Commentary

# Vocation in Healthcare Professions: Between Philosophical Legacy and Contemporary Challenges

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The term vocation derives from the Latin vocatio, meaning "call" or "invitation" (Rahner, 1977). Originally, it referred to a religious experience in which an individual responded to a divine mission. This meaning became central in the Christian tradition, from Augustine of Hippo to Thomas Aquinas, and gradually expanded into secular and professional contexts. The Christian tradition represents the historically dominant framework in the Western context within which the healthcare professions first elaborated their professional self-understanding. Yet the call to care is not the exclusive property of any single tradition. Parallel and equally rich conceptions exist in Islamic medical ethics, in Buddhist notions of compassionate service, and in secular humanist framework, each offering distinct but convergent grounds for vocational dedication in healthcare. A comparative analysis of these traditions lies beyond the scope of this article; what matters here is the recognition that vocation, as a human response to the call to care, is neither culturally bound nor historically exhausted.

Over the centuries, especially with the onset of modernity, this concept underwent a significant semantic and existential transformation. It lost part of its transcendent connotation and came to signify a meaningful choice: not a predetermined destiny, but a direction built over time through freedom, authenticity, and responsibility. The term "modernity" is used here in the sociological and philosophical sense: the structural transformation of Western societies initiated by the Enlightenment and accelerated by secularization, rationalization, and the differentiation of social spheres, a process analyzed most influentially by Weber (1965) and Taylor (1993). It does not denote the contemporary period generically, nor is it assumed to be universally generalizable; rather, it designates the specific historical horizon within which the professional understanding of vocation emerged and was theorized in the literature this article draws upon (Taylor, 1993).

Vocation is not a concept exclusive to the healthcare professions. Contemporary psychological and organizational research, most systematically developed by Dik and Duffy documents the sense of calling across a wide range of occupations: teaching, academic research, social work, environmental professions (Dik & Duffy, 2009). In this respect, vocation belongs to the human condition more broadly than to any specific professional category (Husserl, 2002). Yet in the caring professions

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it takes on a qualitatively distinct form. Daily contact with suffering, vulnerability, and the limits of human life introduces an existential dimension that few other professions share with the same structural intensity. This is not merely a question of finding meaning in one's work, but of confronting the other in their most profound fragility, day after day. That exposure is not incidental: it is constitutive of the act of care itself, and it transforms healthcare vocation into something that exceeds simple professional motivation. A further dimension deserves consideration: the cultural one. The concept of vocation crosses cultural boundaries, but the way it is experienced, expressed, and transmitted is deeply shaped by the context of belonging, religious, social, historical. In some traditions the call retains an explicitly spiritual connotation; in others, an ethical and prosocial reading prevails. Empirical research on this variability remains limited, but to ignore it would mean treating vocation as an abstract universal, stripping it of the very concreteness that makes it relevant for those who care (White, 2002).

A related question concerns the fate of the transcendent dimension. It is tempting to state that vocation has lost its transcendent connotation, and the original text of this article did so. Yet the scientific literature does not support this claim in any unequivocal way, and precision here matters. Contemporary debate distinguishes two main positions. The neoclassical approach, defended among others by Duffy and Dik (2013), maintains that vocation retains a component of external summons: a call perceived as coming from something beyond the individual. This source need not be God or a deity; it can be the need of society, a sense of destiny, or a moral imperative felt as external to the self. Transcendence, in this reading, does not disappear with secularization, it transforms (Husserl, 2002). More contemporary approaches, by contrast, tend to relocate the source of vocation within the individual: the drive toward self-realization, coherence with one's values, the desire to contribute. Even here, however, a dimension that transcends personal interest persists, the reference to the other, to the community, to the common good. What empirical research calls into question is the assumption, often implicit, that the secularized version of calling has simply replaced the religious one. Evidence for this substitution is insufficient (White, 2002). What emerges instead is coexistence: in the healthcare professions today, those who experience their dedication in explicitly spiritual terms live alongside those who ground it in lay values of justice, care, and responsibility. Both forms are authentically vocational. For healthcare professionals, this distinction is not merely academic. It means that vocation can be reduced neither to a religious residue to be overcome, nor to a simple intrinsic motivation to be captured by psychometric scales. It is a complex existential orientation, integrating meaning, relationship, responsibility, and, in many lived experiences, still some form of transcendence, whether lay or religious.

In healthcare professions, this complexity is particularly evident. The concept of vocation has undergone a paradigm shift: the "sacrifice model", in which the healthcare professional was expected to subordinate personal needs to an almost devotional ideal of service—has progressively given way to a "commitment model," in which vocation is understood as a conscious and responsible choice to direct one's skills, time, and emotions toward the care of others. What has changed is not the depth of dedication, but its foundation: no longer self-abnegation, but autonomous ethical engagement. This shift is documented in the empirical literature on calling, which identifies meaning, prosocial orientation, and identity coherence, rather than sacrifice, as the core dimensions of vocational experience in contemporary healthcare professionals. It is a commitment to a way of being, even before a response to a profession. A way of existing in the world with the intent to preserve, accompany, and alleviate.

Edmund Husserl, father of phenomenology, helps us explore this dynamic more deeply. According to his framework, vocation is not passively received, but emerges as an intentional act rooted in the lived experience of authentic values. Vocational action, in this sense, is not driven by utility but by goodness. It results from an internal tension expressed in concrete action and relationships with others (Husserl, 2002).

A related perspective is offered by White's analysis of nursing as vocation, which conceives of the call not merely as a specific response to a profession but as a broader life project, a personal journey of growth shaped by ongoing choices and transformations. In this view, vocation leads individuals to discover their unique role in the world and to contribute to the

common good (White, 2002). Importantly, this framing allows for a conceptual detachment of nursing vocation from its historically feminine connotation. For much of its history, nursing has been understood through the lens of "natural" female qualities, care, self-sacrifice, docility, a characterization that both idealized and constrained the profession. Grounding vocation instead in ideals of social responsibility, moral commitment, and ethical engagement shifts the foundation: the call is not to a gendered role but to a human project. Gender remains a dimension worth considering—research suggests that men and women may experience and narrate their sense of calling differently, and that institutional cultures can shape these experiences in ways that merit attention (Evans, 1997), but it ceases to be the defining criterion of vocational suitability.

In healthcare, this vision translates into the ability to integrate technical knowledge with ethical personal motivation. Caring is not only action, it is also intention, meaning, and orientation toward the other (Heinämaa, 2020, 2023).

This emphasis on phenomenology carries methodological implications that deserve to be made explicit. If healthcare action is not reducible to technique, if it involves intention, meaning, and relationship, then research designed to understand and develop it cannot be limited to positivist frameworks alone. There is a need for studies capable of capturing the epistemological content of specific professional knowledge: the forms of knowing embedded in practice, in clinical judgment, in the relational dimension of care. This does not mean abandoning scientific rigor; it means expanding the conception of what counts as evidence. Phenomenological inquiry, narrative research, and qualitative methodologies offer tools to illuminate aspects of professional knowledge that quantitative measurement alone cannot reach (Benner, 2003; Lincoln & Guba, 1985). Acknowledging this is not a retreat from science, it is a more honest account of what professional expertise actually is.

Thus, competence becomes not only technical but also ethical, reflective, and narrative. It is not enough to know how to intervene; one must also understand why.

This why is not merely theoretical, it is deeply embodied and constructed over time. As Polanyi would suggest, it is a form of personal knowledge involving body, emotions, and experience; it is composed of intuition, memory, and sensitivity. This type of knowledge resists measurement but transforms every technical act into a human act (Polanyi, 1966).

This understanding of knowledge as embodied and personal raises a further question that deserves explicit treatment: what is the relationship between vocation and the development of professional knowledge? The two dimensions are not parallel but deeply intertwined. Vocation sustains the motivation to learn, to question, to go beyond the merely procedural. It is what keeps curiosity alive in the face of complexity and what makes professional development not a bureaucratic obligation but a personal and ethical commitment. Conversely, the growth of knowledge nourishes vocation: a healthcare professional who deepens their understanding of the person, of pathophysiology, of care relationships, finds in that knowledge new reasons to remain present and engaged (Benner, 2003; Eraut, 1994). Vocation without knowledge risks becoming mere sentiment; knowledge without vocation risks becoming a cold technique applied to passive bodies. Their integration is what defines a genuinely professional act.

In this regard, Husserl also emphasizes the temporal dimension of vocation, which links past, present, and future—a pattern well reflected in the healthcare tradition of intergenerational transmission of knowledge and values (Manca, 2018; Moran, 2011).

This temporal dimension of vocation opens a question that the text has so far left implicit: when we speak of phenomenology as a transformative lens for healthcare, are we referring to all healthcare professions, or primarily to nursing? A clarification is warranted. The text has repeatedly invoked phenomenology as a transformative lens for understanding healthcare action. But the question arises: has the phenomenological perspective influenced the transformation of healthcare professions broadly, or primarily nursing? The honest answer is that its impact has been uneven. In nursing, phenomenology has played a particularly generative role, shaping theoretical frameworks, clinical methodologies, and professional identity in ways that are well documented in the literature. In other healthcare professions, its influence has been more limited, though not absent (van Manen, 1990). What phenomenology has offered across

disciplines is a shift in the fundamental question: from what is done to how it is experienced, by the professional, by the patient, by both in relation. This reorientation has changed the way phenomena such as pain, vulnerability, clinical communication, and decision-making are studied and understood. It does not replace the positivist contribution; it complements and deepens it.

It is through narrated transmission that vocation persists and endures. As Ricoeur suggests, human beings are narrative subjects: we construct identity through the stories we tell about our experiences. Vocation is one of these stories, one that gives biographical coherence, connects past and future, and transforms everyday practice into a meaningful narrative (Ricoeur, 1993). It is not static, but a process, a becoming. Each choice and each relationship contribute to writing this story and, in doing so, restore the deeper dimension of healthcare work.

Kierkegaard, from his existential perspective, offers a compelling interpretation of vocation as a radical choice. One is not born called; one chooses to become so, often amidst difficulties, uncertainties, and responsibilities. It is a call renewed daily, one that can be questioned but, if recognized as authentic, becomes an inner strength. In this light, healthcare professionals continually choose to remain present, even when systems are unsupportive, even in adverse conditions. It is an act of freedom but also of fidelity to oneself. (Kierkegaard's analysis in this work centres on anxiety and the psychology of freedom rather than on professional vocation per se; the reference here draws on the broader existential framework he develops, in the interdisciplinary tradition of applying his thought to questions of identity and commitment in professional life) (Kierkegaard, 1984). This understanding of vocation as an evolving construction finds qualified support in the exploratory work of Hey and Nowakowski (an academic thesis rather than a real study, and therefore indicative rather than conclusive), who interviewed physicians and dentists at different career stages and found that all participants described their sense of calling as something that had transformed over time, shaped by professional experience, personal growth, and the accumulated weight of clinical encounters (Hey & Nowakowski, 2013).

However, this idea of vocation is not without risks. Recent history offers a powerful reminder. During the COVID-19 pandemic, the world witnessed an extraordinary display of dedication by healthcare professionals. They were hailed as heroes, angels, and missionaries. Before turning to the risks, it is worth pausing on what this dedication actually was: an act of freedom and moral responsibility. Healthcare professionals chose to remain present, in conditions of extreme personal risk, institutional uncertainty, and social upheaval, not because they were compelled to, but because their vocational orientation made withdrawal inconceivable. The pandemic did not create this commitment; it revealed it. In this sense, the COVID-19 experience is one of the most powerful empirical demonstrations of what vocation means in practice: a freely renewed choice, sustained by identity, meaning, and responsibility toward the other. But the heroic rhetoric surrounding this dedication also introduced a subtle danger: the instrumentalization of vocation (Čartolovni et al., 2021). When commitment becomes a justification for inadequate protections, excessive workloads, or unrecognized sacrifices, vocation turns into a burden, a moral trap (Broome et al., 2024). This is why it must be protected: through sound health policies, ongoing education, and social recognition. Otherwise, vocation risks fading or becoming self-destructive, leading to burnout and disillusionment (Kar, 2020). A recent systematic review by Hernández-Xumet and colleagues confirms this picture: vocation functions as a powerful initial motivator, but its persistence requires sustained meaning-making, self-care strategies, and a training environment that actively supports it, conditions that are far from guaranteed in contemporary healthcare systems (Hernández-Xumet et al., 2025a).

Weber had already grasped this tension. In his analysis of modernity, he described Beruf (vocation-profession) as responsible action in a disenchanted world, but he also warned of the danger that efficiency, bureaucracy, and rationalization might strip this action of meaning (Weber, 1965). Today, this risk is real in healthcare: procedural logic and fragmented work threaten vocational passion. There is, therefore, an urgent need to rediscover the meaning that makes caregiving valuable, not just a matter of time management.

The hermeneutic tradition reminds us that every meaning, including the meaning of vocation, is transmitted through culture,

language, and historical horizon. In this sense, dedication to care as a form of vocation is not an invention of any single tradition but a recurring human response, expressed in different forms across societies and historical periods (Gadamer, 2001). Even in contemporary societies marked by fragmentation, signs of renewal are emerging.

Younger generations demonstrate new sensibilities: attention to the environment, well-being, and inclusivity. If adequately supported, they may rediscover vocation not as a duty but as an opportunity, to live their work as an expression of values, as a space to impact others' lives with authenticity (Dimock, 2019; Williams, 2020). Empirical evidence supports this reading: a cross-sectional study among nursing and physiotherapy students found that vocation for human care correlates positively with empathy and assertiveness, suggesting that these dimensions reinforce one another and that vocational orientation is already measurable and meaningful at the formative stage (Hernández-Xumet et al., 2025b).

From here, a renewal of vocation becomes imaginable, not as a nostalgic return to idealized models but as a reinterpretation aligned with contemporary complexities. A vocation that embraces fragility, resists pressure without losing its integrity; one that demands not perfection, but coherence. One that does not impose sacrifice but values dedication (Morgan, 2023).

One final knot deserves to be untied: the relationship between the transformation of professional vision and the mission of healthcare disciplines, and, within this, the question of foundational knowledge. If vocation is understood as consistent with mission, as this article has argued, then what are the epistemic foundations that sustain it? Healthcare professions occupy a complex epistemological space. Their knowledge is partly anchored in medicine and the biomedical sciences; partly rooted in the social, human, and psychological disciplines; and increasingly, though still haltingly, defined by bodies of knowledge specific to each profession. Nursing, to take the most developed example, has worked for decades to identify its own theoretical frameworks, its own objects of inquiry, its own research methodologies. The same path is being traced, at different speeds and with different degrees of institutional recognition, by the other healthcare professions (Meleis, 2012). Vocation, in this context, is not separable from the question of knowledge: to choose a healthcare profession is also, implicitly or explicitly, to commit to contributing to the development of that profession's understanding of itself. It is a call not only to care, but to know, to question, and to build.

A contemporary vocational model should be grounded in four dimensions:

- Personal ethics: Healthcare as a conscious and responsible choice;
- Community and generations: Continuity between tradition and innovation;
- Narrative and meaning: Constructing meaning through practice;
- Cultural pluralism: Openness to diverse understandings of care and health.

Vocation in healthcare is not an outdated concept but a strategic resource to address today's challenges. Through the lenses of phenomenology, philosophy, and culture, it emerges as an ethical and existential engine that gives meaning to healthcare work, fostering both individual and collective well-being.

Re-centering vocation in healthcare education and organization means reconstructing a social pact based on trust, care, and shared meaning. Because ultimately, every act of care is also a response to the fundamental question of why one chooses a healthcare profession. And every authentic response is already a vocational act. This includes the technical act itself. One of the most important tasks ahead, for research, for education, and for professional culture, is to demonstrate that the nursing gesture, the clinical procedure, the diagnostic reasoning are not vocationally neutral activities onto which meaning is later projected from the outside. They are already, in themselves, the site where knowledge, relationship, and ethical commitment converge. A dressing change performed with presence and competence, a medication administered with attention to the person's experience, a clinical handover conducted with precision and care for continuity: these are not merely technical acts. They are the concrete form that vocation takes in practice. Demonstrating their epistemological content, what they know, what they require, what they transmit, is not only a matter of professional recognition. It is the condition for vocation to remain, in healthcare, a living and generative force rather than a rhetorical inheritance.

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