The International Encyclopedia of Health Communication

Article Template

Article title: Health Occupations/Professions

First author: Full name and affiliation; plus email address if corresponding author
Joshua B. Barbour, PhD, University of Texas at Austin; barbourjosh@utexas.edu*
Second author: Full name and affiliation; plus email address if corresponding author
Casey S. Pierce, PhD, University of Michigan
Third author: Full name and affiliation; plus email address if corresponding author
Shelbey L. Rolison, MA, University of Texas at Austin

Word Count

2,738 words (main text, cross-reference list, references, and further readings)

Abstract

Health communication scholars investigate health occupations and professions to provide recommendations that benefit workers and their constituents. This research spans clinical, administrative, governmental, and technological contexts of work. Health work exists within and in response to broader institutions of control, and communication helps bridge, define, and push back on its relationship to them. This entry provides a summary of how health occupations and professions have been studied within health communication scholarship. Studies of health workers have focused especially on work in clinical settings, particularly on how membership in, attachment to, and beliefs relevant to occupations influence their work. Although much healthcare work and especially those occupations studied by health communication scholars are generally considered professions, studies have also illuminated professionalizing processes in which workers negotiate and defend its claims to specific knowledge, what counts as the work of the occupation, and the occupations' legitimacy. Research topics include the connections between occupational and organizational processes, professional identity and identification, occupational and professional outcomes, interprofessional communication, and the influence of occupational factors in technology and organizational change processes. A principal contribution of health communication research to studies of health occupations and professions is the attention it dedicates to meaning-making processes that shape work, identity, professional relationships, health outcomes, and life beyond the job.

Keywords

occupations, professions, professional identity, interprofessional communication, patient-clinician interaction

Main text

The study of health occupations and professions is a vibrant and important domain of health communication scholarship. Health contexts provide rich examples for the study of work. Health occupations are important because they can be stressful and hazardous for workers and because of the high-stakes outcomes of the work. More specifically, health occupations provide particularly robust exemplars for the study of professions, professionals, and professionalizing, and health communication scholars have a particular interest in health occupations because so much of the work is communicative.

An occupation is a category or field of work. As an indicator of the sheer scale of activity in the sector, the World Health Organization (WHO) (2019) estimated that spending on health accounted for approximately 10% of the global gross domestic product (GDP) or US$ 7.8 trillion. Spending growth in health has outpaced GDP growth since 2000 and is likely to continue apace. Taking an expansive view of what counts as a health occupation suggests that the WHO data are likely conservative indicators of the range and magnitude of important work related to health (see Table 1).

Occupational and Organizational Interface

The lists in Table 1 are not an exhaustive of all health occupations, and the categorizations of particular occupations as (a) patient-facing or caregiving-focused and (b) inside or outside clinical settings are also imperfect. A registered nurse may work in a hospital or school or another non-clinical context. They may begin their careers in a patient-facing role and leave it to work in administration while retaining attachments and beliefs born of being a nurse. Nonetheless, it illustrates just how many occupations are health related. Because so many of the examples involve communicating with those in need of care, the table also makes clear the centrality of communication for health occupations and the importance of occupational context for health communication. In this context, laws and regulations help define the scopes of practice, licensing, education programs, tasks, responsibilities of health occupations, and the communication involved. Research has often examined the relationship between occupational and organizational contexts as related but distinct. For example, Apker et al. (2020) found that primary care physicians' role engagement depended on working conditions such as communication with patients, interactions with health leaders, and often draining experiences with electronic health records and patient portals, and they argued for the urgent need to intervene in these conditions to address burnout, turnover, and workforce shortages.

The list in Table 1 also makes clear how many health occupations may be considered professions. Clinical health occupations—particularly occupations involving the medical treatment of patients—may be the most frequently studied domain of professional work, such that research on health, especially physicians and nurses, has underwritten the study of professions, professionalism, and professionalizing in general. Professions are institutionalized occupations "characterized by formalized beliefs that specify and emerge from established practices transcending particular workplaces" (Lammers &

Garcia, 2009, p. 358). All occupations are professionalizing or rejecting professionalization in the sense that all occupations orient to circulating, macrosocial notions of what work ought to entail (Dean et al., 2016). Professions articulate who may be a member, what is in and outside of the boundaries of the knowledge and practice of the profession, and professions influence and are influenced by organizing in which work occurs. More established professions may be distinguished by the degree to which they involve "(a) knowledge providing, seeking, and sharing; (b) self-management of behavior, emotions, and productivity; (c) internal sources of motivation; (d) a service orientation; (e) the invocation of field standards; and (f) participation in a knowledge community beyond the workplace" (Lammers & Garcia, 2009, p. 366). To study occupations as professions is to focus on the occupation's development and effects in and beyond the workplace.

[A] Professional Identity and Identification

Health, communication scholarship has also focused on professional identity and identification and their implications for health work. This research centers on trying to understand how workers come to understand and enact what it means to do work well and the implications of that meaning making for the definition of self and workers' attachment to and beliefs about the work. Health communication scholars have studied the socialization processes of health workers as key to the development of professional identity. That research has included studies of clinician education and training, professional identification over the lifespan, and the influence of institutionalizing entities such as the legal, insurance, and contractual arrangements that influence healthcare work and boards and trade associations that shape the professions. For example, in the United States, such organizations would include the American Medical Association, the American Association of Medical Colleges, the boards that oversee the certification in specialties, and the Accreditation Council of Graduate Medical Education (Lammers & Proulx, 2016).

Furthermore, communication researchers have examined particular communication practices that contribute to professional socialization. Those practices may include the use of work objects and artifacts that signal status and role, such as the proverbial white coat representing physicians' position in the medical hierarchy or the psychologist's iconic couch symbolizing the history of the psychoanalytic process. Apker and Eggly (2004) studied the "morning report," meetings wherein resident physicians "discuss diagnoses and approaches to patient care in front of an exclusive audience of departmental faculty physicians, peers, and invited guests" (p. 414). During these conversations, participants performed what it meant to be a professional just as they did when interacting with patients or administrators. Apker and Eggly found that the morning report contributed to professional identity formation and socialized an ideology of the profession of medicine that held that physicians should control the flow of topics in interaction, convey the science of medicine while minimizing other concerns, and act with authority over other professionals and patients. Efforts to expand the work of medicine to encompass not just biological but also contextual factors has focused on socialization processes in particular.

Health communication scholars have also studied the professions of medicine relative to other domains of work and the professionalizing of health occupations with an emphasis on power dynamics. For example, Norander et al. (2011) studied osteopathic medical students' accounts of their identity finding that they argued for the legitimacy of osteopathy by focusing on specific, distinctive practices such as being hands-on. Indeed, research has focused the negotiation of competing hierarchies in health communication, hierarchies based on (a) tenure and rank such attending, fellow, and resident physician, (b) educational and certification differences embodied in the competing perspectives of registered nurses, nurse practitioners, social workers, and doctors of philosophy, psychology, or medicine, and (c) domains of practice such as medical versus administrative leadership in health organizations. Much research has also focused on the imposition of managerial logics and concerns about the costs of healthcare as inconsistent with the emphasis on caregiving in health professions and as undermining the power of health professions to dictate how they work and to what ends.

[A] Occupational/Professional Outcomes

The broad interest in health occupations has been motivated not just by an interest in professional identity and identification for their own sake but also because of their important effects on health. For example, health communication scholars have paid particular attention to stress and burnout experienced by health workers. Their work is stressful in part because the communication required of health workers can involve complex information management and meaning making, difficult emotional work, and time pressures for interaction. For example, health workers deliver difficult news, grapple with life-or-death decisions, provide emotional support, and communicate during emergencies; all of which require stressful, emotional management. Thus, research focused on cultivating communication skills such as empathy is an important focus in the study of health occupations. For instance, research has found that communication that is responsive to emotions without feeling emotions vicariously can insulate workers from burnout (Miller et al., 1995). A robust professional identity can also buffer against the difficulties of day-to-day work because it offers a mechanism for meaning making that transcends local, organizational constraints.

Additionally, health communication research has focused on the influence of occupational factors on important patient health outcomes. Identity work can have implications for how health professionals communicate and for related health outcomes. For example, Lu and Guan (2018) examined how changing societal beliefs about the nature of healthcare also involved changes for relationships between clinicians and patients including the erosion of notions of implicit trust in clinicians. Their findings echoed similar results across contexts where market, consumer, and managerial imperatives have challenged and eroded the dominance of established medical professions and raised concerns about negative effects on patient clinician relationships and, by extension, health outcomes.

Health communication research has also documented the influence of professional dynamics on patient-clinician interaction in general as well as other important communication processes. For instance, much attention has focused on patient handoffs across professional groups or across shifts. Beliefs about how work should happen grounded in professional mores can complicate health work and make it more difficult because of such differences and also because of differences in the power of professional groups relative to each other.

[A] Interprofessional Communication

The proliferation of health professions and the growing and diverse knowledge base required for work in health has also coincided with the growth of healthcare teams and team-based, collaborative approaches to health—inspiring the study of interprofessional work in health. This research joins a long interest in the dynamics among physicians and nurses, and other important interprofessional relationships such as pharmacists and prescribers and specialists and referring clinicians. Hospice care settings have proven a particularly important site for the study of interprofessional dynamics because the dominant models of caregiving include multiple professions. Health communication scholars have also developed interventions focused specifically on helping teams. For example, Goldsmith et al. (2015) tested the efficacy of their COMFORT curriculum for physical therapists. The curriculum aims to bolster the narrative sensibilities and skills of clinicians, and it includes an explicit focus on managing team dynamics. The effectiveness of communication strategies that support interprofessional work depend on understanding professional commitments and belief systems and differences among them. Effective interprofessional communication empowers health workers' navigation of differences grounded in professions.

[A] Health Professions, Technology, and Organizational Change

Last, health communication scholars have also tried to understand technology adoption, use, and effects as influenced by and influencing health work. Occupations are embodied and performed through the spaces and tools of work. The adoption and use of technologies reflect power differences among professional groups, and because professions have greater power in the workplace, they can exert greater influence over organizational change processes. At the same time, the adoption of new technology can also involve the renegotiation of professional identity and power balances among professions. For example, Barrett (2018) examined health workers' resistance to the implementation of electronic health records (EHRs) and found multiple differences among professional groups. The pushback on EHRs could be explained in part but not completely by the shortcomings in their design and implementation. Health workers are nearly universal in their criticisms of EHRs and with good reason, but reactions to technologies may also reflect reservations about how technologies reconceive or undermine the profession. Health communication scholarship focused on technology adoption, use, and effects and health occupations joins a rich tradition of allied research in organizational and information studies (e.g., Kellogg, 2011). Advances in data collection and analysis, machine vision and machine learning, and robotics have

widened the possibilities for the automation and augmentation of healthcare work. These advances and the pressing need to address the shortcomings of health information communication technologies such as EHRs have heightened the importance of questions of technology and organizational change in health contexts and the professional dynamics involved.

[A] Future Directions

Future communication research focused on health occupations and professions will need to understand changes to healthcare work, the emergence of new occupations, and the transformation of existing ones. For example, the augmentation and automation of health work may bolster health occupations by supporting their work and opening up more time for caring. However, professional identity, the time pressures on health work, and the organization of caregiving also contribute to the time devoted towards communication. Automation and augmentation will likely complicate these dynamics and affect health occupations in ways that are difficult to predict. Likewise, whereas much research to date has focused on the gendered nature of health occupations, future research will need also to make sense of how other forms of difference intersect with occupational dynamics. Health workers' professional status as experts in society may be changing as well. As research examines the changing nature of health occupations, perennial questions about professional identity, stress and burnout, and the implications of occupational dynamics for patients will continue to be key.

References

Apker, J., Brim, L., & Isacksen, R. (2020). Exploring workplace communication contributors to primary care provider experiences of role engagement. *Health Communication*, 1–11. https://doi.org/10.1080/10410236.2020.1751382

Apker, J., & Eggly, S. (2004). Communicating professional identity in medical socialization: Considering the ideological discourse of morning report. *Qualitative Health Research*, *14*(3), 411–429. https://doi.org/10.1177/1049732303260577

Barrett, A. K. (2018). Electronic health record (EHR) organizational change: Explaining resistance through profession, organizational experience, and EHR communication quality. *Health Communication*, *33*(4), 496–506. https://doi.org/10.1080/10410236.2016.1278506

Dean, M., Gill, R., & Barbour, J. B. (2016). “Let’s Sit Forward”: Investigating interprofessional communication, collaboration, professional roles, and physical space at EmergiCare. *Health Communication*, *31*(12), 1506–1516. https://doi.org/10.1080/10410236.2015.1089457

Goldsmith, J., Wittenberg-Lyles, E., Frisby, B. N., & Platt, C. S. (2015). The entry-level physical therapist: A case for COMFORT communication training. *Health Communication*, *30*(8), 737–745. https://doi.org/10.1080/10410236.2014.898014

Lammers, J. C., & Proulx, J. (2016). The role of professional logic in communication in health care organizations. In T. Harrison & E. Williams (Eds.), *Organizations, communication, and health* (pp. 13–30). Routledge.

Miller, K. I., Birkholt, M., Scott, C., & Stage, C. (1995). Empathy and burnout in human service work: An extension of a communication model. *Communication Research*, *22*(2), 123–147. https://doi.org/10.1177/009365095022002001

Norander, S., Mazer, J. P., & Bates, B. R. (2011). “D.O. or Die”: Identity negotiation among osteopathic medical students. *Health Communication*, *26*(1), 59–70. https://doi.org/10.1080/10410236.2011.527622

Tang, L., & Guan, M. (2018). Rise of health consumerism in China and its effects on physicians’ professional identity and the physician–patient relationship and communication. *Health Communication*, *33*(5), 636–642. https://doi.org/10.1080/10410236.2017.1290015

World Health Organization. (2019). *Global spending on health: A world in transition*. https://www.who.int/health_financing/documents/health-expenditure-report-2019.pdf

Tables

Table 1. Examples of health-related occupations across care delivery and organizational contexts

Connections to care delivery	**Organizational context**	**Examples of Health Occupations**
Patient-facing / caregiving-focused occupations	Clinical sites of care where medical treatment is delivered to patients (e.g., hospitals, pharmacies, clinics)	dental assistants and hygienists, dentists, diagnostic medical sonographers and cardiovascular technologists and technicians, dietitians and nutritionists, emergency medical technicians and paramedics, genetic counselors, licensed practical and licensed vocational nurses, medical assistants, medical records and health information technicians, medical transcriptionists and scribes, nurse anesthetists, nurse midwives, nurse practitioners, nursing assistants and orderlies, occupational health and safety specialists and technicians, occupational therapists and assistants, opticians, optometrists, orthotists and prosthetists, pharmacists and pharmacy technicians, phlebotomists, physical therapists and assistants and aides, physician assistants, physicians and surgeons, podiatrists, psychiatric technicians and aids, radiation therapists, radiologic and MRI technologists, registered nurses, repertory therapists, speech and hearing pathologists, and surgical technologists, hospital chaplains
	Non-clinical sites of care where no medical treatment is delivered to patients (e.g., hospice, schools, community	athletic trainers, exercise physiologists, art and music therapists, audiologists, chiropractors, clinical laboratory technologists and technicians, community health workers, home health and personal care aides, massage therapists, recreational therapists, health/sport coaches, health teachers, social workers

	centers, patients' homes)	
Occupations that support caregiving	Administrative	hospital administrators and staff, legal, science communicators
	Governmental, Public	public health information officer, regulators and staff in governmental health agencies, policy makers, epidemiologists
	Payer, Insurance	health insurance professionals, actuaries
	Technology, Vendors, Suppliers	nuclear medicine technologists, UX/UI designers for health consumer technologies, EMR/EHR software developer, pharmaceutical sales representatives, biomedical scientists and researchers

Further Reading/Resources

Abbott, A. D. (1988). *The system of professions: An essay on the division of expert labor.* University of Chicago Press.

Apker, J. (2012). *Communication in health organizations*. Polity Press.

Harrison, T., & Williams, E. (2016). *Organizations, communication, and health*. Routledge.

Kellogg, K. C. (2011). *Challenging operations: Medical reform and resistance in surgery*. University of Chicago Press.

Lammers, J. C., & Garcia, M. A. (2009). Exploring the concept of "profession" for organizational communication research: Institutional influences in a veterinary organization. *Management Communication Quarterly*, *22*, 357–384.

Contributor Bios

Joshua B. Barbour, PhD, is an associate professor of communication studies in the Moody College of Communication at the University of Texas at Austin. His research centers on the confluence of the macromorphic and communicative in organizational life. He studies the design and disciplining of communication to solve organizational problems. His work has appeared in *Communication Monographs*, *Management*

Communication Quarterly, the *Journal of Applied Communication Research*, *Health Communication*, and the *Journal of Health Communication*.

Casey S. Pierce, PhD, is an assistant professor at the University of Michigan School of Information. Her research focuses on the changing nature of work as it relates to technology, policy and knowledge sharing in organizations. In this line of research, she has examined offshoring work arrangements, the role of technology in U.S. healthcare policy implementation and new forms of digital labor in mental healthcare. Her work has appeared in *Journal of Communication, Information Systems Research,* and *Journal of Association for Information Science and Technology.*

Shelbey L. Rolison, MA, is a doctoral student of communication studies in the Moody College of Communication at the University of Texas at Austin. Her research focuses on personal health data tracking, the communication that supports it, and its implications for articulating health narratives, improving health outcomes, and navigating an increasingly datafied world. Her work has appeared in *Management Communication Quarterly* and in *Organizing Inclusion: Moving Diversity from Demographics to Communication Processes.*

This material is based upon work supported by the National Science Foundation under Grant No. SES-1750731.

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