Introduction

Professions for many sociologists have become a key part of the occupational structure in the social stratification system of the modern western world (Macdonald, 1995), with a mission typically expressed in their ideologies to serve the public interest – including addressing issues of social inequality (Saks, 1995). Accordingly, a substantial amount of the literature in the Anglo-American sociology of professions has examined the role of professions – from doctors and nurses to accountants and lawyers – in tackling inequalities amongst client groups and the wider public. This is illustrated by longstanding work in the United States both generally (see, for instance, Krause, 1971) and in specific fields (see, for instance, Navarro, 1986). It is also apparent in more recent work on professions on enhancing social inclusion and citizenship in Britain and the rest of Europe covering dimensions such as social class, ethnicity and gender (as illustrated by Matthies et al., 2000; Saks and Kuhlmann, 2006). This contribution, though, considers the literature on inequalities within professions themselves from a neo-Weberian perspective, and in particular the hierarchical relationships between professional groups in the Anglo-American context where professions are characterized by the greatest degree of self-regulatory autonomy (Collins, 1990). Making reference to the health field and the case study of complementary and alternative medicine, this article outlines such inequalities and notes that there is a significant gap in the research literature exploring the implications of inequalities within professions for inequalities without.

It is often assumed in the sociological literature that professions as single occupational groups are homogeneous entities, when, as classically pointed out by Bucher and Strauss (1961), there is considerable diversity and conflict of interest within professional groups. This conception of in-fighting within specific professions, which includes tensions between the professional elite and the grassroots as well as competing status hierarchies of sub-specialisms, is at odds with many codes of professional ethics and associated ideologies which typically foster the idea of professions as collegial groups forming communities of equals serving the good of the client and/or the wider public (see, for example, Abbott, 1983). However, if the notion of professions as communities of equals serving the public interest in single professions may be considered a myth (Saks, 1995), this is also true of the relationship between professional groups which is often distinctly hierarchical, as highlighted by the concept introduced here of marginal and marginalized professions. With illustrations drawn from health, it is noted that such
inequalities between professions may have considerable implications for clients and the public in liberal democratic societies such as Britain and the United States, especially as regards patterns of inequality. This relatively unexplored dimension of the sociology of professions is therefore an important topic for future research.

**Professions, hierarchies and inequalities**

From the interest-based neo-Weberian perspective adopted in this article, professions are defined in the Anglo-American context in terms of exclusionary social closure in the market based on the establishment of legal boundaries creating ranks of insiders and outsiders, with associated privileges accruing to insiders in terms of income, status and power through credentialism (Saks, 2010). This said, professions are conceptualized in various ways related to exclusionary closure in the contemporary neo-Weberian literature – from having direct market control over technical decisions and work organization (Freidson, 2001). Most importantly, though, in this context, the professions are centred in practice on different forms of legally underpinned exclusionary social closure linked to their operation in specific societies (see, for example, Moran and Wood, 1993). In Britain, for instance, following the passing of the locally based guilds, there is a national system of professional regulation, whereas a state by state pattern of licensure is more prevalent in countries like the United States (Krause, 1996). Similarly, a de facto professional monopoly based on protection of title while still allowing wider practice under the Common Law characterizes professions such as medicine in Britain, compared to the more prevalent de jure monopolies in the United States, related to different sociohistorical circumstances (Berlant, 1975). There is also now increasingly an international dimension to the delineation of the boundaries of exclusionary closure in a single profession in neo-Weberian terms – as exemplified by the opening up of geographical mobility with the mutual recognition of qualifications in the European Union which could lead in future to some degree of convergence of national professional regulatory regimes (Bianic and Svennson, 2010). Moreover, all of these different patterns of regulation have potential implications for the way professions operate in terms of both client groups and the broader public because of the different conjunction of interests that they generate – in terms of the balance of benefits and costs to professional groups and sub-groups in particular decision-making situations (Saks, 1995).

More pointedly in relation to this contribution, though, is the hierarchy of professions which has emerged in particular countries linked to different patterns of professional social closure. In this hierarchy, professions like law and medicine are classically seen to be at the apex in the Anglo-American setting – albeit with their own internal sub-specialist rankings which can be illustrated in Britain by the long-standing division between higher status barristers and solicitors in the English legal system (Burrage, 2006) and between elite consultants in niche specialisms and general practitioners in the National Health Service (Klein, 2010). Other professions variously lie below these groups in a pecking order resulting from legally embedded patterns of referral, oversight and other arrangements in relation to top tier professional groups – which are also typically reflected in differential financial and related rewards. The position of such middle and lower order professions has been conceptualized in neo-Weberian work as ‘dual closure’, where such occupational groups as nurses and teachers take on the characteristics of both exclusionary and usurpationary closure, the latter of which is more typical of union action in the working class (Parkin, 1979). Some other occupations, moreover, have not gained full legally enshrined social closure and are in the process of professionalizing – and may be governed by voluntary rather than statutory regulation which places them still further down the occupational pecking order (Saks, 2003a). Importantly, it should be stressed in setting out the regulatory inequalities between professional and proto-professional groups that the interrelationship between professions is not static, but shifts over time (Abbott, 1988).

In terms of social theory it should also be noted that the neo-Weberian approach to the professions adopted here has not been beyond criticism. It has been variously criticized for lacking empirical rigour (Saks, 1983), being excessively negative about professional groups (Saks, 1998) and failing to link its analysis to the wider occupational division of labour (Saks, 2003b). These criticisms, however, relate more to the inappropriate way in which the approach has been implemented than its intrinsic structural weaknesses (Saks, 2010). It is, however, worth noting that advocates of the neo-Weberian perspective – because of its focus on the interplay of competitive group interests in the market – tend to take a more critical approach to professions and the way in which their myriad of privileged monopolistic positions have originated and developed. As such, neo-Weberianism stands in a common stream with interactionism (see, for example, Becker, 1962), Marxism
(see, for instance, Carchedi, 1975) and Foucauldianism (as illustrated by Johnson, 1995), which view the hierarchical position gained by professions as respectively based on their skills in negotiating the acquisition of an honorific label, their role in fulfilling the global functions of capital and the not always progressive process of governmentality. The main distinction, however, is that the framework of the neo-Weberian approach – with its focus on exclusionary closure as the touchstone of professionalism – lends itself more strongly to analysing particular professions in a more open way, avoiding the problem of other more critical approaches of building in an excess of tautological and other theoretical assumptions that are not in principle amenable to empirical examination (Saks, 2010).

As part of the more critical perspectives on professions, neo-Weberianism also differs markedly from the largely deferential earlier trait approach which painted a more positive picture of professions (Millerson, 1964). In the trait approach professional groups are defined as based on features such as high levels of expertise and rationality (see, for example, Greenwood, 1957) – and even bulwarks of democracy (Lewis and Maud, 1952). This analysis is particularly developed in functionalist work where it is usually held that there is a trade-off, in which professions with knowledge that is very important to society are provided with a privileged position in exchange for committing to use this knowledge to the public benefit (see, for example, Barber, 1963). The functionalist theoretical approach is also used to explain inequalities between the professions in the analysis of Etzioni (1969), who differentiates what he labels as ‘semi-professions’ like social work and teaching from more fully fledged professions on account of their weaker development of professional characteristics like expertise and altruism. This clearly departs from the earlier neo-Weberian work of Johnson (1972), who sees the lofty position attained by medicine and law in the professional pecking order in terms of power and interest and is highly sceptical of the claims of such groups to serve the public interest, not least in tackling social inequalities. Here he queries, for example, the extent to which lawyers’ interests allow them to represent those who seek radical change to the existing order, but also notes that the services of practising lawyers are very unequally distributed. Little seems to have changed to judge by recent reports from Britain and the United States about substantial differences in access to legal services by geography, as well as by low income, disabled, elderly and ethnic minority groups despite legal aid schemes (Robins, 2011; Sandefur and Smyth, 2011). An antidote is therefore provided to the professional ideologies which trait and functionalist writers have been accused of reflexively mirroring in building such positive features of a profession into the very definition of their operation (Roth, 1974).

Johnson (1972) also provides an alternative perspective on middle and lower ranking professional groups, which suggests that the assumed ‘natural’ order of the professional division of labour may not always be rational. More specifically, after disparaging the expertise of general medical practitioners and lawyers as being based more on interpersonal than technical skills in terms of their ability to relate warmly to clients, he notes that:

The emergence of a succession of subordinate ‘professions auxiliary to medicine’ in Britain is the history of how physicians have been able to define the scope of new specialised medical roles, and cannot be regarded as … a product of the most rational utilisation of human resources. (Johnson, 1972: 35–6)

This illustration raises many questions about the potential existence of unjustified inequalities between professions, as well as their impact on the public interest in the Anglo-American context – and in particular in this context their implications for inequalities. Not least of these from a neo-Weberian perspective is how far the limits on both the definition of, and delegation to, allied health practitioners have reduced access to medical care further than it needs to be in less well-served populations (Saks, 2003a). This leads neatly on to a discussion of marginality in the professions, the literature on which will now be considered more specifically in the health field to highlight further inequalities among professional groups and their potential significance for exacerbating or otherwise divisions in the stratified societies in which they work.

### Inequalities and marginality in the health professions

Current work on the health professions indicates that they, no less than other professions in the Anglo-American setting, contain their own share of specific internal inequalities – such as in the divide between specialists and generalists in both medicine and nursing as discrete professions and indeed between specific specialisms which are more or less highly ranked in the pecking order (Klein, 2010). In medicine in Britain and the United States there can be seen to be an elite group driving the profession which has meant that there are also internal divisions in relation to grassroots practitioners, notwithstanding formal democratic structures for elections. In
pharmacists, dentists and opticians whose practice is second category is that of subordinated health professions legally restricted to particular parts of the body. The professions like nurses and midwives, physiotherapists categories. The first is 'limited' health professions such as chiropractic as a marginal profession in the United States (see Wardwell, 1952). In this context, the categories of 'marginalized professions' and 'marginal professions' have recently been defined in the literature (Saks, 2014 forthcoming) which helps to conceptualize the relationship with dominant professions and underline the position of other professions in the pecking order. As such, 'marginalized professions' have a less well accepted standing within orthodox ranks, which is typically reflected in different levels of income, status and power, but still have some form of legally enshrined exclusionary social closure. ‘Marginal professions’ in contrast are professionally aspiring occupations largely operating outside the state-supported orthodox division of labour. The resulting inequalities between professions are at their greatest in relation to dominant groups with respect to these two categories and provide the strongest potential for generating, or at least exacerbating, inequalities without – from patterns of geographical dispersal to the nature, sufficiency and affordability of practitioners operating in particular health fields.

The category of marginalized professions maps well on to the classification of health professions outside of the dominant medical profession as set out by Turner (1995). He distinguishes two relevant categories. The first is 'limited' health professions such as pharmacists, dentists and opticians whose practice is legally restricted to particular parts of the body. The second category is that of subordinated health professions like nurses and midwives, physiotherapists and radiographers who take on delegated tasks from doctors in the orthodox division of labour. Despite their lower positions in the pecking order compared to physicians, marginalized health professions have nonetheless gained through professionalization official legal recognition and legitimation as well as associated benefits, including protection of title linked to enhanced income, status and power (see, for instance, Allsop and Saks, 2002). This separates all shades of orthodox health professions from marginal health professions which lie mainly outside state-endorsed frameworks and are viewed by Turner (1995) as being based on 'exclusion' rather than 'limitation' or 'subordination' within the health care division of labour. Examples of marginal health professions include elements of aspiring groups like health support workers who are striving to professionalize – such as, most recently, operating theatre practitioners in Britain (Saks, 2008).

This categorization and the hierarchal ordering of professions becomes more politically charged if the position of marginal or marginalized health professions are not seen to be based on their level of expertise and contribution to the wider society, but rather on dominant medical professional interests in the neo-Weberian frame of reference. This is precisely what was being suggested by Johnson (1972) in pointing to his view of the 'irrational' utilization of resources in analysing the comparative position of allied health professions in the division of labour. This view, however, contrasts with the lofty pedestal on which the medical profession is placed relative to groups like nurses by functionalist theorists who argue equally fiercely that their privileged position has been gained, amongst other things, by its possession of knowledge of vital importance to the public (Etzioni, 1969). The question of whether the medical profession is to be condemned or applauded for its exalted position in the division of labour ultimately must, of course, be resolved through empirical investigation rather than simply by fiat. What should be said, though, is that the division into either dominant, marginalized or marginal professions in terms of the unequal hierarchy of health professions is inevitably fluid – it was after all little more than a century and a half since doctors themselves were professionalized, in the mid-nineteenth century in Britain and the early twentieth century in the United States, and even later when nursing, midwifery and other allied health professions emerged as marginalized professions (Saks, 2003a). Before this time in the nineteenth century in both societies there was a relatively open field in which practitioners of all types – including some of those who are now defined as complementary and alternative medicine (CAM) therapists – competed in the market on a
relatively level playing field where they were very difficult to distinguish in terms of theories, practice or repute (Porter, 1995).

This leads on to the consideration of the position of CAM, which has been one of the most controversial areas in the sociology of professions from the viewpoint of inequalities within the health professions in the Anglo-American context. Certainly by far the greatest numbers of those engaged in marginal health professions are CAM practitioners who are not yet fully professionalized (Saks, 2008). In terms of the inequalities between professions, it should be noted that CAM is defined here not in relation to its intrinsic characteristics, but rather its position of being largely excluded from the orthodox health care division of labour underwritten by the state and based on an increasingly unified biomedical paradigm centred on drugs and surgery. CAM is defined in this way because it encompasses such a great diversity of practices in the Anglo-American context, from aromatherapy and herbalism to homeopathy and naturopathy. As such, it is impossible to capture the CAM field through overly simplified concepts such as holistic and/or traditional medicine which only relate to a part of its conceptual universe (Saks, 2003a). It is also equally important to note in terms of inequalities between the health professions that the orthodoxy of one era can become the CAM of the next, and vice versa. With these definitional bridges traversed, the article will now turn to consider the literature surrounding the CAM case study in the Anglo-American context.

Case study: complementary and alternative medicine

As Saks (2003a) has documented, the marginal profession of CAM in the contemporary context has taken shape following a long history of attacks by medical orthodoxy on both sides of the Atlantic. In both Britain and the United States, over many decades, medical elites have striven to reduce the credibility of CAM through, amongst other things, enforcing orthodox curricula control in medical schools, debunking the practices and practitioners of CAM in the medical journals, limiting access to medical research funding, and orchestrating career blockages for collaborators. In Britain, as in the United States, marginalization meant that the CAM therapies concerned lacked legitimation. However, while CAM practitioners in Britain could normally practise under the Common Law without obtaining exclusionary closure backed by the state, licensing was required in the United States (Freidson, 1994). Nonetheless, the odds were still stacked against CAM therapists in the pecking order for health professions, especially with restrictive codes of medical ethics inhibiting collaboration between physicians and CAM practitioners. In Britain, moreover, laws were passed creating state shelters for medicine in the first half of the twentieth century initially through the National Health Insurance scheme and then the National Health Service. This barrier was augmented by legislation in the same period prohibiting CAM therapists from claiming to treat a range of diseases such as diabetes, epilepsy and glaucoma (Larkin, 1995). The consequence of this and similarly restrictive practices in relation to such areas as health insurance schemes and hospital attendance in the United States (Saks, 2003a) was that CAM was increasingly heavily depleted in face of the rise of the medical profession by the mid-twentieth century – not least with the mushrooming growth of a range of limited and subordinated practitioners in orthodox health care on both sides of the Atlantic which reinforced the dominance of medicine (Saks, 1999).

Having said this, there was a resurgence of public interest in CAM both during and after the counterculture of the 1960s and 1970s (Roszak, 1970). This led to an upsurge of demand such that most members of the public in the Anglo-American context wanted selected CAM therapies more freely available by the 1980s and by the start of the new millennium in Britain one in seven members of the population were regularly visiting CAM practitioners and in the United States over four out of 10 Americans reported using CAM (Saks, 2003a). This was related to such factors as an increasing awareness of the limits of orthodox medicine, a desire to go beyond a technocratic approach to medicine centred on depersonalization and disempowerment, and a search by consumers for greater control over their own health (Saks, 2000). The upshot is that there are growing pressures from users for access to CAM therapies – including through the incorporation of CAM by the medical profession and allied health professions. This led to some moderation of the stance of orthodox medicine towards CAM, particular in its less challenging complementary, rather than alternative, forms (see, for instance, British Medical Association, 1993). It also further promoted the practice of CAM by health professions in the public and private sector – the usage of which was backed by political lobbies in both Britain and the United States, as well as by health professional bodies and government (see, for example, Cohen, 1998).

The current position outside medical orthodoxy is that, while some CAM therapists prefer solo practice to becoming part of a profession, most CAM therapies have sought professionalization of some kind. In Britain this has typically been as marginal...
professions without the statutory backing required for full exclusionary social closure (Saks, 2014 forthcoming). Thus, a number of CAM therapies currently operate with voluntary forms of self-regulation, including setting out minimum educational standards and codes of ethics. In Britain acupuncture has taken this step through the British Acupuncture Council and British Acupuncture Accreditation Board and homoeopathy has done so too through the Society of Homeopaths (Saks, 2006). In the United States sporadic state licensing for CAM practice as in the case of naturopathy is more of the norm, except in self-help contexts. Some types of CAM, moreover, have now gained systematic statutory underwriting on both sides of the Atlantic – most notably, that for osteopaths and chiropractors (Saks, 2003a). In this regard, there was earlier licensing for these CAM practices in the United States followed by the Osteopathy Act and the Chiropractic Act in Britain setting up a professional register and giving protection of title in the 1990s – bringing them more into the realm of marginalized, not marginal, professions. Moreover, the British government is currently considering setting up similar registers for herbalists and traditional Chinese medicine practitioners in light of licensing requirements in the European Union which may otherwise mean the end of such practice in Britain (Hansard, 2011).

In terms of the implications of the inequalities between groups of professionalizing and professionalized CAM practitioners and more orthodox health professions, the impact of CAM simply being a marginal profession without statutory regulation is very significant as there is less legitimacy, less private and public funding support and certainly no legal protection of title – despite attempts by relevant CAM practitioners to put in place voluntary regulation (Saks, 2006). However, even for those CAM practitioners who have gained statutory licensing and have therefore become marginalized rather than marginal professions, there are still major disadvantages in the hierarchy of more orthodox health professions. Although they do have protection of title, they share a highly restricted presence in the orthodox medical curriculum and mainstream medical journals and are rarely in receipt of official research grants – even if more research funding opportunities have opened up recently, through the National Center for Complementary and Alternative Medicine in the United States (Adams et al., 2012). Moreover, there remain legally enforced limits on the claims that can be made for treatment in both societies and in Britain the ability of CAM therapists to practise in the National Health Service is restricted – even if the ethical restrictions on medical collaboration have slackened. In the United States meanwhile only some CAM therapies qualify for reimbursement under Medicare, Medicaid and private health insurance schemes and there are often strong restrictions on such matters as referrals in state licensing for CAM – which can in itself be quite patchy from state to state (Saks, 2003a). In sum, even the few CAM occupations that have gained statutory regulation are still very much marginalized in the health care division of labour on both sides of the Atlantic – with generally negative consequences for practitioner income, status and power.

What, then, of the impact of inequalities between marginal and marginalized CAM professions and more orthodox health professions on inequalities without – namely, for clients and the wider public? There certainly seems to be a major impact on geographical access – particularly as CAM has largely been driven into the private sector with little central planning in Britain and there is sporadic state licensing in the case of some CAM therapies in the United States (Saks, 2003a). Moreover, there are associated financial barriers to access in terms of support for visits to many types of CAM therapy in a predominantly private market, in which there may in both societies be particularly significant negative effects for lower class groups in light of their ability to pay (see, for instance, Fitzpatrick, 2008). In addition, there are issues for minority groups in relation to ethnicity and gender which should not be ignored given the concentration of white males in higher positions in the dominant health professions (see, for example, Kuhlmann and Annandale, 2012) – a pattern which is interestingly also replicated in the pecking order for CAM professionalization in which the predominantly white male professions of osteopathy and chiropractic are in receipt of the greatest state support for their practice in Britain and the United States. Such inequalities in access and availability have been systematically examined by Saks (1995) in relation to the predominant rejection by the medical profession in Britain of acupuncture and the subsequent hierarchical position of medical and CAM practitioners of this therapy over many decades – which he concludes after careful scrutiny has not been in the public interest. In this respect, there are other dimensions to the public interest in liberal democracies than egalitarianism, including liberty and the general welfare – which in the case of CAM may not be best served by the often limited knowledge of CAM by orthodox health professions in referral networks and the untoward effects of positioning in the health professional pecking order on the quality of recruits to CAM practice.

Notwithstanding rising public demand for CAM, such implications become more defensible if there are major health hazards with CAM or evidence that
CAM therapies are ineffective in particular cases. In this respect, Wallis and Morley (1976) argue from a functionalist perspective that CAM has been marginalized in the health care pecking order because its therapies lack scientific evidence in comparison to orthodox medicine. However, this is not entirely credible when the conditions under which medicine first gained statutory standing as a profession are considered. When the Medical Registration Act was passed in the mid-nineteenth century in Britain, there was little to differentiate doctors from their competitors; medicine was primarily classificatory rather than curative; neither anaesthesia nor aseptic and antiseptic techniques were in use; and hospitals were associated with death (Saks, 2003a). Of course, the licensing of physicians in the United States took place some five decades later when a little more medical progress had been made and there have since been further medical advances in a range of fields, from the use of antibiotics against bacterial infections to cataract and hip surgery (Le Fanu, 2011). Nonetheless, while more systematic research may need to be conducted into CAM (Ernst et al., 2008), orthodox medicine has arguably become rather too heavily fixated on randomized controlled trials which do not fit many CAM therapies as evaluative tools and have not been applied pervasively to orthodox health care – accentuating the need for more flexibility in the use of qualitative and quantitative health research methods (Richardson and Saks, 2013).

In this light, given the threat that CAM has posed to elite and other medical interests particularly in relation to CAM therapies presented as panaceas with counter-posed philosophies to biomedicine – such as traditional forms of acupuncture based on needling underpinned by yin-yang theories and meridians (Saks, 1992) – it is difficult to believe from a neo-Weberian perspective that such interests are not a central explanation of the general orthodox medical resistance to CAM. There is in such instances a real challenge to professional income, status and power – except of course when incorporation is an attractive option for orthodox health professionals in the marketplace where non-threatening CAM opportunities exist. These circumstances apply when, for instance, CAM is adopted within medical orthodoxy in limited form to enhance private practice for generalists or provide innovative career profiles for more established medical specialists – as in the case of consultants adopting formula acupuncture to treat specific conditions based on neurophysiological explanations of its *modus operandi* (Saks, 1995). It should be stressed, though, that the incorporation of CAM by orthodox health practitioners does not significantly mitigate the exacerbation of inequalities through the marginalization of CAM in health professional hierarchies because such practice is typically more restricted and usually based on much shorter training as compared to that undertaken by non-orthodox CAM practitioners themselves (Saks, 2003a).

### Conclusion

In conclusion, the review of the literature undertaken here suggests that inequalities between the professions as illustrated in the case study of CAM – and facilitated by the concepts of marginalized and marginal professions outlined – seem to have had a substantial impact in exacerbating such external inequalities as those based on geography, class, gender and ethnicity in both Britain and the United States, especially in relation to access to services for individual clients and the wider population. At a time when governments are more sensitive than ever to the principles of equality and diversity, it is therefore very important that they are alive to the policy implications of the hierarchical professional designations of the workforce, including the impact of sanctioning different relational forms of social closure in the health field and elsewhere. Following on from this review, additional research from a neo-Weberian perspective would be very helpful in health and other professional domains to understand more fully the implications of inequalities and marginality between professional groups – in a complementary way to the further study of inequalities within particular professions. This would be most apposite at a time when much of the sociological literature to date has focused more on ‘top dog’ rather than middle and lower order professions and has not always sufficiently considered their roles in the context of the wider occupational division of labour. This is critical not only in terms of the responsiveness of professions to clients, but also in relation to the broader public interest. As this contribution indicates in highlighting the need for further research in this area, currently the ideologies of professional groups may not be appropriately representing their activities to government and the wider community in terms of the impact of their hierarchical interrelationship on societal inequalities.

### Annotated further reading


This edited volume is significant because it illustrates...
well one dimension of inequality in relation to the health professions, their clients and the wider public – bringing together contributions from authors on gender and health care in a range of international contexts.


This book provides a useful overview of various theoretical perspectives on professions and the operation of a wide range of professional groups in the stratification system, drawing on studies of professions in Britain, the United States and Western Europe.


This book is important because it covers the integrated history of orthodox and alternative medicine in Britain and the United States over the past 500 years – examining dynamically some of the key issues of marginality and inequality amongst the health professions.


This article is helpful as it comprehensively explores the nature, strengths and weaknesses of the neo-Weberian approach to the Anglo-American sociology of the professions adopted here – as well as its comparison to other theoretical perspectives on the professions.

References


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Les idéologies professionnelles, lorsqu’elles relèvent des missions de service public, prônent généralement le combat des inégalités parmi les usagers à titre individuel et/ou sein de la population. Les sociologues des professions dans le contexte anglo-américain se sont penchés sur la question de savoir dans quelle mesure cet engagement est honoré. Cette contribution offre toutefois une revue de la littérature sur les inégalités entre les groupes professionnels dans une perspective néo-Wébérienne, en ayant recours au concept de marginalité et se focalisant sur le secteur de la santé. En faisant spécifiquement référence au cas de la médecine complémentaire et alternative, on souligne que la recherche future doit se centrer davantage sur la façon dont cela se répercute sur les inégalités en dehors des catégories socioprofessionnelles.

mots-clés

índice 8

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resumen

Las ideologías profesionales vinculadas con el ejercicio de funciones de servicio público abogan por el combate de las desigualdades entre los usuarios a título individual y/o el público en general. Los sociólogos de las profesiones en el contexto anglo-americano han analizado hasta qué punto se verifica este compromiso. Esta contribución brinda no obstante una revisión de la literatura sobre las desigualdades entre los grupos profesionales desde una perspectiva neo-weberiana, apelando al concepto de marginalidad y centrándose en el sector de la salud. Haciendo particular referencia al caso de la medicina complementaria y alternativa, se destaca que la investigación futura deberá focalizarse sobre todo en la manera que esto influye sobre las desigualdades al margen de las categorías socio-ocupacionales.

palabras clave

desigualdades, marginalidad, medicina complementaria y alternativa, neo-weberianismo, profesiones, salud