Policy, People, and the New Professional

De-professionalisation and Re-professionalisation in Care and Welfare

Jan Willem Duyvendak
Trudie Knijn
Monique Kremer
(eds.)

Amsterdam University Press

Table of Contents

Authority, Trust, Knowledge and the Public Good in Disarray

Monique Kremer and Evelien Tonkens

Over the last thirty years, welfare states have witnessed a considerable number of debates concerning the identity and power of clients of social and care services. Criticism of the authoritarian and paternalistic practices of professionals and a call for democratisation have stimulated changes in services delivery. Western countries have witnessed a trend towards more user-based services, with increased attention towards clients' wishes and demands. The clients' position towards services delivery has strengthened. This shift in power was initiated by the assumption of new roles as citizens and consumers. These roles were carved out against the older idea of clients as patients (in health care) or underprivileged (in welfare and social work). The three roles of patients, citizens, and consumers respectively correspond to the three logics of services delivery: professionalism, bureaucracy, and marketisation (Knijn 2000; Freidson 2001).

In the process of turning patients into citizens or consumers, the positions of professionals were hardly ever taken into consideration. Professionals were simply seen as the problem, as the opponents. Ironically, professionals themselves have played a prominent role in this attack on professionalism. Social workers, for instance, were the first to argue that they themselves were too powerful and paternalistic towards clients and should step back (Duyvendak 1999). Health care professionals were the main force behind the strong wave of criticism of psychiatry and mental health professionalism (Tonkens 1999). Social professionals reinforced guiding notions like autonomy and independence that fundamentally changed the client-professional relationship.

But even while professionals played a crucial role in the process that resulted in new roles for patients, such as citizens and consumers, little attention has been paid to what the corresponding new roles of professionals should be. What is the new identity of professionals and what are their tasks when clients are turned into consumers or citizens? What defines good professionals in the eyes of clients as consumers and/or citizens? Are they expected to wait passively and refrain from using their powers unless asked to by the client? Or do powerful clients need powerful professionals? While the clients have changed, no explicit new role has been defined for the professionals.

We argue that the new roles of citizens and consumers tend to create new, conflicting demands of professionals, while leaving these profes-

sionals completely in the dark as to how to cope with these demands. In this chapter we identify and analyse the unresolved issues concerning the new identities and activities of professionals. We argue that the redefinition of clients from patients to consumers and citizens demands reflection and a redefinition of the roles of professionals and the interactions between clients and professionals. We focus on four aspects of the roles of professionals that have upset by the redefinition of clients: the status of their knowledge, their authority, their orientation towards the public good, and the trust between professionals and their clients. In their new roles of citizens and consumers, clients have claimed to possess more knowledge and skills concerning their own problems.

Yet what exactly is the status of their knowledge, and how does it relate to the knowledge of professionals? The question of the authority of the professional is also under pressure. Both citizens and consumers have claimed increased control over their own lives. The authority of professionals has never been totally dismissed, but it has never been made totally clear either. Additionally, the new roles of clients have also affected the issue of trust. Clients, now considered citizens and consumers, no longer trust professionals to know best and act in their interests – yet trust is acknowledged to be a precondition for any good relationship in the care and welfare sectors.

How can new forms of trust be developed and on what basis? This is the expression of the public good. While professionals used to be considered guardians of the public good, consumers and citizens have debated this notion. In different ways they have both concluded that the notion of the public good is not very valuable, because what is most important is self-interest. They presume that professionals too are only self-interested, but at the same time criticise professionals for it. So the question of what relationship professionals should have toward the public good versus their own self-interest remains unresolved.

In this chapter we sketch the ideal types of patient, consumer and citizen, and try to formulate what kind of professional would fit each ideal type. What does this role imply for the four themes mentioned – authority, trust, knowledge and the public good? What comes to the fore is that these three client roles are highly problematic when we consider these four themes. Therefore we request a fourth role, that of co-producer or participant, which is a more recent invention and fits a fourth logic, that of democratic professionalism. The role of participant or co-producer is the most promising one, as this role allows for a good balance between professionals and clients in which both perspectives and positions are acknowledged. It is built on the strengths of both, especially when it concerns trust, knowledge and the public good.

Professionalism and its Siege

In the 1950s and 1960s, people who needed care or welfare were referred to as patients (in care and cure) or the underprivileged (social work). This fitted the ideal type of professionalism: a highly exclusionary system that excludes others – especially other workers and clients – using criteria of (abstract) knowledge and skills based on expert education and training. This claim to abstract knowledge and skills was often followed by regulations of professional, regulatory schools and associations, and finally ethical codes (Abbot 1988). Although there seems to be a constant battle about what kind of occupation can be called professional, Freidson (2001) nevertheless distinguishes five characteristics: 1) a body of knowledge and skills officially recognised as based on abstract concepts and theories, and requiring the exercise of considerable discretion; 2) an occupationally controlled division of labour; 3) an occupationally controlled labour market requiring training credentials for entry and career mobility; 4) an occupationally controlled training program associated with 'higher learning', providing an opportunity for the development of new knowledge; 5) an institutionalised 'secular calling' or vocation. This vocation is rooted in an ideology serving some transcendent value (professionals work not only for the money) as well as in institutions that embody that vocation and introduce newcomers into it. Professionals, in other words, are also defined by their desire to serve the public good and given the chance, to do so via some institutionally organised practice.

Distinctive and protected knowledge and skills as well as the secular vocation to serve the public good constitute the basis of the authority and trust of professionals. This notion of professionalism can be found in the work of Parsons (1964; 1968), who used the relationship between the professional and his patient as an exemplary case of functionalism. Parsons believed that the separate and one-sided roles of professionals and clients – the uneducated patient listens to the all-knowing expert – were necessary for successful treatment. Such professional power was necessary as it was grounded in expertise, guaranteed by professional control and, Parsons argued, offset by the trust between professional and client. Authority was based on the assumption that clients had little expertise and knowledge concerning their own situations. The solid training and expertise of professionals formed the basis for the unconditional trust of clients. The professional, in turn, trusted the patient to follow his advice. This trust has been reinforced by social institutions and symbols: professionals were well-paid, had their own control mechanisms, and were often supported by welfare states and welfare insurance schemes.

As for vocation, the trust in professionals was also based on their (alleged) commitment to the public good. Freidson's fifth feature addresses this issue. Professionals were benevolent and their main aim was to cure

the sick and support the underprivileged. Consequently, social workers, doctors, and other professionals assumed an important role in the allocation of care, welfare and health services. They were supposed to serve as gatekeepers of (often costly) state interventions. Because they possessed expertise and were supposed to be benevolent, they were responsible for balancing a patient's claims with the common good.

Professionalism has been fiercely criticised since the 1970s precisely because of the Parsonian 'myth' of professionals having exclusionary knowledge and who only serve the common good. Critical professionals as well as patient movements argued that professionals at best possessed a one-sided knowledge of the problem. Professionals may possess specific scientific knowledge, but without the everyday expertise of patients they would simply be incapable of making solid diagnoses. Patients claimed that their knowledge was also crucial in the care and welfare processes. Knowledge, they claimed, does not come exclusively with training and education. The criticism of professional knowledge, led to growing doubts about professionals' trust and authority as a consequence. Patients claimed that they could study their diseases themselves, and that they had much more experience with the available services than most professionals.

In the 1970s, doubts also arose about whether the unprivileged were really underprivileged and the ill really ill. It was argued that the ones who were labelled as patients were really the only sane ones because they were close to themselves, more authentic, while it was society that was sick or crazy (Tonkens 1996; 1999).

It was also argued that professionals' commitment to the public good masks their power positions and strategies, towards both other professionals and the public. Behind the mask of servitude, critics saw the alleged enjoyment of power and self-interest. Since the late 1970s, critics like Foucault and Illich – as well as Freidson in his earlier writings – pointed to the disciplinary power of professionals. The Dutch philosopher Hans Achterhuis (1979) argued that welfare professionals were not solving or reducing social problems, but were actually creating a new market, which he called The market of welfare and happiness and was also the title of his book. Professionals were more interested in keeping their jobs than in sorting out the problems of clients and more guided by self-interest than the public good. This assault received unexpected support from both workers in the field and left-wing writers (Duyvendak 1997). Professionals, it was argued, simply reinforced the passivity and helplessness of their clients.

Because of their presumed lack of real knowledge and the pursuit of their own self-interests, professionals could no longer be trusted as guardians of the public good. To be able to break professionals' power position, patients demanded a stronger voice (by way of client councils and specific rights) as well as more exit options (by choosing their own services, their own professionals). They hoped this would function as a le-

ver and change the nature of health and social services. The two major responses to professionalism were promoting clients as consumers and as citizens. We will start with the latter.

Claiming Rights and Accountability: Bureaucracy

Clients' organisations demanded that the interests of clients be secured by legal rights as well as via the accountability of professionals. This created a new logic of performance for clients: bureaucracy. The authority of professionals was overruled by the authority of the law. Clients defined themselves as (rather passive) citizens and, as the bearers of rights in a judicial and state context. As citizens they claimed their rights to services (access) and to good treatments and protection. A stronger voice became the dominant paradigm.

Claiming power as citizens resulted in a new provisional regime in professional organisations, such as health care and welfare. Clients gained various rights such as the right to take part in decision-making, the right to complain backed-up by official complaint procedures, and the right to legal assistance from institutions and/or the state (see also Trappenburg's contribution in this volume). As a result, clients could take their grievances to court. The degree to which these rights are implemented varies by country and sector. Since this emphasis on clients' rights emerged as a way of balancing the power of professionals, no attention was ever paid to rights of the professionals or the duties of the clients. The client-professional relationship became part of a legal regime.

This bureaucratic logic of course did create new duties for professionals, who had to develop new knowledge about legal procedures and the actions that increased the risk of being taken to court. The emphasis on clients' legal rights gradually created a whole series of procedural duties for professionals that made them more accountable and would allow them prove themselves not guilty in a trial. This performance logic institutionalises distrust between clients and professionals. Not only are clients encouraged to critically observe every step a professional takes, professionals also end up distrusting their clients (will he sue me?). Professionals may, as a consequence, actually alter their behaviour to avoid lawsuits. As one senior social worker in a British study on accountability said: 'One of my clients hung himself in the garage yesterday afternoon. The first thing I was asked was "is the file up to date?" Because it's so important that the file is up to date and nobody can be held to be responsible' (in: Banks, 2004:151).

In fact, because of this growing mistrust in risky situations, professionals may opt to no longer take on high-risk clients. This came to the fore in the Savanna case in the Netherlands, where a three-year-old girl named Savanna was found dead in the trunk of a car. Her mother and

boyfriend turned out to have killed her. The investigation showed that the Child Welfare Council (kinderbescherming) had seldom intervened because it had focused more on maintaining a good relationship with the mother than on protecting the child. It was the first time in Dutch history that a public prosecutor opened a criminal investigation on a legal guardian. Could she, the guardian, be charged with culpability in the homicide when carrying out duties? The organisation for child protection services warned that this strategy could cause a backlash, as guardians already felt they were faced with great difficulties in their jobs caused by the high levels of bureaucratisation. They argued: 'Who would still dare to provide child support in the Netherlands?' Top officials argued that they feared that guardians would no longer want to work in the field any longer. The professional organisation was shocked because this pressure would make the job even tougher, considering that guardians already had excessive workloads (Trouw, 12 March 2005).

Mistrust is heightened even further by the bureaucratic procedures. With clients in the role of citizens, professionals now had to focus more on following procedures than on spending most of their time providing real help. Dutch research shows that in medical care, where accountability has become more important, medical specialists spend one quarter (26%) of their time filling out bureaucratic forms and living up to procedures. This figure was only 6%, 25 years ago (Kanters et al. 2004). This is also documented in Dutch youth care, which is known to be very bureaucratic.

Bureaucracy is also a threat to the public good. Pols (2004) shows that legal procedures can also remove the moral deliberations necessary for professional intervention. In her study of nurses and care workers in psychiatric wards, the separation of clients was sometimes considered exclusively an administrative routine – as separation is now strictly regulated – rather than as a situation that needs moral deliberation. In this sense, laws do not add morality to practice but may actually be removing some.

At the same time, it is good to remember that clients have demanded and continue to demand bureaucracy and its core values: equal rights for patients and the legal and procedural accountability of professionals. The above examples also show that the rise of the bureaucratic logic creates new tensions and dilemmas because professionals were not actually supposed to completely give up the logic of professionalism. For example, the professional maxim to do everything in one's power to help a client was still adhered to by everyone. In other words, client movements attacked the entire logic of professionalism, but at the same time were silently counting on professionals to continue with their old professional habits to some degree.

Professionals thus have to find ways to balance their professional duty to provide the specific kind and amount of care or help that each client needs, while treating all clients equally. The special treatment of one cli-

ent can create a whole series of lawsuits from other clients who may legally claim that they deserve the same treatment. Conversely, and particularly in a medical context, the professional maxim of trying to refrain from medical intervention if there is no imminent danger conflicts with the bureaucratic claim that all of the treatment option that are legally available be offered. John Clarke (1998) signalled a 'dispersed managerial consciousness' whereby the calculative framework of managerialism becomes embedded in everyone who works for a particular organisation. This 'dispersed juridical consciousness' also develops when citizens take more active steps toward legal strategies such as filing complaints or going to court. This only further exacerbates the mistrust between professionals and clients. Professionals then have to protect themselves from all kinds of legal claims that may have a negative impact on their professionalism.

This indicates that, although bureaucracy is seen as a guardian of the public good, the lack of discretionary professional space is problematic. Of course the law articulates the public good. Yet, while bureaucracy puts equal treatment first, in the care and social work sectors equal treatment does not always coincide with the best quality treatment for each individual or group. Here too we find a tacit return to professional values because people often still expect professionals to make an exception for their particular situation. If they do, professionals distance themselves from the bureaucratic logic and thereby become more vulnerable concerning complaints and lawsuits. Empirical research shows that professionals in care and welfare would like to be held accountable for their behaviour (Vulto & Moree 1996; Hutschemaekers 2001; Kremer & Verplanke 2004; Banks 2004). This distinguishes them from informal carers or other lay people. But with clients as citizens, the meaning of accountability has become unclear. So has the 'public good'; is it equal treatment for all, or is it tailor-made treatment for each individual?

Also, what is the public good when some clients are better-equipped to act like citizens than others? Professionals signal that some clients have more 'bureaucratic expertise' than others. Some speak up more, perhaps thanks to being better educated. These citizens know how to manoeuvre their way through the bureaucracy or an alderman or the mayor and have their demands heard, while others have no idea how to get what they want. Some health care clients know the legal procedures by heart, while others are still grateful when a doctor pays attention to their problems. When patients are primarily classified as citizens, professionals can no longer use their discretionary space to compensate those with little bureaucratic expertise.

Clients as Consumers: The Market

The 1980s and 1990s gave rise to the ideology of the market as a new model for reforming the public sector in many welfare states. Client movements embraced the market as a saviour, hoping it would provide them with the rights of bureaucratic logic without the inconvenience of slow procedures. The market was also going to put an end to clients' dependency on professionals: its logic promised that whenever the professional service lagged behind clients' standards, the new 'consumer' could simply move to another supplier. In other words, the market ideology would skip the vices of bureaucracy but preserve its virtues – having power over the professionals. But the market has instead brought authority, trust, knowledge, and the public good into disarray.

Market logic assumes that consumers have the last word on knowledge: they know best who is the most knowledgeable. Hence consumers – also called users or choosers (Cornwall & Gaventa 2001) – possess the authority over what help or care is needed, and professionals are supposed to deliver this service. Services are then called demand-based or user-based: the demands of the client are the point of departure. Professionals and professional organisations are now compelled to compete in the care and welfare markets.

Consumerism makes vague promises that the ultimate authority will be in the hands of clients. What does this mean for professionals? How can professionals be critical of clients' behaviour if they are being directly paid by them? In many European welfare states it is increasingly possible for care clients to hire a care-giver with public money. In Britain a system of Direct Payments has come into being, in the Netherlands people in need of care can receive a Personal Budget that allows them to hire an employee. But giving clients power as consumers also raises problems. In the Netherlands people employed by a Budget holder sometimes report that they have to act against their own professional standards, as otherwise they may be fired (De Gruyter 2004). Moreover, consumerism in general allows social professionals to intervene in the lives of clients or in collective problems only if they are explicitly asked to do so. It is the consumer who decides which care or welfare is necessary. This does not mean the end of their authority, but rather a focus on negative behaviour and interventions. Professionals are not entitled to interfere, unless clients cause damage or injury (Tonkens 2002). This necessarily creates a negative dynamic in the relationship between professionals and clients, further augmenting distrust.

In practice, however, consumerism actually seriously limits the authority and knowledge of consumers. First of all, competition is not based on expertise and skills, but merely on prices. Cheap care may win, rather than the care that best fits the client's needs. Marketisation also stimulates organisational mergers to eliminate competition. Since most forms of care are scarce there is little choice anyway, as Dutch marke-

tised child care sector proves (Marangos & Plantenga 2005; RVZ 2003). Finally, in practice it is often not the consumer who chooses but intermediaries. This is clearly the case, for example, when we look at the Dutch icon of consumerism, the Personal Budget in care.[1] Many budget holders hire organisations to choose for them and arrange their care. This has led to the development of a whole new 'market' of intermediaries, simply because choosing and organising one's own care is quite complicated.

A big caveat of consumerism in the care and welfare sectors is the fact that no one is ultimately responsible for the development of knowledge and skills. Freidson was among the first scholars to criticise professional power in the 1970s, but has since become increasingly worried about the consequences of this critique, especially the loss of knowledge and skills development. One feature of professionalism is that professionals actively invest in knowledge and safeguard its use. But when this is left to the consumers – who have tight budgets anyway – it is doubtful whether individual clients are willing to pay for professional innovation. This is evident in the practice of the Dutch Personal Budget. A quick scan of home care workers who are employed via a Personal Budget also shows that they themselves are concerned about their professional development. They not only miss the direct contact with other professionals to discuss their vocation, but they also complain about the lack of space for developing their knowledge and education. Some would prefer to improve the quality of care but lack the prospect of being able to do so because they have no opportunity to consult other professionals or train and educate themselves (Sting 2004). They have no control over the development of professional knowledge, as Freidson has warned.

Moreover, the consumer does not trust the professional as the possessor of knowledge, nor as the authority to decide how to proceed. Professionals can at best be trusted to deliver what is demanded, as clients can easily take their services elsewhere. This is particularly so in the case of personal budgets where consumers are allowed to fire professionals without the usual employer-employee relationship which allows for discussion of an employee's performance. Consumerism thus makes trust weak rendering it fragile. The continuous threat of exit options is quite a contrast to the long-term investments in a relationship and the trust that may develop over time. Mol (2004) shows the difference between what she calls the language (and logic) of markets and that of care. In market language transactions are short and finite. After the transaction, the relationship is finished. The logic of care is based on continuity and interdependence as this is crucial for trust and thereby for the quality of care (Mol 2004).

Consumerism does not leave much room for the notion of the public good either. The market renders the public good as obsolete, and not something to foster. The market presumes that if all of the actors pursue their own self-interests, this automatically results in the best outcome for

everyone. Freidson also worries about the disappearance of the notion of the public good by the successful assault on professionalism. His main concern is the corrosion of morality, in other words the decline of the institutional ethics of professionalism. 'What is at risk today, and likely to be a greater risk tomorrow, is the independence of professions to choose the direction of the development of their knowledge and the uses to which it is put', Freidson (2001:14) observes. Professionals have a duty to balance the public good against the needs and demands of clients and employers. Transcendent values add moral substance to the technical content of disciplines. Professionals are obliged to be the 'moral custodians' of their disciplines (Freidson 2001: 222).

Participants and Democratic Professionalism

A new, fourth logic is gradually emerging, both in the literature and in practice. This most recent logic tries to do justice to the demand for democratisation and gives rise to the criticism of professionalism while still retaining its core public values. The new logic can be described either from the perspective of the client or the professional. With the client as the starting point, this logic can be called co-production or participation (Cawston & Barbour 2003, Cornwall & Gaventa 2001) or collaboration (Vigoda 2002).) Starting from the perspective and tasks of the professional, this same logic may be called democratic professionalism (Dzur 2004a, 2004b) or civic professionalism (Sullivan 2004).

This logic should not be mistaken for client participation as such, which is often participation without professionalism. Many current examples that focus on listening to clients surpass professionals' voices altogether. This is discernible, for instance, among client panels that have been established in care services and in interactive policymaking. The dialogue in these situations is generally somewhere between the interests of the clients and managers. Professionals are usually not part of these dialogues, and if they are, they are basically there to listen, not to participate (Pollitt 2003).

The fourth logic is an adaptation of the logic of professionalism. It shares with professionalism the idea that public services are different from bureaucracy and the market in their commitments to the public good and their 'secular calling' to values such as health, education and justice, as well as their dedication to maintaining these values in society. Knowledge and skills are also very important in this logic. But there is also a crucial difference with the standard logic of professionalism. Knowledge and skills are not exclusively owned by professionals – they are the object of a dialogue between professionals and clients. Democracy itself should be seen as an important 'higher value' that should be promoted by professionals in this logic; it is comparable to health, education, and justice. Therefore the dialogue between professionals and

clients plays a crucial role in this logic at the individual, group, and collective levels. This fourth logic thus resembles professionalism because professionals are acknowledged and defined as driven by a vocation rather than by status or money (Sullivan 2004). But they can only maintain that vocation via a democratic exchange with clients.

It shares the core values of participation with professionalism, and as with professionalism, the development, maintenance, and exchange of knowledge is very important. Professionals are defined by their possession of and willingness to preserve specialised knowledge from their field. By exchanging this knowledge with others collective knowledge is cultivated. But knowledge is not only exchanged among colleagues but also with clients. Professionals explain their views and procedures, acknowledge the specific knowledge that clients possess, and come to a compromise regarding the problems and solutions. 'Traditional boundaries between expert and lay become blurred. The perceptions of participants become indispensable to providing a greater "fit" with the unique features of their situation' (Cawston & Barbour 2003: 721).

This vague idea can be made more concrete with the help of Richard Sennett's *Respect* (2003). Sennett proposes that the client acknowledge the superiority of the professional's knowledge in terms of diagnosis and treatment, while the professional should acknowledge the superiority of the client's knowledge in terms of how it feels to live with a demented husband or to live on welfare for years. Note that the boundaries here between expert and lay do not become blurred at all. On the contrary, they remain quite clear, but there is a new balance as to who is the expert and who is lay in a particular area.

Including the experiences and wishes of clients and an emphasis on professionalism are tried out in innovative ways in geriatric patient care as described by Pols (2004). Even so-called silent patients offer their opinions via an 'act of appreciation', for instance. Nurses use professional strategies to find out what these enacted appreciations are (does the person like to drink coffee or not?), and then produce situations in which silent patients can enact their wishes. The latter is what Pols labels as co-production.

Various authors have claimed that trust can be restored via dialogue and the greater openness and accountability of professionals. 'Growing and serious risks of citizen's alienation, disaffection, scepticism, and increased cynicism towards governments' can be averted 'only [by] a high level of co-operation among all parties in society' (Vigoda 2002: 538). Here too, Sennett's notion of the organisation of respect can be helpful. His model is promising when it comes to restoring trust, because he makes it clear when and how authority is delegated to whom, thereby generating more peaceful and respectful situations in which trust may flourish.

As with professionalism, democratic professionalism also considers professionals as guardians and promoters of the public good. But again,

defining the public good is no longer just a task for professionals, but is shared with clients. Yet civic professionalism dictates that professionals take the initiative in this respect to keep the debate on the public good alive. This is characteristic of their vocation because they are paid to be responsible. Community workers still see their task as such and they want to be able to point out the dominant social problems in specific neighbourhoods (Duyvendak & Uitermark 2005; Kremer & Verplanke 2004).

In previous decades, however, teachers were also much more involved in articulating both social and pedagogical goals and the broader needs of society. In the new professional logic, 'professionals take public leadership in solving perceived public problems' (Sullivan 2004: 18) and 're-engage the public over the nature and value of what they do for the society at large' (Ibid). Professionals must be 'in real dialogue with their publics and open to public accountability' (Ibid: 19), thereby 'inviting public response and involvement in the profession's effort to clarify its mission and responsibilities' (Ibid.).

Within this logic, the basis of trust is different than it is within professionalism. Again, the secular calling is a reason for trust, but this is combined with the democratic dialogue sketched above, as well as with the degree to which professionals actively create this dialogue and open themselves up to accountability procedures. It is also acknowledged, however, that trust is a precondition for this dialogue and cannot be a result. The starting point of a fruitful democratic dialogue is that the different parties involved dare to trust each other and only stop doing so temporarily and for a reason – if something happens that destroys that trust. Even then, they may actively seek to restore that trust, since democracy cannot flourish without it. Therefore, all parties try to stay away from a juridical relationship, reserving this for situations of serious and irresolvable conflict.

Authority is shared, since professionals and clients recognise each other's knowledge and come to a joint understanding of the problem and a mutual solution. Clients are 'seeking greater accountability from service providers', among other things 'through increased dialogue and consultation' (Cornwall & Gaventa 2001: 9). This approach combines the strength of professionalism with the recognition of clients as knowledgeable and responsible citizens. Yet professionals have to earn their authority, which means they have to discuss their actions, not only with their clients but also with a larger audience like the public at large.

Democratic professionalism leaves space for paternalistic professional interventions; at the same time, efforts are made to debate such interventions in public and thereby gain the support of the broader politically democratic community. Democratic professionalism not only means that professionals are accountable and take a leading role in discussing the public good; it also means professionals themselves need the active and clear support of the democratically elected political elite in coping

with dilemmas that cannot be solved, since this coping cannot be decided on an individual basis alone. Democratic professionalism in child protection, for instance, can only be enforced when guardians are more accountable for what they are doing, and when they receive the necessary support from a broader political debate – among professionals, clients and citizens – to help sort out the devilish dilemmas they now have to sort out by themselves. The issue of whether some particular care or welfare intervention is necessary should never be confined to the private arena (as in consumerism), even though it cannot be completely resolved, the discussion on authority has to be supported in both the public and political domains. Social professionals are part of a political and normative project (De Boer & Duyvendak 2004). This entails that the discussions between professionals and clients should be inspired, motivated and supported by the broader political and social community.

Note

1. In 2004 nearly 70,000 Dutch people received a budget to purchase the care they needed and to hire a professional of their choice. Some 10,000 of them are members of the organisation of budget holders called 'Per Saldo'. This made anti-professional sentiments obvious and this policy was the result The right-wing liberal Secretary of State, Erica Terpstra, observed upon it's the policies introduction in 1995 that 'A personal budget makes handicapped people less dependent on professionals' (in Munk 2002, 11).