and market). In his account, however, neither affectual nor value-rational orientations offer strong foundations for social order. Affectual action is foundational in social orders of the charismatic type, and Weber argued that such orders tended to "routinize" and to revert to the traditionalistic or bureaucratic type.

of the spectrum of expert occupations, the others taking the form of organizational professions (e.g., managers, salaried engineers, technicians, and teachers), and experts for hire (e.g., consultants, project engineers, and computer analysts) (Brint 1994; Reed 1996). Across this entire spectrum, *professional responsibility increasingly meant conformance to formal bureaucratic standards and to market norms of self-interest.*

The Professions at a Critical Juncture

The trend toward instrumental rationality and to organizational forms based on contractual self-interest is incompatible with professionals' responsibility to higher social purposes. Tensions have mounted accordingly. When insurance companies attempt to control medical treatment decisions through denials of payment authorization, and when they restrict the range of medications physicians can prescribe (Himmelstein et al. 2001; Warren et al. 1998), we have seen physician resistance and public revulsion. A wave of hospital conversions to for-profit status has increased profits, but has also led to reduced staffing and salary rates, to increased mortality rates (Picone et al. 2002), and to public anger. When teachers are subjected to standards imposed by U.S. government in the *No Child Left Behind* Act and other reform efforts, teachers and communities often fight back. Law firms have experienced growing turbulence as initiatives for growth, more aggressive marketing, and more individualized performance-based financial rewards have torn the fabric of collegial relations; many firms, even very old and prestigious ones, have split apart or failed.

Moreover, this drive for instrumental rationalization has not addressed a mounting concern that the professions are not only inefficient but also unresponsive to their stakeholders: neither marketization nor bureaucratization has done much to overcome the inward focus of the guild form. Although professions have been primarily legitimated by their claim to serve client and societal needs (Parsons 1939), clients and social institutions have been increasingly dissatisfied with the results. Patient deference to professional judgment has declined over several decades, a trend accelerated by the rise of the easily available information on the Internet (Fintor 1991; Landzelius 2006). There are strong demands for information on physician performance and greater accountability to the public. Meanwhile, the personal relation between physician and patient has weakened: medical care, as Kuhlmann (2006) observes, is increasingly "disembodied," founded on information rather than personal trust. These developments have contributed to the rise of malpractice suits and courts' gradual acceptance of challenges to medical custom (Peters 2000). In university education, a range of constituencies are now questioning the value of research and education. Students (and their parents) have grown less willing to defer to professorial judgment and have become more assertive in demanding justifications for grades and requirements. Student ratings of professors have become popular and influential, undermining the professoriate's claim of autonomy and guardianship of standards. At primary and secondary levels, there

has been a substantial "invasion" of teachers' curricular autonomy by both community school boards and by governmental bodies.

One response by professionals to these mounting tensions has been a hardening of the defense of traditional autonomy. While professions have always insisted on independence, this was in the past a positive claim based on special knowledge that was used for the good of society. However, in the last 50 years, this insistence has become increasingly a defensive claim, a wall against the claims made by other actors.

The Emerging Contours of Collaborative Community: Examples from Healthcare

We argue that the cause of the current crisis in professionalism is not that professions have left behind the guild model, nor that they have been insufficiently subordinated to market and bureaucracy, but rather that they have not yet developed an organizational form that can effectively buttress their value-rational raison d'être. We argue, further, and against Weber, that this is not an insurmountable problem, although it is certainly a difficult one. In our research, we have documented the emergence over recent decades of a family of organizing techniques that can meet this challenge and overcome Weber's skepticism. We think of these techniques as elements of a new organizational form for large-scale, value-rational collectivities—a form we call "collaborative community." In the collaborative community, *professional responsibility means a commitment to a higher social purpose and to the organizational systems that support collaboration in the pursuit of that purpose.*

In the following paragraphs, we sketch this new type along four dimensions—norms, values, authority, and economics—using examples from healthcare.[2]

Norms

Collaborative communities develop norms that support horizontal coordination of interdependent work processes in a complex division of labor. Traditionalistic guild community relies on what Durkheim (1997) calls a mechanical division of labor—pooled, in J. D. Thompson's (1967) terminology—where specialization is limited and coordination relies on norms of inherited practice and status. More complex interdependence can be managed in two ways. One is instrumental-rational and contractual, relying on market prices and bureaucratic authority to ensure coordination. This has been developed to a high level in modern industry, but it is not effective in managing complex knowledge interactions requiring high levels of expertise and trust, and it is precisely these characteristics that characterize the work of professionals. Collaborative community, like bureaucracy, supports interdependence with

[2] Much of the material in this section is taken from Adler et al. (2008).

explicit procedures, but whereas under instrumental-rational, contractual norms these procedures are defined by hierarchical superiors and used by them to monitor performance and drive improvement, under value-rational, collaborative norms the procedures are designed collaboratively and used by peers to monitor each other and to work together to improve performance. In collaborative healthcare organizations, clinical guidelines and pathways may take this form (Maccoby 2006).

In contrast to the traditionalistic model of the medical staff described by White (1997), consider the portrait painted by the Institute of Medicine (IOM) of a new health system for the twenty-first century (Institute of Medicine 2001). Where the traditional (and traditionalistic) care delivery model is one in which "individual physicians craft solutions for individual patients" (p. 124) in the model advocated by the IOM the delivery of services is coordinated across practices, settings, and patient conditions over time. Information technology is used as the basic building block for making systems work, tracking performance, and increasing learning. Practices use measures and information about outcomes and information technology to refine continually advanced engineering principles and to improve their care processes (p. 125). Collaborative learning is the heart of the new model. Its procedures support a focus on patient service; utilization management is a responsibility shared by all physicians; information systems support both individual physician decision-making and collective discussion of individual performance differences; and strong leaders develop relationships of trust and communicate a vision (Maccoby et al. 1999). Healthcare organizations such as Intermountain Health Care and the Mayo Clinic exemplify aspects of the emerging model, although neither of them appears to have implemented all its features (Bohmer et al. 2002; Maccoby et al. 1999; Maccoby 2006). Robinson (1999) describes the mutation under way in these terms:

> "The now passing guild of autonomous physician practices and informal referral networks offered only a cost increasing form of service competition and impeded clinical cooperation among fragmented community caregivers. The joining of physicians in medical groups, either multispecialty clinics or IPAs, opens possibilities for informal consultation, evidence-based accountability, and a new professional culture of peer review" (p. 234).

Values

The new model explicitly invokes values of collaborative interdependence (e.g., Silversin and Kornacki 2000a, b). And this interdependence reaches beyond the boundaries of the profession to embrace interdependence with peers from other professions: surgeons, for example, need to develop more comprehensive collaboration with other physicians (such as anesthesiologists), with lower-status colleagues (nurses, clerical, and janitorial staff), with clients (patients), with administrators (hospitals management), with organized stakeholders (unions and patient rights groups), and with regulators (JCAHO and government). Collaboration circumscribed by guild insularity will not satisfy the demands currently weighing on the professions. A more outward-looking, civic kind of professionalism is needed to embody more fully value-rationality (Hargreaves 2000; Sullivan 2005).

Rather than defining and maintaining values through internal processes and traditions, collaborative professions are open to dialogue about their purposes with these outside stakeholders. They are thus both *value*-rational, because they are oriented to ends that represent higher values beyond self-interest, and they are value-*rational* insofar as those ends are subject to rational discussion based on public standards of validity (Habermas 1992). This contrasts with the attitude of most professionals today: under pressure from outside stakeholders, and seeking to protect themselves against the alien logic of market and bureaucracy, professionals often insist that only they can judge the validity of their work, and that they cannot discuss their value-standards with outsiders. This is one reason that professions have become isolated and delegitimized by the outside world on which they nevertheless rely for funding and regulatory approval.

A growing number of hospitals are drawing physicians into collaboration with nurses and other hospital staff to improve cost-effectiveness and quality, often bringing together previously siloed departments in the process (e.g., Gittell et al. 2000). Bate (2000) describes the new form of organization that emerged at one United Kingdom National Health Service hospital as a "network community," characterized by constructive diversity rather than unity, by transdisciplinary forms of working rather than "tribalism." Hagen and Epstein (2005) describes how Riverside Methodist hospital in Ohio created "clinical operating councils" that brought together cross-functional and cross-status groups to examine improvement opportunities in broad service lines such as primary care, heart, and women's health. Other hospitals have found that such committees are an ideal vehicle for developing and tracking the implementation of clinical pathways (Adler et al. 2003; Gittell 2002). Here, guidelines are not imposed on physicians by insurance companies aiming ruthlessly to cut cost; instead, they are developed collaboratively by teams of doctors, nurses, and technical and administrative staff aiming simultaneously to improve quality and reduce cost. In these new structures, physicians are drawn out of their fiefdoms and beyond their traditional identity as "captain of my ship." Intermountain Health Care (Bohmer et al. 2002) and San Diego Children's Hospital (March 2003) exemplify such collaborative approaches to pathway development. Beyond the individual organization, "communities of practice" are increasingly being used in lieu of conventional continuing medical education to accelerate learning and diffusion (Endsley et al. 2005; Frankford et al. 2000; Parboosingh 2002). Quality improvement collaboratives have attracted considerable attention as a way to bring together a broader community around specific improvement goals (Massound et al. 2006; Mills and Weeks 2004). The most ambitious of these brings together a variety of stakeholders from different hospitals, medical groups, health plans, and employers to learn from each other (Solberg 2005).

Authority Structure

Collaborative communities require distinctive authority structures that enable coordination across multiple dimensions simultaneously. In some of the larger medical groups, governing boards thus have been evolving away from simple

partnership meetings toward more complex, articulated structures capable of exercising more effective group leadership (Epstein et al. 2004).

The second aspect of this mutation in authority structures is the changing role of staff functions—from external control to collaboration. Whereas instrumental-rational bureaucracies use staff functions to formulate and enforce standards backed by the authority of top management, staff at collaborative organizations like Mayo and Intermountain Healthcare work with the line organization to capture and disseminate practice-based knowledge. Where Freidson (1984) feared that staff functions would fragment the profession and erode the autonomy of the practitioner, the experience of hospitals such as these suggests that strong collaboration between staff and line organizations is a crucial success factor (Kwon 2008; Tucker and Edmondson 2003). As a result of this reconfigured staff-line relationship, best practices such as disease management programs, quality-oriented practice pattern information, and financial bonuses for quality are far more common in large, integrated medical groups such as Permanente than in the cottage industry of private practitioners in small offices (Rittenhouse et al. 2004).

Economic Structure

Collaborative communities equip themselves to confront the economic implications of their decisions—implications for professional competencies and incentives—without renouncing their commitments to social values. As concerns competencies, broader interdependencies necessitate training to equip professionals with the requisite technical, social, economic, and managerial skills. As concerns incentives, whereas guild doctors focused exclusively on patient outcomes and refused to engage any discussion about fees or value-for-money, and whereas contractual relations orient professionals in the opposite direction, collaborative healthcare organizations encourage physicians to seek the best patient care while also paying attention to the optimal use of society's resources. This dual orientation creates tensions for the professional ("dual loyalty"), but in collaborative communities professionals accept that they bear some economic responsibility to society and reject the traditionalistic professional strategy of jurisdictional economic monopoly. This means physicians' compensation models evolve toward a more complex mix of criteria.

Collaborative Community in Schools

Teaching is another illuminating case. According to Hargreaves (1994, 2000), teaching once relied on a craft type of community. Beginning in the 1960s, teaching required more advanced degrees and moved into the age of the autonomous professional. Although this brought greater status and higher salaries, it also inhibited innovation by impeding the diffusion of superior practices. By the 1990s, a new age had begun, that of the "collegial" professional. In the current period, the scope of collaboration is broadening, drawing teachers into more active civic engagement

with the wider community (Nixon et al. 1997). This engagement seems emblematic of true value-rationality.

The flourishing education literature on "professional learning communities" reflects that transition away from craft and autonomous professionalism, but it is largely silent on what type of community has replaced them. McLaughlin and Talbert (2001) point out that beyond the distinction between weak communities and strong ones, it is just as important to distinguish between two very different types of strong community—"tradition oriented" and "learning oriented." Several other studies have sought to differentiate types of teacher community and their different effects (Achinstein 2002; Little 1990; Louis and Marks 1998; Wohlstetter and Griffin 1997). Our typology aims to give this critical distinction greater precision and a stronger theoretical foundation.

To test whether the value-rational, collaborative form of community helps professionals pursue their ultimate purposes, we have developed a survey instrument that aims to capture the mix of different types of community at work in any given organization. We have used it with the teachers in one school district, which allows us to test the hypothesis that the more collaborative the relations within a school—among teachers, between teachers and administrators, and between administrators and unions—the better will be student outcomes.

As yet, our data are imperfect in many ways. The sample size is small—just 26 schools in our final sample. This makes it difficult to achieve statistical significance. Nevertheless, we find that the *strength of collaborative community* correlates more strongly than that of any other form of community with the *improvement in student performance*.

Methods

With the cooperation of union officials in what we will call the Western School District, we launched a survey in January of the 2011–2012 school year. The district has 30 schools, of which 19 are elementary schools, five are middle schools, and five are high schools. One school is an adult school offering remedial education and career development for older students in the surrounding community

Over the period of this study, the student body consisted of roughly 20,800 ethnically and linguistically diverse students. Roughly 46 % of the student population is on reduced or free lunch, indicating considerable economic hardship in their families.

Four schools were removed from our sample. One was an elite high school that served especially gifted students. The school was highly competitive with an extensive acceptance process. Another school represented the opposite extreme—a high school serving students with disciplinary problems such as those with histories of violence or drug use. Given the peculiarities of the student body, we removed these two sites from our sample. We also excluded the adult school from our sample given its nontraditional student population and because the school did not administer standardized tests. Finally, we removed an elementary school because of poor participation on our survey. This left us with an n of 26 and a response rate of 69 %.

Variables

Community Type

Community type is measured with a survey instrument we have developed—see Exhibit 18.1. It has 20 items measuring each of our theoretically defined dimensions of traditionalistic, contractual, and collaborative relations, as well as a type we call "fragmented" reflecting situations of generalized conflict and alienation. In the school context, "traditionalistic" is associated with the guild ethic of professional autonomy and independence; "contractual" is associated with structures that subject

Exhibit 18.1 Survey items for four types of professional community in schools

Traditionalistic	
1.	People here do things the way they have traditionally been done.
2.	Disagreements between grades/departments are resolved by trading favors.
3.	When we recruit new people in this organization, we look for people who will fit in to our established ways of doing things.
4.	Administrators here are especially protective of teachers who are loyal to them.
5.	Union leaders here are especially protective of members who are loyal to them.
Contractual/Bureaucratic	
6.	People work according to policies and procedures defined by supervisors or specialists.
7.	Disagreements between grades/departments are handled according to formal policies and procedures.
8.	When we recruit new people in this organization, we look for people who have the right credentials.
9.	Administrators here focus on ensuring everyone follows policies and procedures.
10.	If there is a conflict between teachers and administrators, union and administration rely on the formal collective bargaining and grievance processes to resolve it.
Collaborative	
11.	People participate in defining and improving the school's policies and procedures.
12.	Disagreements between grades/departments are dealt with by peers in rational, open, and direct discussion.
13.	When we recruit new people in this organization, we look for people who will play an active role in contributing new ideas.
14.	Administrators here decide jointly with teachers about both work goals and how best to achieve them.
15.	If there is a conflict between teachers and administrators, a labormanagement team will be put together and will usually be able to solve it.
Fragmented	
16.	It is very hard to change policies and procedures even when they are not helping us work effectively.
17.	There is a lot of unproductive tension in relations among grades/departments.
18.	When we recruit new people in this organization, it is hard for these newcomers to get accepted here no matter what they do.
19.	Teachers here often see a lot of unproductive tension in relations with administrators.
20.	People here see a lot of unproductive conflict between union leaders and administrators.

educators to bureaucratic standardization or market competition; and "collaborative" is associated with positive and participatory working relations with other teachers within a school, across schools, between teachers and administrators, and between administrators and union representatives. Individual factor scores were averaged to the school level for our statistical analyses.

We have partially validated this instrument through expert surveys and through use in several other contexts. We should note that our constructs are not "reflective" ones but "formative" ones: they are derived from theory, and that theory does not predict that items would load together in either a confirmatory factor analysis, nor a fortiori in an exploratory factor analysis. Our theory is best tested not by the covariance of the items but by their combined ability to predict the expected dependent variables. This instrument has been tested in several previous settings—in healthcare, justice systems, and businesses—and results so far have been supportive.

Student Performance

Student performance is measured by Academic Performance Index (API) Score. In California, the Academic Performance Index (API) reflects students' performance on a variety of assessments, including the California Standards Tests (CSTs), the California Alternate Performance Assessment (CAPA), The California Modified Assessment, and, for high school students, the California High School Exit Examination (CAHSEE). State officials in California use API scores as a primary means by which they monitor and rank the relative performance of schools and school districts and publicize district and school-level scores online (http://www.cde.ca.gov/ta/ac/ap/). API scores range from 200 to 1000. For this study, we examine the determinants of the API score from mid-2012 (the end of the 2011–2012 school year). It is important to note that administrators and teachers do not know how their school performed on the API until late into the summer or the start of the following school year (the 2012–2013 school year, in our case). Thus, while our performance data and climate variables were obtained in the same school year, it was not possible that teachers' knowledge of how their school performed in 2012 affected their perceptions of school climate.

Controls

We control for socioeconomic disadvantage (SED) using the percentage of students in the school who are on reduced or free lunch in the 2011–2012 school year. Thus, higher numbers for this variable correspond with a greater percentage of socioeconomically disadvantaged students in the school. We controlled for school size (the number of full-time teachers employed at the site), since larger schools may have more resources on hand (e.g., more personnel to devote to student issues and more financial resources). In predicting API performance in 2012, we also controlled for the API score from the prior year (2011).

Findings

We provide descriptive statistics in Exhibit 18.2 and bivariate correlations in Exhibit 18.4. In the year our study was carried out, school API scores ranged from 740 to 967 (Mean: 849; SD: 66), while the percentage of students in poverty ranged from 13% to 100% (Mean: 53; SD: 28). Collaborative was the best represented community type (Mean: 41), followed by Bureaucratic (Mean: 36), Traditional (Mean: 20), and Fragmented (Mean: 13). In Exhibit 18.3, the correlation between API scores in 2011 and 2012 is positive and very strong, suggesting a high level of consistency in school performance from year to year. The percentage of students who were socioeconomically disadvantaged shows a strong, negative bivariate association with school API score. The Traditional and Fragmented community types show strong positive associations with one another and negative associations to the Collaborative and Bureaucratic community types. The bivariate association between Collaborative and Bureaucratic community is positive but not statistically significant.

Exhibit 18.4 regresses API performance against the four community types. Given a high level of multicollinearity between baseline performance and socioeconomic status, we ran models that included baseline scores and excluded socioeconomic status as well as models included socioeconomic status and excluded baseline scores. The models presented below include both baseline API score and socioeconomic status as control variables, but the direction and significance of the coefficients were essentially the same across these different specifications. As shown in Model 1, baseline API, socioeconomic status, and school size are strongly associated with API scores in expected directions and together explain roughly 96% of the variance in API. Models 2 through 5 introduce the four community type variables one by one. We find a weakly significant positive association between Bureaucratic community and school API score (Model 2). As illustrated in Models 3 and 4, the Fragmented and Traditional communities both show strongly significant negative associations with school API score. The Collaborative type, introduced in Model 5, shows a strongly significant positive association with API score ($p < .01$). When all four types of community are included in the same model (Model 6), the Traditionalistic and Collaborative ones preserve moderate explanatory power.

Exhibit 18.2 Descriptive statistics

Variable	Mean	Std. Dev.	Min	Max
API 2012	849.22	66.38	740	967
API 2011	834.70	76.35	685	971
% SED	52.98	27.95	13.2	100
School size	34.25	18.96	19	92
Traditional	20.31	6.54	9.51	37.63
Bureaucratic	35.58	4.59	26.40	45.55
Collaborative	41.87	9.59	21.55	62.36
Fragmented	13.44	7.34	2.71	28.67

Exhibit 18.3 Correlations

	Collaborative	Bureaucratic	Traditional	Fragmented	API 2011	API 2012	School size
Collaborative	(0.756)						
Bureaucratic	0.3431	(0.535)					
Traditional	−0.7366*	−0.3997*	(0.575)				
Fragmented	−0.8874*	−0.5040*	0.7427*	(0.746)			
API 2011	0.1705	−0.1628	−0.2195	−0.0303	1		
API 2012	0.2214	−0.1242	−0.2875	−0.081	0.9783*	1	
School size	−0.2785	−0.1455	0.1857	0.2131	−0.105	−0.1326	1
SED	−0.0242	0.2401	0.0942	−0.0698	−0.8700*	−0.9014*	−0.0977

Cronbach's alphas for Community constructs are in parentheses
* $p < 0.05$

Exhibit 18.4 Regression results predicting 2012 school performance

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
% SED	−0.65**	−0.706**	−0.772**	−0.747**	−0.801**	−0.837**
API 2011	0.63**	0.615**	0.549**	0.577**	0.538**	0.517**
School size	−0.29*	−0.267*	−0.242*	−0.228^{+}	−0.196^{+}	−0.200*
Bureaucratic		0.882^{+}				0.409
Traditional			−1.318**			−0.925*
Fragmented				−0.905**		0.566
Collaborative					0.957**	0.873^{+}
Constant		350.9**	466.3**	426.4**	407.8**	427.3**
Observations	26	26	26	26	26	26
R-squared	0.96	0.974	0.985	0.98	0.983	0.988

**$p<0.01$, *$p<0.05$, $^{+}p<0.1$

Digging further, we can examine the specific role of each of the items composing our community types. Exhibit 18.5 reveals that all the items composing each of the Community types have similar effects in direction and in approximate magnitude.

Conclusion: Collaborative Community Among Professionals—Promise and Obstacles

Our survey results for teachers and our case-based analyses of medical care support our theoretical claim concerning the value of collaborative community in professional contexts. We should not, however, underestimate the difficulties facing the propagation of this new form of professional organization. On the one hand, the continuing ethos and structures of traditionalistic autonomy among the liberal professions create a powerful counterweight to any move toward the broader and denser interdependencies characteristic of collaborative community. On the other hand, the pressure of instrumental self-interest creates a powerful counterweight to any effort to prioritize higher social purposes. Leape and Berwick (2005) analyze the multiple factors that explain why progress on quality in medicine has been so slow in recent years and highlight the role of the culture of medicine and its "tenacious commitment to individual, professional autonomy" (p. 2387) as a "daunting barrier to creating the habits and beliefs that a safe culture requires" (p. 2387). Indeed, even when the appropriate formal organizational structures are in place, the new models face deep resistance:

> "Many physicians, however, are individualistic in orientation and do not necessarily enter group arrangements very easily or comfortably. [B]uilding physician groups is a difficult process. Most of the groups visited [in this study] are not well organized—they are groups in name only. Whatever group culture does exist is often oriented to preserving this loose-knit affiliation rather than developing a stronger organization. This culture of "autonomy," however, is not conducive to building an organization that encourages the development of physician-system integration or care management practices" (Gillies et al. 2001: p. 100).

Exhibit 18.5 Item-level correlations between community type and performance

Collab	People participate in defining and improving the school's policies and procedures	0.118
Collab	If there is a conflict between teachers and administrators, a labor management team will be put together and will usually be able to solve it	0.116
Collab	Administrators here decide jointly with teachers about both work goals and how best to achieve them	0.109
Collab	When we recruit new people in this organization we look for people who will play an active role in contributing new ideas	0.102
Collab	Disagreements between grade levels/departments are dealt with by peers in rational, open, and direct discussion	0.0790
Bur	If there is a conflict between teachers and administrators, union and administration rely on the formal collective bargaining and grievance processes to resolve it	0.0651
Bur	Disagreements between grade levels/departments are handled according to formal policies and procedures	0.0542
Bur	People work according to policies and procedures defined by supervisors or specialists	0.0486
Bur	When we recruit new people in this organization, we look for people who have the right credentials	0.0288
Bur	Administrators here focus on ensuring everyone follows policies and procedures	0.0267
Frag	People here see a lot of unproductive conflict between union leaders and administrators	–0.0558
Trad	Disagreements between grade levels/departments are resolved by trading favors	–0.0666
Frag	It is hard for these newcomers to get accepted here no matter what they do	–0.0746
Trad	When we recruit new people in this organization, we look for people who will fit in to our established ways of doing things	–0.0797
Frag	There is a lot of unproductive tension in relations among grade levels/departments	–0.0829
Frag	Teachers here often see a lot of unproductive tension in relations with administrators	–0.0923
Trad	People here do things the way they have traditionally been done	–0.117
Frag	It is very hard to change policies and procedures even when they are not helping us work effectively	–0.119
Trad	Union leaders here are especially protective of members who are loyal to them	–0.124
Trad	Administrators here are especially protective of teachers who are loyal to them	–0.132

Col 3 shows the standardized correlation coefficients in a model regressing the residuals from Model 1 in Exhibit 18.4 on each item separately, ranked by size

As for teachers, the challenges are so less daunting:

"School teaching has endured largely as an assemblage of entrepreneurial individuals whose autonomy is grounded in norms of privacy and noninterference and is sustained by the very organization of teaching work. Teachers are now being pressed, invited, and cajoled into ventures in "collaboration," but the organization of their daily work often gives them scant reason for doing so. Long-standing occupational and organizational traditions, too, supply few precedents; rather, they buttress teaching as a private endeavor" (Little 1990, p. 530).

Cooper et al. (1996) delineate the complex dynamics of change in the presence of sedimented organizational archetypes and active resistance. The professional categories whose market and political positions are most entrenched—such as specialist doctors—can mount formidable opposition to the forces of change. This resistance gains strength from professionals and their allies who feel that the attack on the autonomous liberal profession model is an attack on the quality of professional service (Fielding 1990; Hoff and McCaffrey 1996; Warren and Weitz 1999).

Despite these resistances and obstacles, collaborative community seems to be a promising way to preserve the core value-rational orientations of the professions in the modern world. It remains to be seen whether this organizational form can flourish or if Weber's skepticism will be vindicated.

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Part V
Designing for Responsible Professionalism in a Diverse Society

Introduction

The single chapter in Part V draws together the lessons learned from this inquiry into professional responsibility and lays out a potential blueprint for revitalizing professionalism in education and medical practice. This chapter begins by reviewing the underlying conceptual frameworks found within the previous 18 chapters and weaves them into a relatively coherent whole. While there are certainly gaps in the analysis, and not all the authors agree on some key points, this chapter finds ten points of broad agreement that offer a cogent interpretation of the need for, the nature of, and strategies for realizing professional responsibility for diverse communities in ways that are inadequately supported by contemporary education and medical professionals. Following a description of these ten points of agreement, the chapter concludes with a tentative "blueprint" for the development and maintenance of professional standards in the human service professions.

Chapter 19
Summarizing the Lessons: Shaping a Blueprint

Douglas E. Mitchell and Robert K. Ream

This chapter begins by summarizing key points of convergence among the analyses presented throughout this volume. Following that summary, we outline a blueprint for nurturing and sustaining robust commitment to professional responsibility in the fields of education and medicine. We find nine points of convergence which, taken together, frame a comprehensive picture of how education and medicine, along with other social and human service occupations, could be positively transformed into more equitable and effective services for the nation's children and adults. These convergent points cover the conceptualization of professionalism, the social, organizational, and political contexts of professional work, the importance of recognizing the power of institutional environments to either support or deflect professional actions, and the extent to which the working relationships among individual physicians and teachers need to be transformed into collaborative community action systems in order to define and promote responsible professionalism. The tentative blueprint for professional practice reform in the last section of the chapter aims at providing some useful guidance for turning scholarly insight into practical action.

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The Points of Convergence on Responsible Professionalism

While the evidence and analyses presented throughout this volume contain many insights not summarized below, the nine points discussed here cut across the diverse perspectives found in previous chapters. Each numbered point of convergence presented below is summarized in a central proposition and briefly elaborated in text that follows. We begin by recognizing that the concept of professional responsibility is at the center of a reconceptualization of how improvement of education and health care delivery might be pursued.

1. *The concept of professional responsibility identifies and highlights an inadequately understood and poorly supported aspect of education and health service delivery.*
   All of the authors represented in this exploratory analysis of professional responsibility argue that delivery systems for essential human services have become deeply embedded in large, complex, highly regulated, and bureaucratic organizations. As a result, school students and hospital patients have found themselves alienated and disengaged from processes essential to quality education and healthy life styles. Moreover, disengagement and alienation are not limited to organizational clients. Professionals themselves—teachers and physicians and other human service professionals—are also experiencing high levels of frustration and emotional conflict as they try to deal with organizational managers, political regulators, and community interest groups. Even as the organizational machinery for developing client services has been elaborated, resourced, and regulated in aggressive pursuit of quality, equity, and accountability, the working relationships between education and health professionals and their clients have frayed, displacing attention away from moral and fiduciary responsibility for client well-being. Pernicious financial incentives, heavy handed organizational management strategies, regulatory intrusiveness by governmental agencies, and disruptive demands by groups within the civic culture all converge on professional practitioners. The authors agree that creating more responsive, responsible, and trustworthy professionalism is an essential strategy for improving medical and educational outcomes. Sadly, over the last several decades, reform efforts in both education and health have tended to ignore the development of professionalism and professional responsibility, focusing instead on resource and regulatory mechanisms to constrain rather more than empower professional teachers and physicians.
2. *Professional work is best understood from the perspective of the layered task structures distinguishing labors, crafts, arts, and professions.*
   The notion that professional responsibility is concerned with performance of a specific type of work tasks rather than a characteristic of particular occupations or work roles is one of the most important contributions of this study. While there are two rich traditions of scholarship addressing professionalism as a property of specific occupations (e.g., law, medicine, or architecture), or as an attribute of individuals whose work is guided by specific moral and fiduciary

principles, the dominant theme in this volume is that it is more informative to distinguish four basic task structures—labors, crafts, arts, and professions—and recognize that each unique structure has its own guideposts for quality performance. Laboring work requires diligence, craft work depends on skill, artistic work involves creative sensitivity, and professional work requires acceptance of responsibility for client well-being. The capacity of professionals to accept responsibility for client well-being creates and sustains trustworthy interpersonal relationships between professionals and their clients. However, this kind of responsible professionalism has been seriously challenged by interest group demands, organizational regulations, and governmental policies which, though often intended to encourage attention to professional norms, too easily have the effect of replacing responsibility for clients with responsibility for compliance. Differentiating professional tasks from their nested labor, craft, and artistic task structures frames the legitimate use of coercive controls and points the way to integrating the appropriate use of financial and other incentives.

3. *Professional responsibility involves accepting both the moral dimensions of care for clients and the enforceable fiduciary responsibilities associated with supporting and protecting their social well-being.*
   Professionalism involves public accountability as well as voluntary moral commitments to quality work and client well-being. Even though they challenge professional autonomy and independent judgment, social and political forces are essential to the definition of the proper goals of educational programs and medical treatments. To be successful, reform strategies must not only secure and maintain professional commitments to diligent, competent, sensitive, and trustworthy engagement with client needs, but also provide mechanisms for reviewing and disciplining the conduct and competence of the professional workforce.

   There are, of course, always opportunities for workers to be neglectful, unskilled, and insensitive, but these problems are more easily managed through regulation and supervision than are problems that spring from irresponsibility and mistrust. Indeed, when inadequate services are addressed through policies and regulations intended to enforce diligence and skill without taking adequate account of the need for sensitivity and trust, the result is likely to be a deterioration of quality rather than its improvement. Professional responsibility can be nurtured and encouraged, but it does not respond well to coercive mandates and pay-for-performance incentives. That is not to say that coercion has no place in professional work settings—coercion is quite appropriate to the discipline of insensitive, irresponsible, and incompetent professional workers. But containing malfeasance does not go very far toward assuring responsible action.
4. *Substantial responsibility for identifying the social goals and defining the appropriate technologies for professional service has become the purview of organizations rather than individual professional workers.*
   Employment in complex organizational delivery systems denies professional workers the independent judgment and latitude of action previously thought to define professionalism in the workplace. The challenge is to find ways of supporting, indeed demanding, professional responsibility within these complex

organizations. As professional workers moved from their origins where independent, fee-for-service contracts defined the professional–client relationship into systems that coordinate multiple professional workers with diverse specialized responsibilities, independent judgments were substantially replaced by routinized and regulated practices. The administrators of these complex organizations, negotiating with governance regulators and client interest groups took over much of the responsibility for establishing work norms and setting the goals to be reached. As organizational employees, professional workers confront dual loyalties. They are responsible to and for their clients' well-being, but are simultaneously responsible to the expectations of management and through management to public policy regulators and significant pressure from organized stakeholder groups.

5. *Institutional theory highlights two important features of the complex organizations coordinating professional task performance: (a) social values combine with production technologies to legitimate and guide work behavior and (b) organizational activities are substantially influenced by external pressures emanating from governance regimes and civic cultures.*
   Professional work responsibilities arise in the context of complex social organizations that are constantly wrestling with issues of internal legitimacy and productive efficacy while simultaneously responding to the expectations and actions of political regulators and important stakeholder groups operating in their organizational environments. As the market demand for high-quality human services has expanded, bureaucratization and regulation of professional service work has become essential to its quality and efficiency. At the same time, establishing strong environmental ties has become equally important to the establishment of professional missions and goals. While it is essential for professional workers to focus on their clients and create relationships of trust in both the efficacy of services and in the fiduciary and moral responsibility of the professional practitioner, institutional dynamics are constantly challenging the professional–client working relationship by demanding that the work meet institutional standards and be held publicly accountable for both service quality and ethical standards of client treatment. Institutionalized professional work relationships are frequently subjected to coercive demands for specific task performance standards. While this may create a more standardized service delivery system, it can also lead to disruption of trust and distraction of the professional from the duty of client care. To produce effective and efficient professional services within institutional settings, it is necessary to integrate employee duties to institutional managements, civic duties to stakeholders, legal duties to political regimes, and moral and fiduciary duties to clients.
6. *Collaborative professional communities, by building routines of practice, can offset the domination of individual workers by managerial directives and organizational regulations.*
   Arguably the most important insight to be found in the analyses presented in this volume is recognition that professional responsibility requires collaboration among the professionals within typically complex, bureaucratized, service delivery

organizations. The era of individual professional autonomy and independent judgment has passed. Professional practice norms and routines can now only be competently designed and executed when professionals collaborate with one another to create norms and standards of practice within their employing organizations and across the large service delivery organizations where colleagues with similar professional responsibilities are employed. It is becoming increasingly clear that individual professionals are unable to single-handedly withstand the distractions and interference pressures arising from special interest stakeholders, public policy regulators, and efficiency-oriented institutional managers. These distractions are real, but they also serve as mechanisms for assuring that professional workers are held accountable for the quality and the equality of their task performances. What is needed is the creation of a strong collaborative community among the professionals who are serving the same client groups and working for the same institutions. Once organized, these collaborative communities have the capacity to establish professionally defensible routines of practice. As they articulate agreed upon routines of professional practice, they are able to persuade or pressure institutional managers to forego intrusive regulations and rely, instead, on implementation of the agreed upon professional work routines.

One reason why the collaborative community approach to defining professional work routines is so important is that professional workers are, by virtue of their responsibility for client well-being, attuned to the need for clearly articulated ethical norms of practice—norms that are necessary to client relationships but not necessarily visible to managers, regulators, or interest groups.

7. *Robust professional associations, operating outside the workplace, are essential to the preservation of responsible professionalism—they provide external validation of professional norms and enable employed professional workers to resist pernicious incentives, inappropriate regulations, bad policies, and biased cultural norms.*

   The professional association is the appropriate vehicle for defining professional responsibility and for striking the appropriate balance between political regime governance policies, organizational management expectations, and civic cultural aspirations. At present, professional associations in both education and medicine are too steadfastly committed to protecting their professional members and not sufficiently dedicated to realizing high quality and thoroughly equitable service delivery.

8. *The most potent points of leverage for reform of professional practice are encountered along the preparation "pipeline" stages of (1) recruitment, (2) selection, (3) training, and (4) induction of individuals into the profession. Once trainees are inducted into professional practice, the most powerful leverage points include (5) strengthening leadership, (6) collaborative working arrangements, (7) public policy improvement, (8) incentives management, and (9) building robust professional associations able to balance government and civic culture pressures.*

   Reform strategies differ significantly from one leverage point to the next. At some points clarity of moral and social commitment is most important, at others

analysis of technical options and building political and social support for action are more important. The capacity of existing service delivery systems to socialize novice professionals into cost-and-corner-cutting work routines is increasingly recognized by leaders as well as reformers in the education and healthcare sectors. Hence, it is important for reform energies to be invested at every step in the training, induction, and practice points of leverage. The reform energies need to be directed by a common understanding of what changes in practice are needed and how those changes might be produced.

9. *The University is a potent force for reform and improvement when it focuses attention on defining professional practice standards, recruits, and trains professionals to meet those standards, and works closely with practitioners in schools and hospitals to insure that novice professionals come to grips with the realities of practice as they arise at the point of service delivery.*
   As the primary locus of professional training, universities have a unique capacity for defining professional responsibility, shaping professional commitment, and preparing candidates for professional practice. The universities also have important relationships with the schools and hospitals where education and medical services are delivered. These relationships provide universities with potent opportunities to influence organizational norms and set workplace standards. In the support of professional excellence, universities are increasingly aware that training programs work best when they engage professional trainees in guided practice. Too often, however, universities have separated their attention to research and technological improvement of practice from their attention to the socialization and induction of novice professionals.

Toward a Blueprint for Realizing Responsible Professionalism

This concluding section briefly outlines strategies for improving training, practice, and public policy implied in the points of agreement outlined in the previous section of this chapter. The blueprint begins by calling attention to the primary reason there is an urgent need for redesign of professional practice in both education and health service delivery.

The first step is to recognize that alienation, mistrust, emotional exhaustion, disaffection, and disengagement are eroding the capacity for responsible professionalism.

The United States policy community has been engaged in high-profile efforts to improve both education and health services for more than half a century, with rather limited results. The primary weakness in these reform efforts is that they have concentrated on accountability for performance of the primary craft tasks within these occupational domains, rather than recognizing the importance of professional engagement and the development of professional responsibility for their clients. Until reformers recognize the erosion of professional commitment and begin to address

the hollowness in contemporary professional/client relationships, reforms are likely to continue to miss the mark.

Training programs are limited in their ability to nurture responsible professionalism and work cultures sufficiently tolerant of unprofessional work activities that it will be important to devote substantial effort to building "pipeline programs" to draw young people into the human service occupations.

During their public school years, young people develop the habits of mind and spirit needed to become responsible professionals. Reform efforts need to work with school-age children to nurture their commitments to learning the craft technologies of a chosen profession, to develop creative sensitivity to diverse client needs, and to nurture the capacity for the caring, respectful, and committed relationships necessary for responsible professional task performance.

When recruiting and selecting candidates for professional training programs, it is important to stress a "mission orientation" that links challenging intellectual training with awareness of the rigors of commitment to professional practice.

Both training institutions and the candidates admitted into their programs require this "mission orientation." It is important that these training programs embrace the moral, ethical, and fiduciary values undergirding professional practice. If candidates pursue training primarily for status or economic rewards and have not made a commitment to community and client well-being, there is little chance that training or induction programs can persuade them to make such a commitment after receiving their training. Within this mission orientation, training curricula need to be designed in ways that foster all four of the core work ethics: diligence in the execution of laboring tasks, skill in the performance of technical craft aspects of the work, sensitivity and perceptiveness in artistic elements of their work, and responsibility for the professional outcomes the work is designed to attain.

Train professionals in an environment that links intellectual rigor with professional practice.

Give neophyte professionals well supported opportunities to take professional responsibility for their actions and coach them for sensitivity to client needs and interests as well as the techniques for treatment of human needs. Present-day training programs in both education and medicine currently give novices a substantial amount of hands-on practice. But these practice opportunities too often fail to link intellectual rigor with passionate professional practice. Medical intern programs tend to emphasize treatment of diseases while neglecting engagement with patients; educational interns tend to have the opposite experience—close engagement with students with weak execution of pedagogical craft tasks.

Insist on induction programs and procedures that bring newly trained professionals into environments where they see the consequences of their actions and receive critical feedback and coaching that addresses their capacity for and commitment to caring as well as their capacity to treat their clients.

Once the novice professionals have completed the initial training regimen and are becoming fully responsible for their professional practice, they experience an especially important and vulnerable transition from student to practitioner. It is at this time that the newly trained professional is urged to adapt their training to the

exigencies of the workplace. And that is when professional commitments are most likely to be compromised or abandoned in favor of the "efficient" practice norms that have evolved in the immediate workplace.

Train and support young professionals to work collaboratively not only with colleagues in the same profession but also across professional specialties to develop a collaborative commitment to integrating technologies, sharing responsibilities, creating mutual trust, and insisting on maintaining professional practice standards.

The long-standing tradition of independent, autonomous professional workers formulating their own strategies for serving client needs is deeply rooted in both schools and medical clinics. As has been repeatedly argued in this volume, however, the era of independent professional work is rapidly coming to an end as science and practice converge to insist on collaborative treatment of complex social needs. It is now important to make this transition an intentional part of professional training at all levels.

Teach professionals to map the expectations of various stakeholders and to compare stakeholder interests and expectations against professional practice standards.

In addition to having a tradition of independent decision making, both education and medical practitioners have a tendency to ignore or overtly resist environmental pressures for reform. To be sure, environmental pressures are often characterized by bias and narrow self-interest. However, it is important that professionals understand the environmental stakeholders and accept or reject their expectations through engagement, not by neglect. In addition to changes in attitude and in habit, engaging stakeholder groups in constructive dialogue requires professionals to develop new skills. Learning the vernacular of the stakeholders, and even their languages, is a necessary part of this process.

Organize robust professional associations—communities that interact skillfully and comfortably with organizational managers, political governance regimes, and civic cultural interest groups to maintain the legitimacy of professional norms and continuous review of client interests and needs.

Professionals trained today will be employed and will have to answer to managers, regulators, and civic interest groups. These environmental and managerial forces have only limited respect for the demands of professional task performance and they will need to be balanced by a robust articulation of professional norms and standards. Unfortunately, professional associations in both education and medicine have drifted into worker protection mentality and are now subjected to political and social criticism for their failure to lead toward systemic improvements in practice. The next generation of professionals needs help in learning how to create and lead professional associations.

Provide explicit training in the three distinct ethical systems—deontological norms that honor legitimate rules, consequentialist norms that insist on doing no harm and providing effective treatments, and Aristotelian virtue ethical norms of respect for human dignity and universal human rights.

To assure that they have met ethical standards in their professional practices, educators and physicians need to learn how to undertake serious moral and ethical

analysis. They need to learn that there are at least three distinct foundations for moral/ethical analysis and to be able analyze problems of practice from all three perspectives.

Build incentive systems that reward (1) relationship development as well as service delivery, (2) attention to both craft technologies and caring practices, and (3) support both skill development and diagnostic sensitivity.

Much of the social and political discussion of moderating the incentive systems in education and medicine in order to generate stronger motivations for ethical and effective professional behavior has been narrow and naïve. It is important to examine the actual consequences of changing incentives, not just articulate an ideological position based on some unsophisticated grasp of market dynamics. It is clear that the incentive systems in these two occupations are currently suboptimal. The teacher labor market works very well to insure that the students with the greatest need get the least able and least experienced teachers, while the most able students get the best qualified teachers. It is equally clear that the incentive system in medicine is draining talent away from primary care health services where there are desperate needs and creating expensive health care for low-incidence health problems. Unfortunately, reformers today have very little access to the financial incentive systems in either of these occupations. Working to examine and refine the quantity, quality, and distribution of incentives needs to be a high priority reform activity.

Activate the University to serve as a partner with professional service providers to create a base of operations for critical review of established practices, to offer a safe harbor for development of new skills, and to insure that research programs address the practical constraints encountered in the field.

Universities are the primary agencies for preparing professionals. They have substantial impacts on the introduction of new pedagogical and treatment technologies for educators and physicians after they leave the training institutions. Universities are much more limited, however, in their influence on the professional responsibility practices of their graduates. As we have noted, the workplace norms of efficiency and compliance with regulations are the most powerful influences on professional practice norms. The universities can and should do a better job of keeping their graduates in touch with evolving professional practice standards.

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