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Continuity, capture, network: The professional logics of the organization of care

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Abstract

Cooperation in medicine, as in all group activity, is a key problem both for the actors involved and for sociologists. Classical studies in the sociology of health and medicine are moreover of little help in conceptualizing this problem. While arguing against the idea that affiliation with an institutional structure – such as a part of a professional segment or an area of expertise – determines relations between actors, our analysis seeks to move beyond the description of what is presented as being purely contingent. To understand phenomena related to cooperation and conflict, it is possible and worthwhile to distinguish between professionals according to their position in the therapeutic chain and their form of involvement in the strategy of care. Cooperation is based, in particular, on the match between “acquisitive” professionals who feel it is their duty to coordinate medical care and follow-up on a patient throughout the healing process, and other professionals who see their intervention as being limited to one phase in the therapeutic itinerary.

Keywords: Cooperation; Organization; Referral; Conflict; Network; Cancer; Addiction; Health; Sociology of professions; Sociology of organizations; Sociology of health

Medicine is a collective activity.¹ With clinical and scientific progress as well as professional and organizational specialization, we have come a long way since the time when medical care could be described as the unpredictable encounter between one or several physicians and a person at home, ignorant and helpless in front of the all-powerful expert (Starr, 1982). Not only is clinical practice today based on collectively accumulated, shared and validated knowledge and

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know-how² (Cambrosio et al., 2006; Foucault, 1963; Freidson, 1988 [1970]) but the patient's care network consists of countless activities and tasks accomplished by many actors. It is not infrequent to hear the industry-inspired analogy "therapeutic chain" used to describe a complex assemblage of interventions and professionals. Therefore, as in all group activity, cooperation between actors "who each preserve a degree of autonomy and pursue not necessarily convergent interests" (Friedberg, 1993: 352) represents a central problem for the actors involved as much as for the sociologist studying them.

The problem is all the more remarkable as taking care of a patient is not supposed to conform to a hierarchal type of organization. In the first place, medical care is rarely delivered in a single healthcare organization with all sorts of professionals functionally interconnected and cooperating according to a preestablished plan. On the contrary, for one and the same health problem, patients shuttle between neighborhood doctor and hospital, general practitioner and specialist, and/or between various hospital services that have managed to preserve a large degree of autonomy. In France, despite recent attempts at regulation aiming to prestructure the care trajectory (primary provider, health network, care network, etc.) (Bercot and de Koninck, 2006; Cresson et al., 2003), the care received and the morphology of itineraries observed are still largely the product of essentially endogenous negotiations and organization. Finally, and above all, the project manager masterminding the patient's support structure – the professional who designs, decides and orchestrates the full course of events – is not appointed at the outset.³ In short, it is not easy for individuals entering the health system to imagine the form their itinerary will take, the institutions, systems, and professionals that will be involved, or the types of care they will receive, because several treatments are generally available for the same health problem. It therefore seems essential, when a patient is taken on, to understand how the division of labor will be determined concretely, how it will be organized, and what the logics underpinning its functional distribution might be; why certain medical, paramedical and social professionals will collaborate with certain specialists rather than with others; and how that which is recognized as a care network emerged in the first place. In other words, it is important to grasp the mechanisms underlying this more or less large and specific self-organization and network structure.

As we shall see in detail further on, existing research yields no completely satisfactory answer to these questions: not only have they hardly been explored empirically by the sociology of the health professions, but above all, the few studies dedicated to the dynamics of cooperation and conflict in the field of health do not allow us to account fully for our own findings.

Comparison of three very different types of support structure – for cancer, drug addiction and alcohol dependence – has led us to challenge the notion that the nature of relations between professionals is directly – and almost exclusively – determined by institutional variables such as

² Which, as we shall see, does not prevent controversy, disagreements and more generally a difference in approach concerning the treatment of health problems.

³ The recent reform making a primary provider mandatory sought to give French general practitioners (GPs) first say in guiding the patient through the healthcare system. However, not only did the unions obtain the right for specialists acknowledged by the French social security system to also be able to fulfill that role – a first rift in the reform – but, on top of that, the reform does not stipulate who is responsible for clinical decisions. Similarly, as Magali Robelet, Marina Serré and Yann Bourgueil point out, general practitioners have barely provided the functions of coordination that they are supposed to in gerontology and palliative medicine networks. Their hypothesis is that such functions are devalued because considered as mere auxiliaries to the prestigious role of the clinician. They also have a complementary hypothesis, that GPs remain dependent on the expertise of their colleagues specialized in the given pathology (Robelet et al., 2005).

the type of healthcare organization they work for, the formally organized cooperation between healthcare organizations, or being part of a segment, a specialty or more generally a group of professionals. The analytical framework we are proposing also seeks to go beyond the conclusions of other researches that have concentrated mainly on the phenomena of cooperation claimed to be strictly contingent, i.e. each time unique, so that no analysis can totally detach them from their particular historical fabric. Our intention is not to devise a general theory of professional cooperation between actors in the field of healthcare; much more modestly, we would like to cast some light on the mechanisms that prevail when cooperation networks between partners associated in the patient support system are created. Thus, we defend the idea that it is worth distinguishing between professionals according to the position they occupy in the therapeutic chain and their type of commitment in the care trajectory; thus, between those professionals that we have dubbed “acquisitive” (“captants”) – because they aim for a central role in decisions concerning treatment and consider it their responsibility to provide or organize each step of the cure alone – and those we have dubbed “non-acquisitive” (“non-captants”) – because they feel, on the contrary, that their participation is limited to one stage of the therapeutic itinerary only. This is one of the main distinctions that allows us to grasp the dynamics of matching⁴ and the phenomena of cooperation and conflict between partners throughout the therapeutic chain.

1. Settings and methods

Cancer and drug and alcohol addiction are all pathologies or disorders that constitute long-term health problems potentially involving different medical specialties and several professionals.⁵ But apart from that, the characteristics and etiology of these illnesses, as well as the specialists intervening and the types of structures potentially involved, present sufficiently different starting points to hopefully make the comparison heuristic and allow us to draw more general conclusions.

In the case of cancer, there are many types of interventions and structures. Aside from the medical tests done by clinicians, the main specialists involved in the diagnosis are radiologists, pathologists or specialists of nuclear medicine. The three main “therapeutic weapons”

⁴ Though our way of thinking is related to Pierre-Michel Menger’s (Menger, 1994, 1997) when he studies “the match” between participants in artistic productions, major differences prevent us from extending his analysis to the realm of healthcare. First of all, links between healthcare professionals in France are neither like a contract nor, as in artistic production, part of a single project; they are informal and recurrent. Above all, the relation between professionals and a patient’s care network is not a question of employment. We do, however, maintain the term “match” in the rest of our text, for it expresses well the bilateral nature of those relations, the idea of choice (even if constrained) among protagonists who decide to work together, and the idea of associating actors whose work logics are compatible.

⁵ Some of the conclusions presented here were first developed in a previous research report (Bergeron, 2003) based on material collected during a large study financed by the French Observatory on drugs and drug addiction (*Observatoire français des drogues et toxicomanies*, OFDT) and carried out with students of the Sociology of Action Master’s program at the *Institut d’études politiques* of Paris (class of 2001). Other publications in the fields of drug and alcohol addiction have appeared (see esp. Bergeron, 1996, 1999). We wish to thank all our research partners warmly for their contribution to this article. It should also be noted that results are based on studies done before or at the time that in-depth reforms aimed in particular at coordinating structures for the treatment of drug addiction and alcohol dependence were being set up. However, we feel that these transformations do not basically change the grounds and relevance of the generic analytical framework we propose here (i.e. that extends beyond the case of these two fields). As regards cancer treatment, its organization and recent trends were studied thanks to the support of the National Federation of Cancer Research Centers (1999–2002), and of the cancer network ONCOR (2003–2007) (see in particular Castel, 2005, 2007; Castel and Friedberg, 2010).

against cancer are surgery, radiation therapy and medical treatment (essentially chemotherapy, immunotherapy and hormone therapy) (Pickstone, 2007). There are many specialties involved when prescribing and implementing treatments: organ specialties (in particular gastroenterology, dermatology, lung specialists), surgical specialties (urology, gynecology, pulmonary surgery, otolaryngology, etc.) and oncology (medical oncology,⁶ radiation therapy, cancer surgery). Depending on their qualifications, certain surgeons and radiation therapists can also be authorized to prescribe medical treatments. Very often these individuals are not all employed in the same structure: they may be working in an office, a clinic, a service in a hospital of the public sector or a cancer research center. Twenty such private organizations, some of them founded as early as the 1920s, participate in the French public hospital system. Their mission includes teaching, healing and research.

As the scope of this article does not allow us to present separately the treatments for drug addiction and alcohol dependence, which differ in many respects, we will stress what they have in common. Both can lead to two sorts of intervention: those that aim to vanquish the supposed causes (known as the cure) and those whose main objective is to reduce the health consequences linked to the addiction. Caring for addiction (whether to alcohol or illicit drugs) supposes combating physical and psychological dependence. Treating psychological dependence begins once the patient's withdrawal has succeeded. Several types of therapeutic techniques are then available: ambulatory psychological or psychosocial follow-up, therapeutic community, etc. In the case of addiction to opiates, substitution treatments exist as well. Other more palliative treatments are also available to reduce the deleterious effects of addictive behavior (deterioration of health conditions, contamination by the HIV virus in the case of injected drugs, septicemia, abscesses, etc.). These are public healthcare practices known as "risk reduction". Caring for alcoholics and drug addicts involves a long line of different specialists who all, theoretically, can claim a central role in organizing the patient's treatment: drug rehabilitation centers (psychologists, psychiatrists, doctors, social workers, etc.), hospital withdrawal facilities, psychiatric sectors, post-cure centers, methadone distribution centers, former addicts' associations, structures for risk reduction, etc. Very few organizations can offer all the required therapies at once and meet all the needs of all the patients. Most often, care is the result of more or less successful coordination and cooperation by a wide variety of partners whose beliefs and therapeutic techniques differ or even clash.

These two fields of research⁷ were compared a posteriori by applying a conceptual framework with a common denominator⁸ and a comparable method, borrowing techniques from the sociological analysis of organized action (Crozier and Friedberg, 1980; Friedberg, 1993). The method prioritizes semi-structured interviews in order to comprehend what is mainly at stake in the actors' activity, and who the other actors are with whom they communicate in their work, so as to understand and qualify the nature of their relations. This enables us to determine what brings them together and what divides them.

⁶ Medical oncologists are specialized in the medical treatment of cancer.

⁷ Some of the main conclusions presented here were originally reached in the fields of drug addiction and alcohol dependency (Bergeron, 2003). The fact that similar conclusions were also drawn in the field of cancerology (Castel, 2005, 2007), without direct reference to previous research, led us to review our data, compare our fields systematically and undertake the present investigation.

⁸ Other theoretical perspectives enriched each of these research programs but both were placed in a perspective inspired by Weber's comprehensive sociology of action.

2. How can professional cooperation in healthcare delivery be accounted for?

Few of the studies carried out in the sociology of health or the sociology of professions fully account for processes which, in the cases we examined, presided over the concrete organization of healthcare delivery and created dynamics of cooperation and conflict between professionals at the time of the patient's referral and of the planning, implementation and monitoring of the treatment.

In the first place, few empirical studies have addressed these questions in any detail. To take only two symbolic examples, it is noteworthy that (informal) networks of physicians occupy only five pages in Eliot Freidson's seminal work on the medical profession (*Profession of medicine*, Freidson, 1988 [1970]: 192–7). It is equally significant that, in their analysis of the negotiated order in hospitals, Anselm Strauss and his colleagues explicitly chose to concentrate not on relations between medical professions but rather on the capacity of lay people and paramedical workers to influence that order (Strauss et al., 1963). Secondly, and more fundamentally, those who did examine these dimensions came to conclusions that remain in part unsatisfactory. Without claiming to cover the field in full, we can outline three bodies of analysis.

A first series of authors interpreted the collective struggles between relatively homogeneous sub-groups inside the medical profession as the main explanation for the difficulty to cooperate that professionals experience. Specialties – a specifically medical notion often adopted by sociologists (Pinell, 2005; Weisz, 2005) – and their basic characteristics, at the root of endogenous differentiation, thus theoretically (for these authors) overdetermine the organization of the local patient care network and therefore the mechanisms, supposed more than observed, of cooperation and conflict between concerned professionals (Faure, 2005; Halpern, 1992; Pickstone, 2007; Pinell, 2005). Yet our research shows many cases of conflict and cooperation perfectly independently from the collective competition and rivalry between specialties or professional segments or groups. Symmetrically, having the same specialty and belonging to the same segment or professional group does not, according to our research results, offer the guarantee of full cooperation either. In the field of cancer, we encountered oncologists, for example, working harmoniously with organ specialists while considering themselves the rivals of professionals who belong to the same specialty. The same was observed in the case of patient care networks for drug addiction and alcohol-dependence: we sometimes noted that in certain towns, former alcoholics organizations, for example, worked in harmony with “their” out-patient neighborhood center at the hospital, which was not the case in other towns. In the final analysis, giving priority to the specialty (or to any other form of professional training) as being the independent variable does not allow one to account for the diversity of local situations in the division of labor among specialties, institutions and professionals.

Other authors – sociologists (e.g. Bercot, 2006; Schweyer, 2005) as well as professionals – consider that the key to good cooperation between health professionals lies in sharing similar beliefs concerning “good” care. Once again, our fieldwork in very different places shows that actors with widely diverse convictions concerning therapeutic strategies for a given pathology, or for a given patient, manage to cooperate, while others with similar perspectives are, on the contrary, in conflict, in stages of avoidance or more generally non-cooperation. For instance, psychologists in different healthcare centers, who share similar beliefs about what is done and not done in matters of therapy, in a field where cognitive and axiological disagreements between professionals are extremely strong – between psychoanalysts who refuse to prescribe psychotropic drugs, for example, and doctors who have a more biological explanation for the genesis of drug addiction – manage to cooperate only with difficulty.

Conversely, professionals who do not necessarily share beliefs about care at any given time in a patient's itinerary may agree, sometimes tacitly, on compatible versions of their activity. Such forms of cooperation have been found⁹ in the field of drug addiction among "risk reduction" teams who felt that social and sanitary work – finding a place to live, taking care of infections, etc. – with drug addicts in very deteriorated medical and social conditions had to be dealt with first; and, on the other hand, psychotherapists of psychoanalytical leanings who thought that offering immediate sanitary and social assistance would be reproducing the "logic of emergency" in which drug addicts were already trapped. The normative and cognitive conflicts that opposed the two did not prevent them from defining territories where they could see eye to eye and carry out their different interventions without too much trouble. The same sort of analysis can be applied in the field of cancer, where schematically two conceptions of care compete: organ vs. pathology (Castel and Friedberg, 2010; Pinell, 1992). While organ specialists very often collaborate with cancerologists (whether they are radiation specialists, promoters of medical treatment or surgery), cases where cancerologists or organ specialists feel they are in competition or in conflict among themselves are also extremely frequent.

A third and very different theoretical perspective is the interactionist one in research by A. Strauss and other authors following the same line of thinking (Baszanger, 1986; Ménoret, 1999). It does not explicitly or directly link the organization of patient care networks and the matching dynamics between health professionals to the structuring into professional segments, that A. Strauss himself, with Rue Bucher, had already highlighted (Bucher and Strauss, 1961). Rather, the conclusions of their research reveal the existence of a local and contingent "negotiated order", in which the various actors in medical care interpret and adjust in real-time to suit the expectations of the others involved, and to adapt to the hazards of the patients' care and diseases. For many interactionists, conflicts and cooperation are in fact grounded in the conditions of constantly renewed professional interaction, to the point that looking for factors that determine or circumvent the specificity of the immediate local conditions of their implementation is deemed to be, if not illegitimate, then at the very least misleading. Of course, as we have seen, the specialty of the professional in charge of the initial therapeutic plan and of referring patients to other professionals – and therefore the form that the organization of labor among professionals will take – varies in the case of cancer as well as for drug or alcohol addiction, and these observations seem compatible at first view with an analysis in terms of negotiated order. Nevertheless, it would be risky to conclude that organizing the patient care network, and the professional cooperation related to it, are completely unstable social constructs, constantly renegotiated in the course of an eternally renewed interaction. Once again, our research results uncover stable forms of relations between care partners. As Florent Champy puts it: "the order of the interaction is not questioned anew every time there is a hitch in cooperation" (Champy, 2009: 111).

In fact, whether for cancer, drug addiction or alcohol dependence, relations between professionals are most often of long duration. All the persons intervening, when asked, are able to mention a certain number of privileged partners, often called "correspondents" or "referees", with whom they collaborate on a regular basis, reciprocally referring patients or requesting something in the framework of the organizational routines and protocols repeated for each new case.

⁹ We use the past tense here as this type of cognitive conflict has tended to quieten down over the last ten years. But the outdated historical character of the heart of the matter does not do away with the principle underpinning the development of cooperation, which is what we wish to stress here.

3. Elements of professional differentiation: types of patients, position and commitment

Few studies have concentrated on differentiating between professionals according to their standpoints and the position they choose to occupy along the therapeutic chain, including the various professional commitments associated with that position. Yet, casting light on those positions and commitments has a truly heuristic value in that, by revealing basic and fundamental mechanisms, it allows us to explain how networks are formed and professionals cooperate.

3.1. Positioning along the therapeutic chain

Whether for cancer, drug addiction or alcohol dependence, different types of interventions may punctuate a patient's itinerary in the therapeutic arena:

- interventions for diagnosis and assistance in establishing a diagnosis: physiological tests, biological examinations, talking with a psychologist, administering questionnaires to establish a patient's profile on a psychological scale, etc.;
- therapeutic interventions, of which there may be several for one and the same health problem. These interventions may be complementary, such as surgery, radiation therapy and chemotherapy for breast cancer, or psychotherapy and antidepressants for nervous breakdowns; but they can also alternate, such as surgery and radiation therapy for certain forms of prostate cancer or surgery vs. radiation therapy with chemotherapy for certain ENT cancers, or analytical psychotherapy and antidepressants to reduce neuroses;
- palliative or supportive interventions, i.e. activities aimed at alleviating physical or psychological pain, life-preserving treatments and, in the case of certain pathologies or disturbances, treating the psychological or somatic consequences of the pathology;¹⁰
- post-cure interventions, i.e. supervision and prevention supposed to diminish the risk of a relapse or detecting it as early as possible.

Schematically, the therapeutic chain is organized following temporal and sequential logics, though many exceptions to an exaggeratedly general rule must be acknowledged to account for the diversity in patient trajectories: not only are all the steps not always observed, but some of them may take place simultaneously, or treatment may precede an in-depth examination when establishing a diagnosis.

3.2. Selective systems and professionals

A preference for one or several stages of the cure has serious consequences in terms of recruiting patients: "cure-oriented" professionals typically tend to seek out and maintain in the clinical arena populations who present those characteristics that correspond to their own operative norms. To that end, they attempt to build an environment of providers capable of referring to them a clientele that best conforms to their expectations.

¹⁰ It is a well-known fact that for a considerable number of pathologies or disorders, one cannot speak of being cured *stricto sensu* but more surely of palliative treatments, as is typically the case for diabetes. We do not wish to contribute to this debate but admit, with an eye to convention and simplification, that curative methods are those, which aim to treat the pathology or disturbance itself and not some of its consequences.

Following A. Strauss and his colleagues, who noted that “each ward tries to minimize the diversity of its medical product by having patients with similar diseases or conditions” (Strauss et al., 1997 [1985]: 153), professionals of cancer, drug addiction and alcohol dependence are on the lookout for “patients” suffering from the pathology in which they have specialized, for which they consider themselves competent and which is compatible with the therapeutic orientations of their organization, often specialized in a type of clientele, care, pathology, etc. This observation may seem trivial but we will see that referring a “non-sick” patient to a professional for whom cure is paramount causes conflict or at least incomprehension and avoidance.

We found this concern with building networks to provide “appropriate” patients in the three fields studied. Professionals dealing with drug addiction and alcoholism who are interested in the treatment of addiction per se seek to establish contact with “providers” likely to refer to them patients motivated to successfully cure their addiction. They are hardly “interested” in occasional users or alcoholics who feel their addiction is not a problem and who, though dependent (and thus “ill”), do not see the usefulness of the treatment. As for cancer specialists, who seek to build lasting relations with physicians who have done the initial tests, so that the patients referred to them are indeed suffering from cancer or at least present disorders with a high probability of becoming cancerous. In this way they avoid “wasting time” with patients whom they will not be treating in the end.¹¹

The “right” care in the “right” context is thus the circumstantial result of an actor being positioned at a particular point in the therapeutic chain and a patient having arrived at a specific moment of his/her itinerary and presenting specific characteristics. Drug addiction professionals who offer, for example, essentially psychotherapeutic care, mainly cater for a particular clientele: individuals who are prepared to engage in self-analytical methods. Other structures offer treatments in what is known as a “therapeutic community”, where the group and normative peer pressure play an essential role in making the method effective, and which postulates a patient “easy to assimilate” in the organization. Cancer specialists may specialize in certain forms of cancer (breast, prostate, etc.) but also in certain phases of the illness (initial phase, relapse, metastasis, etc.). They may agree to be a last resort in the case of a relapse or, on the contrary, prefer to intervene “in the front line” of the treatment. In all cases, they must be confronted with the “right” patients.

Some of these observations have already been confirmed by the sociology of healthcare: cure-oriented systems and/or professionals tend to be selective and recruit a clientele liable to espouse the therapeutic forms and trajectories that they have worked out (see e.g., Freidson, 1988 [1970]; Herzlich, 1973). Patient selection must however be analyzed systematically and not only from the practitioner’s point of view or that of the service or organization being studied, as existing research has tended to do to an excessive degree. As we have shown elsewhere (Bergeron, 1996, 1999, 2003; Castel, 2005), selecting patients is not only indispensable to please the individual professional (“I treat the patient for whom I am competent”); it is also fundamental for preserving stable cooperation networks: patients are said to be “well chosen” when their characteristics – pathological as well as social – have the best chance of circulating harmoniously in the therapeutic arena conceived for them by the partners of the care network.

3.3. *The commitment associated to the professional’s positioning*

Within the framework of activities linked to treating a disorder or pathology, our fieldwork showed that two typical forms of therapeutic commitment exist.

¹¹ The appearance of a tumor is not synonymous with cancer; a large number of tumors are classified as benign.

First, either professionals see their intervention as occasional or limited in time and to a specific link in the therapeutic chain: reception and referral (entry into the system), initial treatment and auxiliary care, complementary tests and examinations, therapeutic steps of short duration, etc. In these conditions, professionals must coordinate their activity with a network capable not only of providing them with the “right patients” but also – even above all – of taking over once the phase has been completed. In so doing, these professionals consider themselves as links in a therapeutic chain they do not control from end to end. As the last sentence in the following excerpt shows, however, this sort of commitment is not always intentional; some professionals feel constrained being confined to only part of the care network.

“Q: So, if I understand correctly, in the case of sarcoma, you intervene once and then it’s taken over. . .

R: . . . by a team of specialists. I don’t handle those patients at all. First of all because I only do surgery. Afterwards they get chemotherapy and I don’t do chemo. And if there’s a relapse, it’ll be taken care of by the team at the Center. In case of metastasis, no way, she’ll get chemotherapy at the Center. That’s the problem we surgeons have: we only control part of the treatment, the rest of the story happens somewhere else.”¹² Interview with a surgeon in private practice.

Or else, the professionals feel they must as far as possible accompany a patient every step of the way. In that case they intend to take responsibility for the decisions that determine the entire therapeutic itinerary alone, assure the patient’s follow-up and care network and control the information. In short, they feel they must control, exclusively or with the close collaborators with whom they consult if necessary, what medical experts themselves call “the therapeutic strategy” or what A. Strauss calls “the trajectory scheme”. Consequently, such professionals need not cooperate with other professionals or structures, medical or otherwise, except in cases where the trajectory requires a service or resource that neither they nor the organization in which they work can provide, or else when administering such a service or resource does not interest them. As far as possible, these professionals must stay in close touch with the patients and remain their principal referee during the full course of their healthcare itinerary: they therefore see themselves at the heart of a star-shaped network and try to create ties with the professionals or structures liable to refer the patients “back” to them after their intervention.

“What we managed to do is to say «we’re not service providers. You send us the patient and we’ll decide what to do». We can do that because we’re in a dominant position.” Interview with a radiation therapist, Cancer Research Center.

We called these professionals “acquisitive”, in the sense that they tend to maintain the patient within the therapeutic arena.¹³

¹² It must be specified that symmetrical points of view can be found among radiation therapists and medical oncologists who complain that surgeons, who usually see the patient before they do, “keep the upper hand” with the patient and confine their role to one of temporary intervention.

¹³ It is possible to apply our analytical categories to the description that Isabelle Baszanger (1995) made of two typical ways of functioning by teams working on the treatment of pain, some taking up the position of “assisting” other services and thus performing momentary interventions, while others sought to acquire the role of “coordinator”.

4. Dynamics of cooperation and conflict

Based on the above findings, we contend that:

- the referral of appropriate patients;
- and the combination of acquisitive and non-acquisitive commitments are the ingredients that create the necessary conditions for lasting cooperation between healthcare providers in the framework of collective patient support.

Conversely, we contend that conflicts tend to break out when:

- the referral has been faulty, i.e. one of the partners in the chain, whether committed in the short or the long term, is confronted with a population that does not correspond to its institutional, organizational and/or therapeutic criteria (the three dimensions being related);
- structures or acquisitive professionals attempt to collaborate with similar structures or professionals: competition for the follow-up, the (re)definition and control of the therapeutic strategy generally has deleterious effects on their relationships (when relations exist at all, for sometimes they simply avoid having anything to do with each other), or previously stable cooperation deteriorates with time if non-acquisitive professionals seek to become acquisitive;
- and partners who all claim to be non-acquisitive are thrown together in a care network: being referred from one structure to another or from one professional to another is often the fate of patients whom nobody wants to be responsible for in the long term or whose itinerary nobody wants to control.

In the final analysis, one can reinterpret the diversity of the local situations we came across as being just variations on the two interconnected themes: the selection of patients and the cross-matching (acquisitive/non-acquisitive) of therapeutic commitments.

4.1. *Patient referral, appropriate clientele and conflict*

An illustration of conflict stemming from inappropriate referral of patients is found in relations between legal organizations and organizations specialized in the treatment of alcohol or drug addiction. The former frequently refer to the latter patients who are not known addicts but occasional or excessive consumers who should receive mainly preventive treatment but do not correspond to the main objective of the activity at hand. Systems specialized in alcohol dependence and drug addiction have long claimed to be principally committed to cure, which hardly makes them motivated to treat, or even simply to see, persons not considered as needing attention.

“What the law asks us to do is not care but education (an educational relation has effects on the super-ego whereas the transfer works on the subconscious/the *Id*). Therapists are not accustomed to delivering such a service. The law doesn’t realize that education is not care.” Interview with a psychologist, ambulatory consultation center for alcohol dependency.

“The courts send us people sentenced to receive treatment. Not a very motivated population. There are many and we’re swamped. The same goes for patients blackmailed by their company doctor (certain company doctors will sign a certificate of aptitude for an alcoholic worker only if he promises to get treatment).” Interview with a female facilitator, ambulatory consultation center for alcohol-dependency.

In cancer care networks, conflicts linked to faulty referral concern, for example, terminal patients referred by physicians, GPs or specialists, to structures or other professionals who wish to deal with less advanced stages of cancer. That type of conflict often involves geriatric specialists who complain that some hospitals or clinics specialized in care tend to send them aged terminal patients, i.e. often those for whom treatments have failed.

“What we want to do away with is the «I can do nothing more, you can have them» attitude. That’s not geriatrics! I don’t claim to be Hercules and clean out the Augean Stables! [...] In a word, the vision of some specialists is that geriatrics means sending us all the patients they don’t want, that they reject. That’s still sometimes the case and for us and it’s an ongoing battle.” Interview with a geriatrician, University Hospital center.

We also frequently met medical oncologists who complained that surgeons considered them a last resort when the illness had metastasized, whereas they would like to be able to intervene at an earlier stage.

4.2. *Matching commitments, cooperation and conflicts*

The combination of acquisitive and non-acquisitive commitments is another condition for creating stable networks. This is often the case with relations between hospital centers for alcohol dependency and self-help organizations for cured alcoholics. The former insist that the latter – said to be acquisitive – meet on hospital premises, despite sometimes considerable differences in the conception of what makes for “good therapy”. Since such centers do not have sufficient follow-up resources to provide post-cure consultations, they generally limit themselves to physical withdrawal, expecting the organizations for cured alcoholics to capture a clientele tempted to take root in the reassuring environment of the hospital. To that end, they allow the organizations to do the rounds of hospitalized patients and even to give talks on their merits and therapeutic successes.

“We have a duty towards alcoholics’ self-help organizations. Every week, they take turns sending a representative to talk with a nurse. It’s part of our program. And every evening, somebody from an organization is available for all the hospitalized patients. We don’t interfere at all, we don’t sit in on these meetings. Everything runs smoothly; once or twice a year we answer questions.” Interview with a doctor, alcohol-dependency center.

On the other hand, defiance, misunderstandings, competition or even conflicts exist when acquisitive professionals try to work with other equally acquisitive professionals. There are often conflicts, for example between the psychiatric services and certain centers for drug addiction or alcohol-dependence.

“If, in the outpatient consultation center for alcohol dependency, an underlying mental illness is detected, we send the patient to the medico-psychological center (*centre médico-psychologique*, CMP), but the CMP keeps the patient and the follow-up becomes exclusively CMP, and if the patient has a psychological problem he or she also has an alcohol problem. [...] We don’t see eye to eye with them over that.” Interview with a female community worker, ambulatory consultation center for alcohol dependency.

“Many structures close the door as soon as you send them a young person. They take over saying it must be anonymous and confidential. When I phone X (physician in a specialized center attached to a hospital service of the psychiatric sector), they won’t even tell me if the young person has been hospitalized there or not. So I go through my own network. That

way at least I don't lose touch." Interview with a psychologist, center specialized in drug addiction.

Generally speaking, conflicts in the field of drug addiction and alcohol dependence typically oppose two structures or, more precisely, two professionals belonging to two organizations, that focus on the therapeutic aspect of the care trajectory, whatever their therapeutic orientation might be (psychoanalysis, substitution treatment, sociopedagogical follow-up, etc.). Each of them claim exclusive control of the therapeutic strategy, the medical follow-up¹⁴ and decisions concerning patients' therapeutic destiny.¹⁵

"One has to be able to compromise and adapt. Theoretically, one should consider that a person is leaving one institution for another. But it's not true that everybody makes that sort of connection. It's important for a person to be able to settle down somewhere. [. . .] But it's not easy to set up. Everyone is probably afraid of losing something. The medical is all-powerful and rules over everything." Interview with manager of a home.

"The question for tomorrow is: «will alcohol dependency become part of general medical practice?» The reality of the patient goes unnoticed in other care circuits, the physician who invested and built up a relationship with the patient feels a little bitter if he or she is sent elsewhere, to a service of general medicine." Interview with head of ambulatory consultation center for alcohol dependency.

In a very similar way, conflicts in the field of cancer also concern the control of the patients' trajectories and frequently oppose professionals liable to perform at least one of the three main cancer treatments: surgery, radiation therapy and chemotherapy. As classical sociological texts have already shown (Freidson, 1988 [1970]; Hall, 1946), surgeons tend to compete with other surgeons. But cooperation and conflict are more visible in the analytical framework developed here: conflicts exist because some professionals refuse to be at others' "service", i.e. refuse to be confined to the role of administrator of a treatment which is part of a therapeutic scheme for which the general course of events was defined by other professionals. Conversely, cooperation can bloom when the professionals of one organization agree to intervene at one point at the service of a project manager. The following two cases observed in two different regions are particularly significant in this respect: in two different types of organization, two professionals were similarly criticized by their peers who reproached them for agreeing to implement a treatment decided by colleagues in other organizations, while they themselves aimed for a clearly more acquisitive position.

"I am referee¹⁶ for hematology at the University Hospital, for gastric problems and as oncopediatrician. [. . .] Providing services [in the cancer research center] is still considered prostitution [. . .] For people [of the cancer research center], providing a service means

¹⁴ We specify "curative follow-up" in the sense that what interests the therapist and doctors is the follow-up during the phases punctuating the entire curative process. Professionals do not consider post-cure check-ups for possible relapses to be particularly valuable or to justify investing resources and energy to stay in control. Thus, for example, the post-treatment follow-up of a cancerous tumor, considered routine, will not be fought over and will willingly be left to other professionals, it being expressly understood that those professionals will address the patients to them again in case a relapse is suspected.

¹⁵ Such conflicts around the possible capture of clientele were revealed at the very core of the care structure for drug addiction, where the first encounter with the patient – decisive to set oneself up as permanent referee – can become a stake in the competition between psychologists and/or educators (see Bergeron, 1996; Blangy, 1993).

¹⁶ The term "referee" has a different meaning here from the use we have made of it up to now. In the present case, it means "correspondent" or "appointed interlocutor".

you're being submissive because you're accepting someone else's prescription. I'm not being submissive: University Hospital doctors are just as competent as we are!" Interview with a radiation therapist, cancer research center.

"I had to fight at least fifteen times with [Dr X, medical oncologist in the same hospital] who continues doing chemo for the ENT specialists in town who don't want to go through the consultation [that I'm responsible for]. In my opinion, it reduces patients' chances. I yelled at him. [...] He answered: «I don't have the right to judge. . .» I said to him: "But you're not a service provider!" Surgeon, Hospital center.

It becomes easier to understand that cooperation networks of acquisitive professionals are made in such a way that the structure or specialist to whom patients are addressed for a specific therapeutic act will not keep them but will send them back to the same professional referee once the one-off intervention is over. The general tendency is for a cooperation network to stabilize thanks to those who guarantee what we might familiarly term a "return to sender" system. The wish to constitute a professional network preferentially made up of those who agree to perform limited interventions may even lead some actors to build lasting relationships with professionals or structures that provide complementary and sought-after services but that are not in their immediate geographic perimeter and thus force the patient to make long trips (Bergeron, 1996). On the scale of a territory, such a mechanism offers an explanation for the often compartmentalized and relatively impervious way these connections are built – a result of the fact that the professionals who compose them do not communicate and hardly work together, even though that might conceivably be convenient in the case of some patients, from a medical point of view. The organizations within which these particular forms of network are formed have only a vague idea about what their rationale might be. They must therefore be analyzed as the outcome of professional efforts at creating acquisitive-non acquisitive partnerships.

4.3. Strategies of matching and stabilizing networks

The cooperation networks observed show a form of stability but they are not eternal and continuously need to be maintained, in particular to ensure that certain partners are not tempted to renegotiate their commitment in the network when they are no longer satisfied with the existing forms of cooperation. Without claiming to be exhaustive, we have identified several strategies for constituting and maintaining a network.

To begin with, we identified a strategy of self-interested sharing of information: an acquisitive professional decided to communicate to certain partners some of the information concerning the evolution of the pathology of a patient who was at the end of a phase of treatment. Some acquisitive healthcare people dealing with addictions go to great lengths to share information about their patients' future with their transitory partners, which is a great source of professional satisfaction to the latter, since it allows them to clarify the meaning of the service they render and to set it within the trajectory over which they have only partial control. That information is all the more meaningful in the eyes of the non-acquisitive personnel since, in the case of drug addiction and alcohol dependency, where relapses are frequent, the rate of failure is high and the number of "missing persons" is considerable. It is a way of limiting the feeling of professional burnout so often expressed (Bergeron, 1999) and, by so doing, of minimizing some of the reasons for dissatisfaction linked to the structure of existing networks.

"Alternating follow-up" in the field of cancer is a second strategy by which cooperation networks between acquisitive and non-acquisitive professionals are stabilized. An acquisitive

physician agrees with one of his/her partners to share supervision of the patients. Though the logics are similar to the previous case, sharing here is more significant since the non-acquisitive doctors also get to see the patient. Not only are they able to ask for the examinations they need to evaluate the patient's condition – and the effects of the other partners' action – they also find satisfaction in the direct contact with the patient, which as we know is highly valued in a clinical ethos (cf. e.g., Freidson, 1988 [1970]; Starr, 1982). Similar situations also occur in the field of drug addiction, when two structures jointly follow up a patient. Typically, one takes charge of the social follow-up and the other the somatic and/or psychological treatment. However, in many cases one of the two – often the social follow-up – is subordinated to the more psychological or somatic one, in the sense that decisions structuring the patient's trajectory obviously depend more on the medical or psychotherapeutic team than on the social workers. In our surveys, cases of double follow-up were equitably double only from a formal point of view: it is mainly the teams of psychotherapists and/or doctors who shape the care trajectory of the drug addict under treatment, and the social-pedagogical team can only adapt. One might interpret all these cases as attempts at symbolically staging well-balanced cooperation that maintains the impression of the two teams contributing equally to the cure – and consequently limits the suspicion of simply being used within a therapeutic process whose meaning and direction escape one of the two.

Setting up meetings for “multidisciplinary exchange” in the field of cancer – meaning that the patient's medical file will periodically be examined by a college of doctors in which at least one surgeon, one radiation therapist and one chemotherapist must participate – is another way of building and maintaining a network. Of course, the decision concerning the care trajectory is no longer the responsibility of a single doctor, since the meetings allow other professionals to enter the discussion. Nevertheless, there again, that development has not given rise to absolute symmetry in decision-making or to a control of the trajectory shared equally by all those taking part in the treatment. On the one hand, certain physicians who used to be non-acquisitive may use these opportunities to enhance their local authority and renegotiate an acquisitive commitment – which some colleagues may accept and others only put up with (Castel, 2007). In other words, in such cases the actual organization of the local network may find itself changed even though the underlying logics of acquisitive and non-acquisitive matching persist. On the other hand, acquisitive doctors who so wish, have the resources to maintain their form of commitment. In the first place, not all of them agree to participate in these meetings. Secondly, acquisitive doctors often choose their moment for presenting a case at the meeting. Thus, they may first start the treatment and set it on a course that necessarily limits the range of possibilities. Finally, they have the last word concerning the decision, even though in theory it is necessary for the medical record to justify why they did not accept the solution recommended by the group. They also choose the other partners they will be calling upon as the treatment proceeds. In short, still today, what prevails is a “collegiality of opinion” rather than a “collegiality of direction” (Weber, 1971 [1922]).

Finally, in the various fields that we studied, the more or less generous information-sharing and decision-making, and the concessions concerning the possibility of ensuring a more or less joint follow up, are variations of the matching model that we described here, rather than contradictions that question its relevance. They correspond to attempts to limit the feeling of being used, that certain non-acquisitive professionals experience¹⁷, and aim to stabilize cooperation networks, which

¹⁷ We write “certain non-acquisitive professionals” because, as we have pointed out, certain professionals performing “momentary” interventions are perfectly satisfied with that sort of commitment: such is the case of some generalists,

have remained structurally unbalanced. The elementary logics of the organization of medical work among professionals are and remain on the whole unchanged.

5. Conclusion

The approach presented here, consisting in distinguishing between professionals according to their positioning and commitment in the therapeutic chain, can be seen as an intermediate analytical framework. It lies between approaches that see relations between professionals as emanating directly (i.e. without precisely saying why, or in other words, without revealing their precise mechanisms) from the macrological characteristics of institutional ensembles, and microsociological approaches which content that those relations are essentially the precarious and contingent products of a unique type of interaction (without any underlying principle of (pre)structuring).

Maximizing the number of clients and acts per client has often been presented as one possible reason for the particular structure professional networks have. We have shown that it is only one of the factors in the cooperative or conflictive relations between partners in a patient's care network, which cannot be reduced to simply numerical or financial logics. Although scrutinizing the organization of care to see how it is structured casts some light on situations where certain professionals are dissatisfied with their commitment, the logics of the division of labor among professionals cannot be reduced to contracting out the "dirty work" so often observed following the seminal conclusions of Everett C. Hughes (1996) on these aspects. Performing a surgical act or a diagnosis, even if one is non-acquisitive, remains an activity that many professionals consider noble. The logics of the division of labor and competition that we observed refer more fundamentally, or equally, to the type of positioning and commitment that the professionals concerned have chosen.

Our survey also allows us to understand more precisely why the formal healthcare networks – an institutional innovation in which the French Ministry of Health has placed much hope – tend to endorse and institutionalize existing forms of collective cooperation rather than creating new ones (Schweyer, 2005). The match between professionals is based on network logics that make sudden changes decreed from above on longstanding, stable relationships rather improbable. We must therefore temper the hopes that have been placed in them – including by sociologists – as to the amplitude of changes they would be capable of generating in the actual organization of healthcare. Admittedly, learning to know about their partners' specific characteristics and operative logics (shared knowledge on the roles and expectations concerning the different parties involved in the network) through repeated meetings within a network formally constituted in response to injunctions from above, constitutes favorable conditions for cooperation. It is however doubtful that networks can function based on a "certain conception of care that gives precedence to a shared, i.e. more egalitarian, approach among health professionals" (Schweyer, 2005: 91). On the contrary, networks of professionals associated in patients' care put together partners who are not positioned and committed in the same way. Above all, they do not all take part in what Michel Castra (2003) has called "care politics" and what we have called "therapeutic strategy".¹⁸ Either

alcohol-dependency units or hospital services carrying out physical withdrawal in the case of drug or alcohol addiction, or in the case of cancer of certain radiation therapists, anatomy-pathologists, general practitioners, etc. Capture is a resource for some, a constraint for others.

¹⁸ The study of the networks dealing with AIDS in the Bordeaux region (Langlois, 2007) confirms this sort of study: after a first phase during which, while the battle against AIDS was being organized, certain general practitioners made that pathology their specialization in the hope of establishing more balanced relations with their counterparts in hospitals

the formal networks imposed “from the outside” function because they actualize longstanding acquisitive/non-acquisitive matches, or they remain “empty shells” or an arena for competition between actors either trying to monopolize the definition of the therapeutic strategy or refusing to take responsibility for it.

Even if the “detour” by specialties does not suffice to account for phenomena of cooperation and conflict among professionals operating in local care networks, the analytical framework proposed here does – in a sense conversely – allow us to reinterpret advantageously some of the dynamics of competition that exist between medical specialties.¹⁹ We can thus venture a first hypothesis that, in some cases, the attempt to establish a specialty or sub-specialty is one of the ways members of a segment or group of professionals – who tend to be confined against their will in other specialties – respond to a major commitment of non-acquisitive professionals. The existence of a (sub-)specialty, when efforts to institutionalize it have been successful, represents an official resource permitting non-acquisitive actors to negotiate more efficiently (though without any local guarantee) an acquisitive commitment with respect to the other professionals involved.²⁰

We might try a second hypothesis, inspired by the research carried out by Sydney A. Halpern (1992),²¹ i.e. that phenomena of competition among specialties are not all due to a “jurisdictional battle” aimed mainly at confiscating the responsibility for a disease or a pathology from one specialty at the expense of the other(s) which until then had monopolized it. Some jurisdictional

than was the case with other pathologies. Emmanuel Langlois underscores the frustration they express today with regard to a situation whereby the hospital has recovered its centrality in “pyramidal” networks.

¹⁹ It is however plausible that a connection does exist – although a weak one as we said in our introduction – between specialization and type of positioning and commitment. One may therefore venture that e.g. psychiatrists tend rather to adopt a curative position and an acquisitive commitment. Within the limits of this paper, we cannot list all the specialties or activities whose characteristics are liable to increase the probability that professionals in those fields are acquisitive or non-acquisitive. We might however formulate a few hypotheses – which would deserve to be checked, elaborated more systematically and above all completed and developed – on the differential ability of actors to accept or reject a non-acquisitive status. We might posit that actors belonging to specialties or intervening momentarily at a relatively low technical level, therefore not a very lucrative activity from a symbolic and (often) consequently also financial point of view, tend to make attempts at being associated more manifestly in the follow-up and the definition of the therapeutic strategy. Conversely, a high technical level and consequently high symbolic and financial rewards seem to favor acceptance of the fact that one’s intervention is momentary, as is the case with radiation therapists and anesthetists. In a similar and comparable way, hardship at work supposedly increases the temptation to “rise” from performing an isolated act to controlling the therapeutic strategy. One might also suggest hypotheses on the greater or lesser degree of the conflictive nature of medical fields: e.g. it is likely that the longer the expected treatment of a pathology or disturbance, the more the follow-up will be considered noble, gratifying and interesting for the professionals involved. This will most certainly also stir up more intense struggles for controlling the therapeutic strategy. Lastly, one could also point out that the greater the degree of substitutability of the therapeutic techniques involved in solving a health problem (i.e. when several types of activity can produce relatively comparable therapeutic results), the more the temptation to become acquisitive will be structurally divided among healthcare actors. In contrast, when one technique clearly dominates (in terms of the therapeutic results obtained), the other activities tend to be kept within the bounds of isolated interventions. Many other hypotheses might be suggested but that would be the subject of (at least) one other article.

²⁰ That is for example the case of oncologists and gerontologists who intervene specifically in the field of geriatric oncology and seek to organize as a sub-specialty (oncogeriatrics), to avoid having to play the role of “providers” for medical, “generalist” surgeons and oncologists (Buthion and Castel, 2006).

²¹ This author is the first to have shown that analysis in terms of “jurisdiction”, as proposed by Andrew Abbott (1988) – and for whom it concerned relations between professions or between professional groups – could be used profitably in the study of relations between medical specialties. For the author, there even exists an interdependence between those two levels of jurisdiction: the legal battle between specialties (in the sense of monopolizing the treatment of a health problem) would in certain cases explain the erosion of the jurisdiction of the profession as a whole.

competitions aim rather to capture, i.e. to institutionally assert a more obviously acquisitive commitment, without that capture necessarily meaning that other specialties are excluded from the treatment. This approach facilitates a more effective dialogue between institutional levels (specialties, segments, etc.), from the point of view both of the organization and of the local division of labor.

To conclude, it is worth considering the application of our analytical framework not only to healthcare but also to other fields. Here again, the aim would be a better grasp of the mechanisms underpinning the division of labor between different professionals who, free from any outside (pre)determined hierarchy, participate in a common project – for instance a scientific or industrial project or several lawyers collaborating on a case. It would then be possible to test the eventuality that crossed matches between an actor who controls what interactionists call “the arc of work” (Strauss et al., 1997) and other actors who agree to intervene more occasionally, are also conducive to the stabilization of professional cooperation.

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