The implications for professional roles and occupational identities of an organisational change process in an NHS trust hospital

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The Implications for

Professional Roles and Occupational Identities

of an Organisational Change Process in an NHS Trust

Hospital

Yvonne Leverment
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**ABSTRACT**

This thesis explores reactions to changing occupational roles and identities precipitated by a Business Process Re-engineering management change programme within a National Health Service setting. The thesis offers further understanding of the changing nature of professional roles and occupational identities within health care. Taking a qualitative approach, through the use of interviews and focus groups, the empirical core of the PhD examines professional employees' responses to changes in their own working practices. The main thrust of the argument is that work reorganisation that changes the role and scope of practice impacts on occupational identities. The empirical work demonstrates how the effects of change in working practice create a situation whereby there are clearly defined winners and losers within and between professions. This thesis links such a recognition with the multiplicity of interests and the complexities of professional occupational identities within health care. An added dimension is the extent to which disciplinary knowledge creates these professional roles and occupational identities. If health care professionalism is to be redefined there is a requirement for an agenda which addresses the issue of how knowledge and expertise are acquired.

**Key Words** – National Health Service, role and scope of practice, profession, occupational identity
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GLOSSARY OF TERMS

Social Identity Aspects of the self concept that derive from an individual’s knowledge and feelings about the group membership they share with others

Occupational Identity Aspects of the self concept that derive from an individual’s daily range of tasks which can be identified under a given title

Professional Identity Aspects of an occupation’s identity that are also fostered outside of the workplace by the professional associations
CHAPTER 1

ORGANISATIONAL REFORM IN THE HEALTH SERVICE: WORKING FOR HEALTH PROFESSIONALS?

'The most serious fallacy that has dominated the various reorganisations, is the fallacy that a large and complex system such as the NHS is ultimately efficiently manageable'

(Kelly and Glover, 'In Search of Health and Efficiency: The NHS 1948-94', 1996:30)

Introduction

As the largest British public sector organisation, the National Health Service (NHS) has undergone several major upheavals in its relatively short history. For the country's largest employer, these reorganisations and changes have done much to shape the nature of the professions working within it. Of the NHS, Glover and Leopold (1996:256) write, 'it is domestic, not international in its operations; its tasks are infinitely varied, complex and difficult; its goals are unclear; it is subject to a wide range of political and economic influences; and it is an organisation uniquely and especially close to the hearts, minds and bodies of British people. It is run by special kinds of people too; dedicated, yet often ambitious, highly qualified and skilled, often bloody minded and usually tough minded, yet also caring and even tender'. Rather than give an in-depth political evaluation of health care policy from the inception of the NHS to the present day, the purpose of this chapter is to give a short historical perspective on the structure and organisation of the health service. In doing so, it evaluates the impact of major political and organisational change on the main health care professional groups.
There are two main problems with analysing the impact of NHS reforms on the health professions. Firstly, there is the number of reforms and the difficulty of separating out the impact of each reform in the absence of proper evaluation programmes - there is very limited research certainly pre Griffiths. Secondly, there is the multiplicity of health care professions and the differential impact on them. For these reasons, analysis here will focus on the two latest reforms (and perhaps most major, in terms of organisational change), that of Griffiths (1983), and the White Paper 'Working for Patients' (1989). The bulk of the literature concentrates on the medical and nursing professions. The purpose of this chapter is to highlight the impact of political change on management policies at the organisation level affecting the role and occupational identity of the health care professional. This provides a baseline for examining the impact of organisational reform and changes in working practices at local level, which is the central theme of this thesis. What soon becomes apparent is the pluralistic nature of the delivery of health care by a number of stakeholders, against the backdrop of a unitarist style of management philosophy imposed on the health service by the Conservative government of the eighties and nineties. Indeed, the chapter’s focus is on the Conservative NHS policy legacy.

**The Beginning**

Although July 1948 saw the birth of the NHS, the concept of public and state responsibility for health can be traced back to more than 100 years earlier. The establishment of the workhouses as providers of care, together with the emergence of the voluntary hospital system, isolation hospitals and asylums, saw the beginnings of a public service in which people had access to hospital care, albeit unequal and inadequate. In 1942, the Beveridge Report advocated far reaching recommendations that formed the basis for the post war system of social welfare. Although the name of Aneurin Bevan is...
synonymous with the creation of the NHS, it can be argued that he was at the end of several earlier initiatives and plans. Nevertheless, Bevan did make a number of personal contributions most notably in his deliberations with the medical profession. Much negotiation and discussion took place prior to the creation of the NHS, not least between the Labour government of the time and the British Medical Association (BMA), the main body representing the medical profession, who, concerned for their own professional autonomy, were fiercely opposed to the new health care proposals.

In order to ensure the support of the medical profession, Bevan made two major concessions: that General Practitioners would retain their position as independent contractors; and that hospital consultants, though paid on a salaried basis, were not only left the option of private practice, but also had a major role in the administration of hospital services (Foot 1975). Although Bevan had cleverly divided the medical profession, the financial settlement was favourable to them and their professional autonomy had been secured. Unlike the other health care professions, they were not to be ‘managed’. These concessions had far reaching effects on developments within the NHS in the following years. They also demonstrate how far the role and practice of doctors was deeply embedded in the NHS, from its very inception. In subsequent chapters of this thesis we will see how other health professions based themselves on this medical model in their formative years.

The foremost theme of the new NHS was that the state should take major responsibility in the financing, planning and provision of health care. Heralded as a universal service, in the sense that there was access for all, the NHS was to provide comprehensive medical care that was for the most part free. The Beveridge Report had assumed that following the
introduction of the NHS, public expenditure would level off with a reduction in the level of disease, and even decline as people became healthier. In fact, the reverse happened and, as a result, supplementary funding was necessary almost from the start (Ham 1992:17). As the demand for NHS care rose rapidly resources were often found to be insufficient. This led to the 1952 Guillebaud Report which acknowledged some deficiencies in service, but resisted suggestions that structural changes were necessary, arguing that real increases in resources had been exaggerated (Levitt and Wall 1987).

The arrival of Consensus

By 1974 the organisation of the Health Service was a reflection of the evolutionary development of health care provision in Britain in that the old tripartite system of the previous years was seen to be uncoordinated and fragmented. There was mounting evidence to suggest that a divided service impeded any clear rationale for the allocation of resources and the development of the NHS (Leathard 1990). The 1974 reorganisation saw early signs of modern business skills being introduced into the NHS. Active promotion of management efficiency and the creation of an effective administrative structure gave scope for new management directives. Notions of management training and development were introduced, with the encouragement of managers from the clinical professions. Consensus management had arrived. There was to be maximum delegation downward and maximum accountability upward. Each profession was to manage itself but come together to manage the service as a whole. The health service was to be managed by groups of health care professionals, each representing the interests of their own profession. This consolidated the extension of medical 'syndicalism' to other professions, in particular the nurses, who were able to sustain a nursing hierarchy that reflected a quasi-military discipline (Strong and Robinson 1991:19). The pecking order that had evolved through the
old matron system could now be extended through the new nursing officer role, and although the Royal College of Nursing (RCN) had called for radical reform within the profession (this did eventually happen with Project 2000), nurses showed little professional solidarity amongst themselves. The 1974 reorganisation was not only seen as a ‘high point’ of managerialism at that particular time, but also seen as a means of unifying health services and achieving improved coordination between health authorities and those local authorities providing social services (Ham 1992: 24-26). Consensus management reflected the pluralistic assumptions of Fox’s ‘frames of reference’ Industrial Relations model (Fox 1966). Sectional groups – in this case the professions – all with divergent interests, were to come together for the general interest of the running of the health service. Although there were to be rival sources of leadership between them, there was to be control and balance of activities so as to provide for the maximum degree of consensus.

The reorganisation proved costly, not only in financial terms, but also in terms of staff morale. However, the real failure of consensus management hinged on a number of recurrent factors. Firstly, whilst the absence of an integrated national management structure caused the system to remain fragmented, the new NHS was attacked as being excessively managerialist and criticised for its bureaucratic complexity (Klein 1995:113). It is reasonable to expect that any large-scale organisation will have in some measure a bureaucratic structure. Indeed, the NHS reforms followed the pattern of 1970s local government reform. In Weber’s account of the ‘ideal type of bureaucracy’ (1964:214) he argues that the advantages of bureaucracy allow an organisation to organise its duties ‘precisely, unambiguously, continuously and with much speed as possible’. However, in reality the term ‘bureaucracy’ usually means the exact opposite of the highly rational and
efficient system that Weber refers to. The everyday view of bureaucracy conjures up a picture of excessive paperwork, too rigid rules, and time-consuming procedures that are unresponsive to clients. And this was the image of the NHS.

Secondly, the issue of the continuing powers of the medical profession had been neglected, resulting in a miscalculation of the balance of power between the administrators, the medics and the various health care professions. Despite consensus management, marked differences remained apparent between the professions. Medical individualism resulted in doctors squabbling between each other for resources, but equally saw a united front outwardly, both at local and national level. The nursing profession, on the other hand continued to be run in an extreme hierarchical fashion, showing little solidarity or allegiance within the ranks. Historical differences in educational standards and gender between the two professions (an educated, predominantly middle class male profession versus a predominantly female relatively uneducated profession), still left the nurses, and other health care professions, subordinate. Thirdly, the two main professions proved difficult to manage and in that respect were similar. This is best summed up by Strong and Robinson (1991:49), who suggest that the new medical managers created in 1974, (the community physicians) 'had knowledge but no power over their colleagues', and the new nurse managers 'had power but lacked the expertise to use it'. Up until then NHS development and policy could be likened to Lindblom's 'muddling through' (1959), as a process of disjointed incrementalism. Coulter (1991:115), argues that this incrementalist approach to policy development did little to challenge the autonomy of professional health care groups, making demands for increased professional accountability difficult to realise.
'If Florence Nightingale were carrying her lamp through the corridors of the National Health Service today she would almost certainly be searching for the people in charge.' (Griffiths Report 1983:12)

In October 1983 a report was published that was to transform the management style of the NHS. Roy Griffiths, Managing Director of Sainsburys, had been asked by the Thatcher Government to head an inquiry into the effective use of management, manpower and related NHS resources. The above quote is probably the most famous and frequently used line from the report. It succinctly reflects the underlying theme - that the NHS was suffering from a distinct lack of management initiative. The inquiry itself involved only four people, took only six months to complete and operated on an almost informal basis, consulting many but not formally taking evidence - itself a break from the pluralist political tradition of Committees and Royal Commissions that were representative of all interested parties (Klein 1995:147). The predominant theme of the report was that the NHS lacked a clear management function and that the prescription for change should be based on the principles and culture of private sector management. The report was wholeheartedly endorsed by the Thatcher administration and its recommendations carried out swiftly and almost to the letter. The core of the 1984 re-organisation was the assertion of central, managerial control, using a variety of different methods and involving all those working in the Health Service. This represented a distinct shift away from the pluralistic ideal of management by consent toward a new unitaristic management rhetoric. Fox himself, had suggested that unitarism within large, complex organisations was wishful thinking (1966). Yet now it was becoming practical policy.
Two recommendations were particularly significant. Firstly, the Secretary of State was to set up a Health Service Supervisory Board, chaired by the Secretary, which would set policy. Under this, an NHS Management Board would be responsible for planning of policy implementation, providing leadership and controlling performance, thus attempting to achieve consistency within the service over the long term. Secondly, there were to be Management appointments at Regional, District and Unit level (Enthoven 1991). This new breed of NHS manager was to provide leadership at all levels of the organisation, introduce a continual search for change and cost improvement, motivate staff and adopt a new more dynamic, proactive management approach. Despite the informality of the inquiry and the team's lack of interest in academic research findings, their analysis of management problems in the NHS had mirrored a research based picture previously outlined by Harrison et al (1994). Griffiths hoped to provide an improved environment for the delivery of health care, with higher standards of care from health care workers. Professionals would be more closely monitored than before and be given the opportunity to enhance their working practice. They were expected to not only take pride in their work, but also be more responsible for it.

Clinical professions were no longer to work independently. 'Administrators' were to be abolished and 'line management' was to follow. This meant that within the hospital there was to be a new type of management leader with extensive powers to create his/her own subordinate structure, and new teams to provide a framework for organisational change. A new style of health care professional was to be developed, combining managerial and clinical skills. Emphasis was to be based on cost consciousness, performance, evaluation, distribution of information, enhanced communication, value for money and efficiency. Finally, patients were no longer to be seen as either passive recipients or consumers, but as
tax payers who paid for the service as a *customer*. The changes were the antithesis of the 1974 consensus management structure. They challenged the mechanisms that had served to maintain professional autonomy and career aspirations among the health care professions.

Pollitt (1990:27) refers to a move toward a generic model of management – one which sought to minimise the difference between private and public sector management. He argues that the ‘particular species of genericism which was dominant tended to be of a neo-Taylorian character’. The setting of targets, the introduction of performance management, the strengthening of line management, all emphasised the control of staff rather than their development. And this was to be a constant management theme. This Taylorist perspective of work control form above cut against the complexities of a workplace as complex and pluralistic as the health service. Furthermore, it ignored the cultural aspects of NHS organisational life such as beliefs, attitudes, identities, rituals and symbols.

This was the vision of Griffiths. What then, was the impact? Throughout the previous years of the NHS, medical individualism had been seen in every type of decision made by doctors. Vast variations in treatment and standards existed, not only between different specialities but also from within the same speciality. Competition for clinical resources was strong. Post Griffiths, doctors were encouraged to manage and a division appeared within the medical profession. Whereas public medical debate frequently accused health managers of undermining clinical freedom, others within the profession were taking on the role of manager alongside their clinical duties as speciality directors who were directly accountable to general managers (Hadley and Forster 1993:8). But what of their
management skills? The majority of doctors had often appeared ignorant of management issues and displayed an inability (or perhaps unwillingness?) to understand new management proposals. The immediate reaction to Griffiths was mixed - a trial run in one District was recommended by the BMA. Even though the Griffiths Report was respectful of medical power and advocated close involvement of clinicians in the new management process, for many, the report heralded the beginning of the end of their professional autonomy. Nevertheless, professional medical reaction was cautious and not necessarily negative. The BMA suggested that the new General Managers should be medical - a way perhaps of attempting to safeguard their autonomy. However the majority of managers appointed were not medical. Few doctors could demonstrate proven managerial skills needed to turn the Health Service around (Leathard 1990).

In the aftermath of Griffiths, doctors have complained of a tension between their managerial and clinical roles (Anon 1985, Lyall 1991). One consultant described himself as ‘an experienced clinician, a beginner in management, but lacking in the necessary skills’ (Lyall 1991). However, despite their lack of management skills, the medical profession did manage to wield some protection against managerial power by insisting that Regional contracts for consultants were kept and that their professional advisory machinery remained intact (Cox 1991:97). Yet again, though publicly outspoken about the reforms, the doctors managed to successfully negotiate their own clinical autonomy far more effectively than other health care professions. Authorities on the British health care system such as Harrison (1988) and Scrivens (1988), have viewed the imposition of general management as a serious attempt at challenging medical hegemony. Indeed, the development of Information Systems and clinical budgeting in the aftermath of Griffiths ensured greater managerial control over how resources were to be deployed. However,
research carried out by Banyard (1988), and Pollitt et al (1988), suggested that in the post Griffiths pre White Paper era, control over clinical targets and clinical activity by managers was sporadic.

As for the nurses, few had proven management skills. In that respect they were in a similar predicament to the medical profession. Although large in number, the profession was weak, and the position of nurses under the new management structure was under far greater threat than that of the doctors (Strong and Robinson 1988:65). Perhaps because of this, the reaction from the nursing profession was far more outspokenly critical, especially since relatively few nurses were appointed to General Management positions. Studies following the restructuring, described fears within the profession of role conflict between the separation of management control and professional advice (Glennerster 1988). This led to the 1986 Royal College of Nursing (RCN) advertising campaign which sought public support for nursing advisors who 'understood nursing', to be appointed at every level (Clay 1987). There is a conflict of opinion as to whether the nursing profession fared badly following Griffiths. The RCN told a 1987 Commons Social Services Select Committee that the profession was unhappy about the lines of accountability and the diversity in senior nurse roles following the reorganisation. On the other hand, there were new career opportunities in areas such as quality assurance. And another positive development was the increased responsibility at the lower end of the nurse manager ladder as a direct result of the diminishing district roles. At ward level, Harrison (1988) reported increased pressure on productivity and skill mix, whilst Glennerster (1988) suggested nurses had been demoralised.
As a result of the Griffiths management restructuring, the Thatcher government had hoped to attract managers from outside the Health Service. But the idea was largely unsuccessful. In 1985, 80% of posts had been filled by existing Health Service staff, with 60% of all appointments going to NHS pre-Griffiths administrators (Leathard 1990). This relative failure to attract 'new blood' from outside of the NHS was attributed to factors such as lower salaries than the private sector, an absence of fringe benefits, the notion of continued political interference and an unsettled picture of organisational change in the public sector. Cox (1991:98-99) argues that the effects of Griffiths on the managers themselves was positive. This came at a time, in the mid-eighties, when British Management was emerging with a new self confidence. Trade Union powers had declined and a new 'excellence literature' had emerged, bestowing the virtues of organisational culture and leadership. Thus NHS managers welcomed their new found responsibilities and the opportunity for change. Similar views can be found in Klein (1995:150).

One of the key issues arising from Griffiths was the devolution of power. Did this really happen? Were the managers appointed allowed to manage freely? Certainly, many remained suspicious of Government intervention. The central administration of the NHS was often seen to be driven by political advocacy, not by the needs of the NHS. Central government was reluctant to yield power, with the finance of the Health Service remaining under central control. The new management structure appeared designed to strengthen Whitehall's ability to promote its own ideas and priorities about service provision, and to assert control over Health Service output at Regional and District level. In short, Health Authorities had become executors of nationally agreed policy. Following Griffiths, a chain of command and pecking order had developed within the new management structure. The
implementation of local initiatives was being frustrated by ministers, civil service and management tiers (Day and Klein 1985).

A more positive achievement of Griffiths was the major development of Information Technology within the Health Service. Buzz words such as cost effectiveness, performance indicators, quality assurance, consumerism and clinical audit had begun to appear in NHS terminology. Rationing of resources at the discretion of the clinicians, had been replaced by rationing and planning by managers, based on financial criteria and new Information Technology. As a result, Griffiths had confronted a conflict inherent since the creation of the Health Service in 1948 - a conflict between bureaucratic and professional control. The new managers challenged forty years of professional dominance. In the face of this, working relationships between general managers and the hospital doctors proved difficult. Changing the nature of this working relationship was an essential requirement of Griffiths. Harrison (1988) notes that in practice progress was slow, demonstrating the key positions held by the health care professions, and in particular the doctors, within the health service. This was reflected in the contrasting values of the two groups: the cost efficient approach of the manager and the patient centred approach of the doctor.

The Griffiths model of general management was based on a particular philosophy, a doctrine even. Although this had been widely used in the private sector, it had not been tested in a health care setting. Some felt that Griffiths had not been properly implemented, with emphasis placed on cost rather than quality (Ham 1992:34-35). Although Griffiths had set out the strategic direction of the NHS against a coherent policy framework, the latest reforms had failed to focus on the health status of the nation, resulting in an emphasis on short term financial objectives (Flannagan 1989). Furthermore, though an
apparently effective line management system had been imposed on the Health Service, the government remained in control. The importance of the Griffiths report for this study lies in the vision behind the recommendations. It came at a time of general social change in public attitude – a shift from producer to consumer values. The message was that a more efficient, consumer led service was needed. In the event the ensuing changes, although not radical enough in achieving Griffith’s vision, served to underpin future developments in the health service.

**Working for Patients, the ‘Customer’?**

Having been returned to power in 1988, for a third term of office, the Thatcher administration faced mounting public concern over NHS funding. The media exposed numerous tales of ward closures, postponed operations and excessively long waiting lists, fuelling emotive public responses. This discontent was not confined to the public. Professional organisations lobbied the government and when the presidents of three Royal Medical Colleges issued a joint statement suggesting that the NHS was at breaking point, additional funding was appropriated to stave off ward closures. However, the barrage of open criticism of government handling of the NHS continued, leading Margaret Thatcher to announce yet another review. Klein (1995:176-177) puts forward a number of interesting explanations for this surprising announcement, which even took her closest advisors and ministers by surprise. Firstly, caught between the containment of public expenditure and pressure for increased funding of the NHS, the government was left with little option but to radically review the organisation and financing of health care. Secondly, the boost to Conservatism and the ideological commitment of market forces following re-election for a third term, gave the government increased confidence in pursuit of its ideology. Thirdly, the experience of previous administrations gave the government
confidence to instigate change in areas of insurmountable obstacles and dissent, particularly in the area of public policy. Finally, and probably most notably, Thatcher herself had become increasingly irritated by the public debate over the NHS, and the open criticism by the medical profession. This had, in her eyes, amounted to a break in the tacit agreement between the state and the profession, which allowed for almost total professional medical autonomy in return for recognition that the state controlled the right to set budgetary requirements.

Hence the White Paper of 1989 and its implementation in 1991, delivered the most radical review of health care in the history of the Health Service. The central theme of the White Paper was to instil a sense of competition within the service by separating the provider/purchaser role of the Health Authorities. Thus saw the beginnings of the ‘internal market’. Hospitals (to be given the new title of Trusts) were to take more responsibility for managing their own budgets and resources, but in return for this devolution of power had to compete for ‘business’. General Practitioners (Fundholders) were to be given similar responsibility and the opportunity to ‘buy in’ their services according to their needs. Other key reforms included performance (incorporating quality), efficiency, consumerism and increased management autonomy. In particular these pushed responsibility down to the health care professional facing the consumer, whilst strengthening the control from management (Wheeler 1990). There followed an explosion of opposition from all quarters. For once, the Labour party and the medical profession were united. Critics complained that the Conservative government was attempting to de-rail the NHS in order to create a two-tier system, and promote private health care. Mass condemnation of the reforms by the health professions appeared in the media. Despite this, the reforms went speedily ahead, with little collaboration between government and the professions.
In a paper discussing managerial reform in the public sector, Laughlin and Broadbent (1994), link the creation of the internal market with Hood's seven characteristics of the Finance Management Initiative (FMI). They suggest that the creation of the internal market satisfied five of the seven characteristics: financial devolution, design of measure of performance, increased accountability, emphasis on private sector management style, and development of contracting. Their article questions the suitability of the FMI type model for the public sector. Others have expressed more general concerns over the effects of the reforms, in particular the internal market, on health care (Klein 1995, Baggott 1994, Mohan 1995). There is less to read, however, on the effects on individual professions. Certainly, the mere exclusion of the medical profession from discussions on the reforms, and the subsequent implementation despite outspoken opposition from the BMA and the Royal Colleges, contrasts with the status that the medical profession had previously enjoyed. Mohan (1995:138) suggests that 'this reflected the government's tactics at the time which reflected the view that professional organisations displayed an ability to pursue their own interests rather than those of the people they served'.

The Government claimed that its primary aim was to remove variable standards within the medical profession. And the establishment of Trust hospitals and GP Fundholders, began to divide the profession in a way that had previously been unheard of. As more of the profession came to work within the new structure, some began to concede that there were advantages to the patient. For example, GP Fundholders appeared to have priority referral with the local hospital Trust over non Fundholders. This served to fuel speculation that a two-tier system was developing - something that opponents of the reforms were quick to capitalise on. Increased accountability challenged clinical autonomy through the
introduction of compulsory medical audit and there was to be locally agreed contracts for new consultant appointments and a stronger emphasis on local managerial control. Although there was medical opposition to the reforms, newly appointed consultants appeared more conciliatory in their views on the internal market. They appeared to more readily accept the situation and be willing to work with the reforms in order to achieve their career aspirations.

Armstrong (1990) suggests that this particular dispute between the government and the profession saw another stage in the long term decline of medical power. Later work by Harrison et al. (1994) confirms this, suggesting that evaluation of the changing power of the medical profession needs to be registered at two levels - macro (national) and micro (local). At macro-level, there was no dramatic change in the power base of bodies such as the BMA and Royal Colleges. Even so, Harrison et al argue that there has been a gradual decline. They cite factors such as: a weakening of the cultural authority of doctors as the effectiveness of their medical expertise comes more openly into question, the increasing lobbying strength of nurses and other health care professions in today's debate on public health care; and finally, the shift in emphasis toward community based health care away from the traditional power base of hospital medicine, where medical dominance is less obvious.

It is at micro-level, however, that the medical profession proved themselves most powerful and resistant to change. At this level, doctors held the key to diagnosis, prescription and discharge. It was they who dictated treatment by others, in particular the nurses, and they who had control over waiting lists, operating times and outpatient clinics. The advent of Griffiths and later the White Paper only marginally diminished this
responsibility. Whilst managers dictate the level of intensity of work patterns and control budgets and contracts, doctors still control clinical practice. How much further this power base will be eroded has yet to be seen. However, the status of the medical profession remains largely intact when compared with other health care professions. Baggott (1994:39-43) outlines four areas that serve to define and explain medical hegemony: its social composition, political organisation, clinical autonomy and role in legitimising health and illness. Although, some of these areas are being challenged by health care reforms, the factors which underpin the power of orthodox medicine remain intact, and will probably continue to do so.

There is a vast literature on the alleged ‘proleterianisation’ of medicine, stemming from the corporate rationalisation of health care (Mc Kinley and Archer 1985, Bjorkman 1989). Yet the health service of the 1970’s and early 1980’s demonstrated the continuing hegemony of the medical profession. The reactive nature of managerial control fitted comfortably with Alford’s (1975) structural theory of the relationships between three identified groups - the professional monopolists (of which the medical profession are the largest group), the corporate rationalists (government planners and health care managers), and the community (lay people dependent on health care). However, North (1995) suggests that the internal market has disrupted ‘traditional repositories of power’ that render Alford’s original tri-structural theory inflexible. Examples of this include the new role of the GP Fundholders as both corporate rationalisers and professional monopolists, with their newfound power in purchasing health care and the hospital consultants’ increased accountability in the deliverance of care. In addition, the corporate rationalisers of care, such as the health service managers, have displaced the professional monopolists as the key decision makers about resource allocation, thereby usurping their previous
powers and clinical autonomy. Research into the conceptions of clinical freedom held by the medical profession give credence to North's argument (Harrison and Schulz (1989:203) that medical practitioners 'regard overall financial limitations as being legitimate restrictions on their autonomy'.

As for the nursing profession, education reforms in the wake of Project 2000, have done much to improve their own professional worth and identity. The degree qualified nurse has significantly improved their previous 'handmaiden' and 'angel' image. Changes too are becoming apparent in the professional role of nurses, with more scope for development in quality related managerial roles and as clinical nurse specialists. The latter have more knowledge and clinical influence than the junior doctors.

The much smaller therapy professions such as Physiotherapy and Occupational Therapy have had a smaller voice. Yet they were as outspoken as the two major professions at the time of the introduction of the White Paper and the implementation of the internal market. Concerns about fragmentation of services which had previously been organised on a District wide basis have proved well founded. Services are now very much organised on a Trust basis which, although it leaves the professions more vulnerable in terms of staffing and resources, hasn't directly affected their professional identity in terms of role and status.

The NHS - Redefining an organisational hybrid

In an article comparing health policy in Britain in the 1930s with that of the present day, Powell (1996) concludes that today's reformed NHS shares similarities with health care prior to the NHS in respect to comprehensiveness, free services at the point of delivery,
inequality, planning and adverse selection. While before the NHS some criteria were improving over time, the reformed NHS may well be deteriorating. Following New Labour's return to government, the NHS White Papers *The NHS, Modern, Dependable* (1997) and *Working together - Securing a quality workforce for the NHS* (1998) focused on an agenda for a national framework that addressed the need for improvement in health care delivery. New Labour's intention to modernise the NHS was set out in the *NHS Plan* in July 2000. The report spoke of the NHS being a 1940s system operating in the 21st Century (Department of Health 2000). The modernisation project set out by New labour infers a cycle of cause and effect between its reforming aims, which leads to senior management seeking to improve the job satisfaction of employees, which they claim leads to improvements in job performance, that in turn will bring about the modernisation objectives (Fisher et al 2001). In talking to grass root professional employees involved in generating an agenda for modernisation of health care delivery, this thesis contributes to this debate.

This chapter has not assessed the changes in terms of health quality. In considering national policy agendas it has established a base line for evaluating the effects of local organisational change on the health care professions in terms of role and scope of practice. Before the 1983 Griffiths report, the hospital manager could best be described as a diplomat. Officially called administrator, the NHS manager's role was that of facilitator - an assistant to the mainstay professions. This somewhat weak and ineffective management role was a result of two factors. Firstly, the pluralist consensus team model of 1974 created a multidisciplinary team approach that though outwardly equal, in reality was dominated by the medical profession. Managers were not regarded as the main actors, and doctors were clinically autonomous. The non-medical professions sought to pursue their
own managerial arrangements. Secondly, government control over expenditure was total. With very limited control of their own, either over budget or professionals, reactive management was inevitable. Post Griffiths a more proactive managerial approach was taken in an attempt to challenge the clinical autonomy of professional groups. This was only partly successful. The medical profession, by virtue of their clinical autonomy, were by and large left untouched and a diplomatic culture between doctor and manager continued. It was the 1991 reforms that have seen the biggest threat to professional autonomy. External factors such as the introduction of the quasi market, provider/purchaser split and the threat of competition, and internal factors such as clinical audit and resource management, have increasingly redefined clinical autonomy for all the professions.

Greenfield and Nayak (1996) suggests that whilst doctors are likely to resist managerial pressures, they are unsure how to implement their resistance when confronted by management. Yet, Glover and Leopold (1996) argue that doctors, if not other professionals, are on balance, capable of resisting managerial change successfully by using their professional characteristics of autonomy, status and collegiality to enhance and define their hierarchical position in the health arena. Ashburner (1996) suggests that doctors can maintain their position by fostering co-operative working relationships with management. Whilst the upsurge in general management did appear to result in some loss of control by the health care professions, Harrison and Pollitt (1994: 135-147) suggest that any future increase in managerial control will be more constrained, citing a number of reasons why. As these reasons were highlighted in work published in 1994, an attempt is made to justify them by more recent experience.
Firstly, professional groups will continue to possess powers to resist managerial control as long as they can continue to monopolise their particular skills. Thus, the issue of management led flexible working practices and concepts such as multiskilling presents a threat to the occupational status of the health professional. Secondly, managers will always be dependent on doctors treating patients privately in the NHS as a means of attracting increased income. This remains so, but as new consultants become appointed at Trust level, it is likely that contractual restraints will be imposed on consultant private income. Thirdly, the growth of independent professional groups, who in turn contract themselves back to the health service, is a very real option and one that is already being considered by health care professions, for example, some Professions Allied to Medicine. A fourth limitation is the extent to which managers will want to go in terms of control. There are, after all, advantages in standing back, in particular when directing responsibility for controversial rationing decisions that affect treatment.

The final factor that may restrain management power over professional autonomy is a relatively new force in the health service of today - that is the voice of the customer. Consumer groups increasingly challenge the health professions’ treatment of patients. They are more likely to comment on how resources are deployed, to be more organised in effectively lobbying governments and more skilful in mobilising the media. A number of examples include that of a new children’s hospital in Derby, the only one built this century, threatened with closure due to lack of financial resources within months of opening; the Bristol ‘Heart Baby’ scandal, where parents and media successfully campaigned for a public enquiry; the case of the Manchester General practitioner where public outcry has led to an inquiry into the extent of his malpractice. The most recent scandal involving the removal of childrens’ organs has enraged the general public.
Government imposition of general management on the NHS in the 1980s and the internal market in the 1990s has elevated the role of the manager. Although some see their role as enforcers of strict managerial control over budgets and resources, others see it as one of cultivating responsive organisations where there is devolution of responsibility. How have the reforms of recent decades altered the cultural ethos of the NHS and its professionals working within it? As Newman (1994:59) writes, 'Somewhere during the late eighties the public sector discovered 'culture'.' This is certainly true in hospitals where there is evidence of a more customer focused, and more innovative style to the delivery of health care. But whereas in the cultural literature much is made of the corporate culture, most hospital settings are made up of strongly specialised and individual departments who by their very structure, can be both dependant and interdependent in their work. These are intimately linked to the complexity of professional occupational identities working within the health labour process.

Handy's (1995) work on the classification of organisational culture describes four main typologies – Power (Zeusian), Role (Appollonian), Task (Athenian) and Person (Dionysian). Many organisations display mixtures of all four types, but the NHS has been most likened to Role culture. This is predominantly bureaucratic whereby the organisation develops through the making and adjustment of complex rules, and authority is subdivided between different specialist groups and functions. With a predetermined hierarchical structure according to job type, procedural correctness is deemed paramount and bureaucratic rationality seen as normal. Until more recent times profession and bureaucracy were thought to be contrasting ideals – both at the level of work organisation and at the level of motivation and compliance – thus leading to the notion of
professional/bureaucratic conflict (Davies 1980). However, this notion of conflict may be replaced by the idea of each being complementary on the other. As a negotiated order, hospitals are often cited in the literature as an example of this (Strauss et al 1963, Davies and Francis 1976). Person culture has also played a part in assessment of NHS culture, where the organisation focuses on a group of creative individuals – in the case of the NHS, the medical consultants – who Harrison et al (1994) suggest, have created 'cells of personal culture within a larger role culture'. Bretz and Judge (1994) argue that the person-culture fit is an important aspect of how culture influences behaviour of individuals in the workplace. In work carried out on nurse recruitment in Belgium, Vandenberghe (1999:184) tested this hypotheses, concluding that 'turnover versus staying is linked to the importance of person-culture fit'. Pollitt (1990) suggests that the changing environment of the eighties and nineties has seen a shift towards a task centred emphasis placed on performance, expertise and multidisciplinary team working. Locally orchestrated change programmes such as Business Process Re-engineering (BPR) and Patient Focused Care (PFC) are employed within the health arena to encourage multidisciplinary team working and improve performance. Programmes such as these are deployed to make the most effective use of expertise available. The argument within this thesis is that changes in role and scope of practice introduced by such programmes impact on professional occupational identities. Changes in working practice should create a flexible workforce that is not degraded or demoralised. In chapter 2 we shall see how disciplinary knowledge and expertise is linked to professional occupational identities. In chapter 3 we see how the development and the translation of knowledge into expertise, linked to the role and scope of practice, has contributed to unique occupational identities within health care. The empirical chapters of this thesis illustrate the need for change processes to take this into account.
Organisational culture theories describe well the ethos and the culture of the NHS from its early years through to the ‘consensus management’ era of 1979-1984. Handy (1995) suggests that a cultural crisis in bureaucratic organisations caused by increase in customer demands and a rise in employee aspiration for more creativity and flexibility, resulted in a ‘cultural hybrid’. Certainly the implementation of the Griffiths reforms in 1984 saw a new vision for the NHS. This saw a modification of the Role culture which had previously been dominant. Elements of Task (i.e. the application of relevant expertise in order to achieve results) and the Person culture, where an individuals values matches those of the organisation, have become more prominent. The reforms of 1991 can also relate to this cultural hybrid. Harrison et al (1994) liken the cultural hybrid model to that of the Post Fordist model of management, but suggests that this has contradictory implications for the power/cultural interface. Whilst portrayed as a liberating force for the employee, that employee is expected to go the extra mile for the organisation, and whilst management believes that organisational cultures can be re-fashioned, it may well be fashioned in a way that erodes employee protection. Harrison et al, summarise the main characteristics of a cultural hybrid as follows:

- High autonomy for each part of the organisation. The centre will hold each part accountable for certain key achievements, but will not attempt to prescribe in detail how these objectives are to be met.

- Staff enjoy higher personal involvement and commitment because they identify more with their local, semi-autonomous unit than with the huge, impersonal totality of the organisation.
• An expert professional core, with elements of person culture type freedoms.

• Many staff would be employed on short-term contracts. Again these would specify results and quality standards, but be less prescriptive about methods.

• A much slimmed down middle management. The combination of improved information technologies with a more results orientated, contract based approach would reduce the need for the rule making, controlling administrators characteristic of role cultures. Remaining managers would be more concerned with strategic issues and contract compliance.

With its rhetorical emphasis on empowerment and multiskilling, present health service organisational change programmes currently employed in the NHS such as BPR and Patient Focused Care, encompass many of the characteristics of this cultural hybrid. Emphasis on bottom up led initiatives fully supported by a committed management have the opportunity to change working practices which have a direct impact on the role and scope of practice of professional groups. For these professional employees, their unique practice is linked to their occupational identity within the health labour process. This occupational identity is based on a sound knowledge base and expertise. Three themes are emerging here that cannot be viewed in isolation. Organisational change processes impacting on role and scope of practice of professional employees will have implications for the occupational identities of these employees. These three themes underpin the focus of this thesis.
Conclusions

Organisational changes over the last fifteen years have produced a flurry of hyperactivity directed at making the health service more efficient and quality driven. At the beginning of this chapter, Kelly and Glover (1996) talked of the 'fallacy' of managing the health service. This chapter has explored the impact of two decades of politically driven organisational change on the health service and the professions working within it. Successive Conservative Governments attempted to introduce general management principles into the NHS. These provoked tensions between the managerialist, unitarist approach to change management and the pluralistic nature of the health service. One critical but missing element in this equation is the 'black box' of professional/occupational identity. This is likely to mediate the impact of these reforms and changes. The following chapter considers the literature on the sociology of the professions and social identity theory. The purpose of this is to provide a theoretical backdrop to the key terms used in this thesis – professions, role and occupational identity. In doing this the chapter serves to illuminate further the central subject of this thesis – the effects of an organisational change programme involving health professional employees in terms of role and scope of practice and professional/occupational identity.
CHAPTER 2

THE PROFESSIONS: OCCUPATIONS IN SEARCH OF AN IDENTITY?

"Virtually all self conscious occupational groups apply it (the term profession) to themselves at one time or another either to flatter themselves or to try to persuade others of their importance. Occupations to which the word has been applied are thus so varied as to have nothing in common save a hunger for prestige...Since people do not agree which occupations are professions.... their definitions vary with the occupations they include (or exclude) or else are alike on such an abstract level as to be virtually inapplicable to the task of distinguishing real professions”

(Friedson 1970:3-4)

INTRODUCTION

In spite of the emphasis placed on the significance of professionalism in industrial society, the above quote highlights the ambiguity and difficulty in actually defining what a profession is. Indeed, in the present era, the professions are facing numerous challenges that threaten their authority, autonomy and position in society. Johnson (1972) highlights the inconsistency of much of the early professional literature. He concludes that the professions can be seen as ‘Janus headed’. In the first instance, they are responsible for an independent and free occupational community within a society that is threatened and governed by bureaucracy. Set against this, however, is a more controversial and sceptical view of the role of the professions – that they themselves, through their professional associations, are bureaucratic mechanisms that function to enforce monopolistic practice and control the market. While altruistic motivation and a sense of collectivity are claimed as major components of a profession’s uniqueness; its evolution and subsequent self-regulation is also based on self-interest as the professional association counteracts the influence of the market.
The key attributes or characteristics of a profession are divided by Gargan (1993) into three elements – substance, organisation and regulation. ‘Substance’, he says, is not just about being able to demonstrate a competence based upon a body of knowledge and applied skills obtained through a period of extended study. Rather, it should be expected that the scope and complexity of the knowledge base is such, that it affords the profession a degree of mystery and mystique to the outsider. In his second element of ‘organisation’, he argues that in its early years the profession is relatively unstructured with ‘permeable boundaries’. More permanent arrangements evolve through training, use of members’ skills in the professional work setting, and the protection of those skills through the activities of the professional association. In noting that many professions function within bureaucratic settings, he disputes both sides of the labour process debate. Indeed, Gargan suggests that neither proletarianisation nor bureaucratic adaptation to professional values are relevant today. His own hypotheses is that the structure in which professionals’ operate will be ‘less determining of their autonomy than judgements in society as a whole as to the profession’s worth’. As for ‘regulation’, he argues that the issue is not one of deciding ‘whether to control, but who is to control’.

One of the distinguishing characteristics of a profession is the notion of autonomy. The issue of who controls practice is crucial in determining the level of autonomy a particular profession is afforded within society. If professionals are to be accountable for their actions they need the discretion and freedom to control their own practice. Standards for entry into the profession, codes of practice, conditions of employment and the ‘policing’ of wrongful practice are all controlled by the profession. However, that control is licensed through the state and agreement has to be negotiated between the two. Hence, the issue of control plays a crucial role in defining a profession’s identity. Legitimisation of the
profession by the state leaves control largely in the hands of the professional body. In this way the state itself plays a role in creating professional identities. There are links here too with social status, found in Parkin’s (1974) model and discussed in more detail in the following chapter. Thus state legitimisation favours the middle class professions such as Doctors and Lawyers. In contrast, manual craft workers, such as print workers in Cockburn’s Brothers (1991), rarely receive state endorsement and are often regarded as exercising illegitimate ‘restrictive practices’.

To attempt to specify stages in the professionalisation process is as problematic as defining what a profession actually is. The concept of professionalisation, Johnson (1972:2) argues, ‘is in itself a straight jacket imposing a view of occupational development which is uniform between cultures and unilinear in character’. This approach does not allow for variation in structure, progression and occupational control. There can be no reason to assume that all occupations, now classed as professions, proceeded through similar sequences and circumstances. What is significant, is the commencement of the professionalisation process, as it signals the development of a form of definitive practice which is specific to an occupation. Initially, these practices may be undeveloped and open to alternative approaches. However, at some point there must be evidence of the emergence of a core base. The source of this knowledge base may arise from a variety of circumstances – a scientific method that provides a solution to a problem, an authority that declares an approach as correct, or a crisis event that consolidates opinion on the appropriateness of a solution to a problem.

Once this body of knowledge surfaces there is a need for training. In a discussion on the professionalisation of an occupation, Parsons (1954:33) states, ‘the requirement of formal
technical training is accompanied by some institutionalised mode of validating both the adequacy of the training and the competence of trained individuals...leading to some order of mastery of a generalised cultural tradition, and do so in a manner giving prominence to an intellectual component’. From a historical perspective, training has not only taken many forms but varied in the degree of formality. Many of the occupations classed as professions today involve training in higher education establishments. But there are other examples of how knowledge is translated into skill. These include the master apprentice training of many traditional craft occupations and even ‘on the job factory floor work’. Professions by contrast take the ‘high road’ of more formal education and training. Progress in the professionalisation trail is through interactive means, both internally and externally. Practitioners create internal structures and networks from within, which support the further development and security of the profession externally. Once created these structures and networks serve to orchestrate recognition politically and publicly. As the process proceeds a profession perceives the role of its members as increasingly differentiated from those of other workers. The growing sense of professional pride, cohesion and commitment facilitates the formation and expansion of professional associations and professional interest groups, who in turn take on responsibility for the promotion and protection of the profession’s status and interests.

The image of the profession is enhanced in so far as the activities of its members produce a valued service to the population. The successful profession captures an increasing client market share over other professions and public opinion is supportive. The image of public service is important to the profession and the final professionalisation stage is that of legitimacy. As a profession matures, it follows a rational strategy of influencing the state powers that control it through legislation. It directs control of itself through developing
ethical codes of practice and forms of self regulation that are legitimised by the state and society. If the end state of professionalisation is one of occupational control, a profession is by then no longer just an occupation. It is a means by which an occupation can be controlled and formalised, raising its status and giving it a sense of permanency. Professionalisation therefore - for those occupations who choose to undergo it and are successful in asserting it - is a historical process that occupations have had to undergo, rather than be expected to undergo because of their essential qualities. Today, as the aspirations of the 'customer' continue to rise, the issue of public service and legitimacy is of particular significance for the professions. This is particularly true within the health arena where the image of medicine has been severely dented by high profile 'bad practice' cases.

This chapter attempts to unravel some of the literature on the professions in order to provide a theoretical framework to underpin the key focus of this thesis – the effects of a change programme on the professional/occupational identity of those involved in the process. It begins with a short evaluation of the various models adopted in the professions literature. In doing so, it draws particular attention to Larson's (1977) model of the professional project as an 'ideal type'. Larson's model sits nicely with this study since the following chapter traces the steps of some of the health professions other than medicine and demonstrates how they evolved from the 'medical model'. The research for this thesis concentrates on health professions and the effects of change on their role and scope of practice. For the professional employee, practical skill is firmly linked to a particular field of knowledge and expertise. It is this particular knowledge and expertise that dictates the occupational boundary of the profession and its identity, from both a social and organisational perspective. To this end, the concepts of knowledge (Foucault) and
expertise (Scarborough) are used to explore how a profession determines its distinctiveness and uniqueness.

**What is a profession?**

A number of approaches or 'models' of the professions are found in the literature. Early literature focuses on a functionalist approach. Here writers such as Carr Saunders and Wilson (1933), Parsons (1954) and Durkheim (1957) emphasise the social functions of the professions. Durkheim placed a special emphasis on the role of the professions and occupational organisations in the social integration of industrial society. In *The Division of Labour* (1964) he argues that as societies become more complex there is a 'progressive emancipation of the individual from subordination to the conscious collective' (Giddens 1971:101). Anomie - a form of social breakdown in which society's norms cease to operate - threatens the social system in so far as there is a lack of moral integration between the different layers or strata. The primary purpose of the professions and their occupational associations is to reinforce moral integration and promote solidarity. At a more practical level, professions also provide necessary expertise.

The components of the functionalist model are limited to those elements which have functional relevance to either society as a whole, or the professional/client relationship. The model defines professional behaviour in terms of four essential attributes - a high degree of generalised and systematic knowledge, primary orientation to the community interest, a high degree of control through codes of ethics internalised in the process of work socialisation, and a system of rewards - either monetary or honorary. Firstly, the high degree of generalised and systematic knowledge is based on the notion that specialist knowledge itself provides control over society but benefits it too. And so, importance is
placed on that knowledge being of community interest. In serving the community interest, the professions as holders of that knowledge, are allowed the dominant role in controlling that particular knowledge base. State power is subsidiary to that control. In return society regards that knowledge with high value and so rewards accordingly. However, the universality of such assumptions is questionable, as it is debatable whether such central values can be shared equally by all sections of society. Furthermore, it can be argued that the approach is ahistorical for two reasons. Firstly, it ignores the historical analysis of how powerful groups have been able to control occupational activity. Secondly, it ignores how, through time, the changing distribution of power within the professions has impacted on the client-provider relationship.

During the same period, another school of thought concentrated on a trait approach whereby listings were made of the ideal type of profession (Goode 1957) and occupations could then be assessed as more or less 'professional'. As its name implies the 'trait' approach comprises of a number or list of attributes which represent the common core of professional occupations. Whilst authors using this model show little overall consistency the most frequently mentioned traits are: skills based on theoretical knowledge, the provision of training and education, the testing of competence of members, organisation, altruistic service and finally, adherence to a code of professional conduct. Johnson (1972) points out a number of inadequacies of this approach. He argues that the model firstly assumes that there are 'true' or 'ideal' professions, such as medicine and law, that exhibit the essential and common traits mentioned above. Having listed the essential traits and assumed them to be linked to the assumption of an ideal profession, he argues that there is little or no attempt to theorise the relationship between the traits. For example, is there a link between the growth of knowledge and theory with authority or does this authority
derive from elsewhere? With this in mind he suggests that the trait model too easily accepts the professions’ definitions of themselves. In addition, this ‘checklist approach’ which measures the degree to which an occupation is professionalised, ignores the fact that occupations may need to develop various forms of organisation and structure in order to survive. Furthermore, as with the functionalist model, it is ahistorical in that it fails to recognise the specific historical conditions and organisational contexts in which professional forms may arise. Chapter 3 of this thesis demonstrates how historical conditions and organisational contexts can be highly significant in the shaping of professions. Through tracing the evolution of the health professions the chapter reveals how the creation of the NHS afforded these particular professions the opportunity to enhance their professional status by determining their unique occupational role and practice. Finally, the trait approach fails to recognise the social system within which the occupational groups or professions are located - the prior existence of entrenched groups, the extent to which government imposes its own definitions on the organisation of the occupation and the potential limitations in power of the client group.

Interactionist sociologists have criticised the functionalist approach and developed an alternative way of explaining the emergence of the professions. Here, the debate focuses on the actions and interactions of individuals and groups – how they constituted their social worlds as participants and how they constructed their careers. This alternative gave rise to a number of new models of professions. Writers such as Friedson (1970), who based much of his work on the medical profession, saw power as a major influence in determining professional behaviour and dominance. Johnson (1972) also analysed professions in terms of power, only this time through the client/profession relationship. It was the work of Everett Hughes in 1963 that first questioned the circumstances under
which people attempt to make their occupation a profession and themselves professional people. With this he had attempted to move away from considering the structure of the professions to a more action focused analysis. Groups actively sought to construct professions. This approach, as King (1968) says, creates occupations with a high degree of self-consciousness and 'complete identity'. As the major focus of this thesis, the notion of identity is explored in more detail later in the chapter. This helps to determine how a profession’s occupational identity relates to workplace identity and behaviour.

The ‘Professional Project’,

The early work of Larson (1977) carries forward Hughes’s concept of action as she draws attention to what professions actually do in their life to negotiate and maintain their special position. Building on the work of Friedson, her ‘Professional Project’ model encompasses the thinking of both Marx and Weber. She uses the term professional project as a term which ‘emphasises the coherence and consistence of a particular course of action, even though the goals and strategies of a given group are not exactly clear or deliberate for all the members’ (6). Her approach views professionalisation as an attempt to translate scarce resources, knowledge and skills into the other scarce resources of social and economic rewards. In doing so, the profession develops a monopoly over expertise in the labour market and monopoly of status in the stratification system. Market control and social mobility, she argues, are inseparable, converging in the institutional arenas of the labour market and education system. She emphasises that social mobility and market control are not a straightforward reflection of skill, expertise or ethical standing - more of an outcome of the ‘professional project’. This approach, says Macdonald (1995), encourages the belief that ‘social processes’ should be regarded as the product of
individual and collective actions and 'respectability' as something which is actively pursued.

Foucault (1980) also stresses the relationship between knowledge and power. Here, there is a move away from the classic approach of professionalism to the 'modern' form of knowledge which, instead, is organised into 'disciplines'. Knowledge is endorsed as a core professional trait, a resource, and a 'starting point' whichever sociological model is visited. But, for Foucault, there is a need to see the history of a profession as part of the way in which knowledge is reconstituted. This part of his argument links in to what Abbott (1988) refers to as the socially constructed locations of knowledge. This is emphasised in the following chapter which explores the evolution of the health professions found in this research and the professionalisation strategy adopted by them. In doing so, the chapter demonstrates how knowledge served to construct very specific tasks which determined the role and scope of practice of each profession. This established their individual uniqueness and occupational identity, as their knowledge base underpinned the skills that they use in their everyday clinical practice.

Foucault states that 'knowledge is inextricably entwined in relations of power and advances of knowledge are associated with advances and developments in the exercise of power' (1980:64). Using his philosophical standpoint of the 'le regard medical', translated as 'the gaze', it can be seen that the identity of the health professions has been forged by turning human beings into objects that are subjected to discipline. Humans collaborate in their subjection and surveillance as they look up to, and rely upon superior knowledge. Foucault's stance on the relationship between knowledge and power and his conceptual link with power to surveillance and human subjection, gives us some insight into to the
importance placed on occupational identity by the professions, where it is acquired through a skill base that is specific to them. In sum, to the professional, society is an object on whom we subject our discipline, and through the power that our knowledge base gives us, we exercise surveillance and control. Without that specific knowledge and skill base that is deemed exclusive to us (by both us and society) we loose our identity within society. Foucault’s stance is particularly relevant to professions working in health care today where new forms of work encourage the move away from a hierarchical and horizontal approach, to a more vertical cross boundary, team based approach to work design. Yet, as a professional employee we are associated with a very specific and exclusive knowledge and skill base which forges our occupational identity. Each is interdependent upon each other. New forms of work that encourage interdisciplinary working may well undermine this interdependency.

Exclusivity of knowledge, Larson (1977) reminds us, is essential to the professional project and so there is a need for the profession to demonstrate that its own knowledge base is indeed exclusive. However, Macdonald (1995) argues that exclusivity is not restricted to the knowledge base itself. It is also to do with the prevention of other established professions from poaching aspects of the market that are deemed by them to be possible through their own knowledge. If technique can be separated from knowledge, then there is a chink in what Macdonald (1995:184-185) refers to as ‘the professional armour’. This is a further issue for health professions, particularly for the smaller health professions in this research, where knowledge base of the profession may be certified and credentialised within an educational framework that is controlled by individual professional associations, but where clinical practice can sometimes display similar or overlapping techniques. It is particularly important therefore, for the profession and its
members to be identified with specific tasks and roles. A key factor then, for an occupation following its professionalisation trail, is to acquire some form of identity with what it does. The corollary is that any changes in role and practice will threaten the occupational identity of the professional within the work setting.

This is at the heart of the conundrum for the health professions at the present time. Change in work design which is initiated from below through local change management processes, is seen as an attempt to undermine the control from above by the professional associations over the range of knowledge, technique and scope of practice. The professionals themselves, as employees, are caught in the middle. Tension between a professional employee's identity, acquired through their professional governing body, and their commitment to the organisation for which they work, creates a trichotomy for the professional employee. The previous chapter summarised the characteristics of Harrison et al's (1994) cultural hybrid model of the NHS. These characteristics suggest that improved personal involvement and commitment will lead to employees identifying more with their work group than to the totality of their organisation. Furthermore, whilst maintaining an expert professional core, person culture – where individuals match those of the organisation – will become more prominent. In order to illustrate this, this thesis uses the concept of the 'professional triangle' (figure 1). For local change programmes that impinge on role and scope of practice and occupational identity to succeed it is important to understand where employees are located within this triangle. The triangle is used in later chapters to depict some of the key findings in the empirical work.
Figure 1: The ‘professional triangle’

The notion of expertise

So far, this chapter has attempted to link Foucault’s concepts of knowledge, power and surveillance with professional identity. It has also looked to aspects of what Larson describes as the professional project in determining the factors that affect a profession’s identity. For any profession, knowledge and skilled practice allows a level of expertise that can be specifically attributed to the identity of a profession. Scarborough (1995:23) asks the question ‘what counts as expertise, and how do groups acquire it?’ Suggesting that whilst this was once a question addressed through the domain of the professional model, he calls for ‘more diffuse and coincidental formations of knowledge and social relations’. In reframing expertise in this way, it allows new insights into the management process around expert groups’. In recognising that expertise is central to the change process Scarborough points to a paradox whereby expertise can be the instigator to resistance to that change. It will be seen in this thesis, how some professionals/employees see change as an infringement on their own particular brand of expertise and others see change as beneficial or an opportunity. He goes on to link this paradox with the emergence of postmodern society, arguing that whilst expertise used to be embodied
within the so-called professional groups, it is increasingly being produced as a commodity outside of the professional arena. In pointing to the changing modes of knowledge production in the post modern era, he suggests that expertise is no longer the intellectual property of the professional (see Table 1). To focus on expertise therefore, is more ‘inclusive and dynamic’ than the professional model’s static focus of defining and controlling boundaries (25).

<table>
<thead>
<tr>
<th>Mode 1</th>
<th>Mode 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems defined by academic community</td>
<td>Knowledge produced in context of application</td>
</tr>
<tr>
<td>Disciplinary knowledge</td>
<td>Transdisciplinary knowledge</td>
</tr>
<tr>
<td>Homogeneity</td>
<td>Heterogeneity</td>
</tr>
<tr>
<td>Hierarchical and stable organisations</td>
<td>Hierarchical and transient organisations</td>
</tr>
<tr>
<td>Quality control by the ‘invisible college’</td>
<td>Socially accountable and reflexive</td>
</tr>
</tbody>
</table>

Table 1: Changing modes of knowledge production (taken from Scarborough H, (1995:9)

The above table mirrors the work of Gibbons et al (1994) where, they suggest, Mode 1 is a form of knowledge production that ensures compliance with what is considered sound scientific practice. This mode, through its cognitive and social norms, not only determines what is a significant problem, but who should be allowed to practice and what constitutes good practice. Whereas in Mode 1 problems are set and solved in a context governed by a largely academic and specific community who act within their own interests, Mode 2 is carried out in a context of application. Mode 1 is characterised by homogeneity and hierarchy, is disciplinary and tends to preserve its form. Mode 2 is heterogeneous, heterarchical, transient, trans disciplinary and less stable. As such, it is more socially accountable and reflexive for today’s society since it provides a much wider, more heterogeneous form of labour that is responsive to a specific context. Whilst making an
implicit assumption that these modes both do exist in the workplace, it is too simplistic to
argue that organisations either compromise of Mode 1 OR Mode 2 or even that there is a
wholehearted long term shift to Mode 2. However, some new forms of working practice
currently being introduced have a strong element of Mode 2 and are increasingly being
restricted by Mode 1 in areas such as the health service where a large number of
professionals are employed.

The current reality of work within the health service remains predominantly within the
Mode 1 model of knowledge production. Indeed, it can be argued that initiatives such as
evidenced based medicine, clinical guidelines and clinical governance all serve to
reinforce Mode 1. For the professions are forced to be more responsible, accountable and
responsive. Within health care there is certainly a governmental, and, in some instances,
even professional aspiration to move toward Mode 2 level of production. However, whilst
Mode 1 is under threat, the context of application in Mode 2 is always defined by Mode 1
and, as such, can only ever be viewed as a form of franchise or license because of its
dependency on Mode 1.

Reed (1996) discusses the use of expert labour in what Giddens (1990) refers to as ‘late
modernity’ — the way in which scepticism and uncertainty has penetrated into the fabric of
everyday life in modern society. As modern institutions and organisations become
increasingly reflexive to the economy, monitoring and controlling performance in order to
increase efficiency and competitiveness, expert groups play an important part in the
process. The specialised knowledge that they provide play a pivotal role in decision
making agendas. In order to maintain this control, Reed argues, they need to ‘carve out
and control’ (p575) an area of scarce knowledge and skill. The following chapter will
disclose how the health professions have successfully done this in the past. If it is to provide a stable base for the institutionalisation of expert power the expertise need to be storable, controllable and indeterminable (Larson 1990). Finally, as Abbott (1988) points out the jurisdiction of this knowledge has to be protected from other expert groups.

An alternative professional future

Reed (2000) suggests three frameworks that shape our understanding of the professions and their attempts to restructure themselves in advanced capitalist society. Firstly, he describes the continuity thesis which, as its name suggests, places emphasis on an underlying long term structural and cultural continuity within the professions. Constructed on the neo-Weberian theory of occupational closure and control (see Parkin in the following chapter), it suggests a modified status quo vision for the future of the professions. The argument underpinning this is the notion that the socio-cultural infrastructure of institutional support and legitimacy, renders the professions well equipped to absorb and adapt to change. Evidence of this within the health arena can be found in work carried out by Kitchener (2000). In his research the role of the clinical director, that is a medical consultant taking on a management role, acts as what Lewellyn (2000) describes as a ‘two way window’ for the profession. The privileged professional status of the medical profession makes it better positioned to absorb and adapt to change. One of the questions raised in this thesis is how professional employees react to change at grass root level and the effects of change on their role and identity within the organisation. This notion of continuity and absorption of change is less clear in relation to other health professions than it is to medicine and so the empirical work for this thesis concentrates on professionals who are less well researched.
The *transformation thesis* highlights the neo-Marxist analysis of deprofessionalised and proletarianised expert labour processes. Here, in a blend of Marx and Foucault, the emphasis is on organisational surveillance and control whereby the professions can be both the architect, through increased standardisation and regulation of their work, and the victim in the deskilling of expert labour. The exclusive possession of, and control over, expert knowledge and skill, which once underpinned an effective power base for the professions, is subject to intense pressures exerted by economic commodification and political rationalisation. In the previous chapter of this thesis we saw how political attempts to ‘reign in’ the health professions, forcing them to become more accountable, failed to address many of the problematic issues of power base and the delivery of health care. Whilst acknowledging that the health professions can no longer look to the same level of legitimisation and support from the state that they once procured, they nevertheless hold substantial weight in determining how health care is delivered. A key theme of this thesis is that changes in health care delivery are not simply about the deskilling and proletarianisation of work – the picture is much more complex than that. Yet, once the skill base changes or becomes eroded, the very fabric of the profession is put in question. This is true even where some members of the professional group benefit from changes in the work process.

The *fragmentation thesis* is close to the Mode 2 debate of expertise by focusing on the erosion of strongly institutionalised professional jurisdictional domains and the increasingly porous and blurred boundaries of professional work. Here, the deregulation and marketisation of the professional sector results in the control over expert knowledge and skill becoming more difficult, thereby weakening professional power. The stress is on
the proliferation, differentiation and diversification of a much wider and heterogeneous range of forms of expert labour. A ‘fragmenting’ impact occurs as more competing expert groups vie for position in the market. This fragmentation of work generates an increase in inter-professional and intra-professional conflict as the various professional groups attempt to defend and maintain their position when surrounded by more fluid forms of work organisation. In adopting a qualitative approach using interviews and focus groups, this research enables these tensions within the workplace to be explored.

Mintzberg’s (1993) model of professional bureaucracy refers to a type of organisation dominated by an operating core of professional experts. Co-ordination of activity is based on shared skills that have been acquired external to the organisation. Professional bureaucracies such as the NHS, according to Greenwood and Hinings (1996), reflect highly resilient forms of organisation in which there is a tendency toward inertia and continuity. An explanation for this is that internal coalitions may successfully resist change, though it is reasonable to say that the health professions have not so far been successful at resisting change at the level of government public policy (Ackroyd and Kirkpatrick 2000). Despite this, the health professions do occupy specific and strategically powerful enclaves within the NHS in which they are recognised as organisationally encapsulated mini organisations in their own right. In a paper examining the effects of organisational changes such as flexibility, delayering and flattening of hierarchies on the professional organisation within the public sector organisations, Ackroyd (1996) argues that there has not been significant impact on entrenched professional power. His argument continues that the professional organisations have shown an evolutionary capacity to change character, though there have been periods in their history when they have been less strong and have had less impact. He adds that the professions are in a period of remission.
today. In this remission the professions are not reduced in number or authority, but are on the periphery of dynamic change happening within the economy and society as whole. In more influential times professions through their associations, reorganised their skills and adapted them to the needs of institutions. The following chapter traces the evolution of the health professions and we see how this did indeed happen. By emersing themselves into the NHS they became an integral part of the organisation and were privileged employees. As the professions monopolised their expertise, the health service became dependent on them as a supply of labour. And, as Burrage (1992) argues, professional employees retain some form of identity outside of the organisation that employs them, through membership of their professional associations, which often act as trade unions. Once again this internal-external linkage is demonstrated in the following chapter.

The health professions are firmly institutionalised and entrenched within the NHS. They are surrounded by other groups – vertically by management and horizontally by other professional groups and occupations. By becoming so entrenched, they are capable of acting defensively towards management led change, and against other professional groups that may threaten their position. As ‘organisations within organisations’ they have successfully controlled workplace activity. In addition, in maintaining a narrow and unique focus on their activity they have been able to maintain differentiation between themselves through acquiring and then reinforcing their own uniqueness and identity. Ackroyd (1996) suggests that professions respond in ways that preserve their own position at the cost of smaller groups or groups lower in the institutional pecking order. A strategy adopted is for dominant professions to claim a broader expertise, excluding groups with a narrow identification. In doing so there is a sharpening of boundaries between the various occupational groups who are faring differently within large organisations, according to
their position in the hierarchy. However, new methods of work organisation such as team-based working and greater integration of skills, place new demands on professional employees as it erodes existing professional occupational boundaries. Professionals themselves are not mere ‘actors’ acting out directions from professional bodies. They are working ‘people’ actively mediating between other professionals and occupations, the professional organisations and the organisations for whom they work.

In pursuit of an Identity

This thesis sets out to explore how a change process impacts on the role and scope of practice of health professions and how this in turn impacts on employees’ professional/occupational identities. Part of the problem here is the ambiguity of the term ‘professional identity’. To myself the term has a double connotation. It can either mean the identity that an occupation has in the eyes of the members of society OR it can mean the element of an individual’s identity that is concerned with their individual involvement in the role they play within the organisation. Watson (2001:100) argues that there are two aspects of identity – self, the private notion of who we are, and social, the ways in which others define who we are. In arguing that these two identities are ‘inevitably and intimately interconnected’, he suggests that identity is ‘emergent – negotiated through our interactions with others and our active use of available discursive resources’. In locating the notion of profession and professionalism within the processes of negotiation and construction of reality and identity, Watson argues that we ‘pick up on a relatively neglected strand of literature’. This study contributes to this literature by considering how change impacts on the occupational identity of professions within the workplace. In his work Watson (1995) distinguishes between an occupation and a profession. He defines an occupation as ‘engagement on a regular basis in a part or the whole of a range of work tasks which are identified under a particular heading or title by both those carrying out
these tasks and by a wider public (p380). Professions, he argues, are occupations who have been relatively successful in gaining high status in certain societies on the basis of acclaimed specialist expertise over which they have gained a degree of monopoly control (p384). Professional employees within health care have very clear occupational identities in the eyes of society and the lay person, where public image rebounds against their own professional/occupational identities. Symbolic instances of this include the doctor with the white coat and stethoscope, the nurse in the white uniform and cap, the physiotherapist, sponge in hand, running onto a football pitch, the occupational therapist basket weaving. Although these images are not always welcome by the professions themselves, they can be related to what the profession does - the doctor cures, the nurse cares, the therapy professions rehabilitate. For the individual professional, however, identity is about more than just this external image. It is concerned with how their skills and knowledge base determine their involvement, their occupational identity and worth within the work team. However it is perceived – as a specific brand of expertise, as knowledge base, as role and scope of practice - their occupational identity is intertwined with their daily activities and practice.

One of the most prominent writers on social identity theory and intergroup relations is Tajfel (1982). He refers to the term social identity as those aspects of the self concept that derive from an individual’s knowledge and feelings about the group memberships he or she shares with others. Self categorisation, on the other hand, is the process of seeing oneself as a member of a social group. Categorising oneself as a group member has a ‘me, you, and them’ effect on our stance within society. Here, ‘I’ becomes ‘We’ (social categorisation and the self), ‘Others’ become ‘We’ (social categorisation and the in group), and ‘Others’ become ‘They’ (social categorisation and the out group). In addition,
group belonging and identification gives us a basis or anchorage for how we think, feel and act. It is said that when we as individuals lose our social identity, or if that identity is threatened, we experience feelings of being devalued and lose our esteem. The benefits of group belonging include self belonging, self worth, and of being of value for who we are. These benefits however come at a cost. They are of such importance for defining the self that we need to see them as attractive, valued and successful. Regard, esteem and liking for the 'in' group is often regarded as disregard, derogation and dislike for the 'out' group. Turner (1982) argues that there is always a sufficient condition for group formation that is found in the processes of social influence. This leads to individuals internalising certain social norms, seeing themselves in appropriate circumstances as embodying the norms in their attitude and their behaviour. Thus their social location is defined in terms of certain selected group affiliations. In the context of health care and the health professions, both the second world war and the inception of the NHS, can be seen as external social processes that impacted on the formation of occupational groups. A variety of social and cognitive factors conspire to make a particular group membership accessible and these are considered below.

Figure 2 summarises these factors in the context of the one of the professions involved in the research for this thesis – the Physiotherapist. The example of Physiotherapy is used since the author, a Physiotherapist, can draw directly on her own experience as a professional employee.

Turner’s six shaping factors are:

1. Direct Reminders of membership: Honorary titles and labels bring home vividly your social identity. The title of doctor, nurse, physiotherapist reminds us of who we are. In addition, work circumstance can be a reminder of our similarities with
others within our own group. The fragmented delivery of health care has hitherto tended to compartmentalise the delivery of care, reinforcing the occupational identity issue. In addition it is important to remember that most individuals carry more than one identity. Using the author as an example, as well as being a physiotherapist, she is also a university lecturer, a mother and so on. When considering response to change happening around you any one of these multiple identities may be affected and you respond accordingly. The focus in this thesis is limited to the question of occupational identity within the work organisation.

2. **Presence of Out group members**: The presence of outsiders makes us more aware of our own group membership and what we have in common. Their presence emphasises the importance of our own identity. The large number of professions in health care precipitates the need for individual professions to establish themselves as distinct from others, who are either 'non-professionals' or belong to other professions.

3. **Being a minority**: Individuals are more likely to think of themselves in terms of individual characteristics that are distinctive in their own social group. This is more apparent in memberships of smaller groups. This is highlighted in the following chapter when the evolution of the health professions is discussed. In particular, we see how the smaller professions struggle most to determine what is uniquely theirs through their role and scope of practice. In addition, it highlights the particular importance placed on membership of the professional association by members of the smaller professions.
4. **Conflict and Rivalry:** This is said to be the most potent factor that reminds us of our group identity since it reinforces our group loyalty and who we, as individuals, identify ourselves with at times of conflict. In the history of the health service, this has been seen many times at national level. For example, the debate between the medical profession and the government at the inception of the NHS, the introduction of Griffiths in the 1980s and later the White Paper, *Working for Patients* in the 1990s. At local level, change policy that effects the manner in which health care is delivered can lead to opposition of rival groups of health workers – especially where professional boundaries are threatened. But again, professional/occupational identity is rarely complete or exclusive. Not all employees line up behind the professional view, particularly if there is a perceived benefit to themselves in terms of reward and recognition. Different individuals define for themselves very different locations within the professional triangle.

5. **Cultural differences in the importance of group membership:** Although this category is primarily concerned with trans national cultures in society, observations can be made within the health care systems. Group memberships make a substantial difference to people’s ways of thinking about themselves and those around them. Since the inception of the health service, the culture has been one of a fragmented delivery of care by individual professions who define roles and tasks that are unique to themselves. This corporate professional identity fostered by the professions outside of the workplace, sits uncomfortably with individual professional employees who hold other sources of identity as a hospital employee or a workgroup colleague.
6. *Individual Personality differences*: Group membership is personally very significant. Not everybody has the personal attributes to make an attempted success of being either a nurse or doctor.

The focus in this study is not on all the potential elements of social identity but on the three way tension between professional, work group and management/organisational identities. To this end, some of the six dimensions of social identity theory are more relevant than others. Using Physiotherapy as an example Figure 2 illustrates the aspects relevant to this study.

![Diagram of social identity factors](https://example.com/diagram.png)

**Temporary situational factors**

- Direct reminders
- Presence of out Group members
- Being a Minority
- Intergroup conflict
- Chartered and State Registered Physiotherapist
- Mixing with other health workers
- Being part of a departmentalised profession
- Practice that transgresses professional boundaries

**Accessibility of social identity as a group member**

- *I AM A PHYSIOTHERPIST*

**Long term stable factors**

- Culture emphasising group membership
- Individual thinks about group membership
- Role strongly defined by professional associations
- Individual professional has assurance of state registration and professional membership

*Figure 2: Factors that make an occupational identity accessible. A health care example – Physiotherapy*
Parker (2000) writes of three types of divisions in organisations – spatial/functional, generational and occupational/professional. He argues that these divisions function as a way of classifying the identity of self and other and in doing so create a grounding for a particular assertion about the distinctiveness and uniqueness of an individual or group. The divisions may not work in isolation, with a degree of overlap possible.

Spatial/functional divisions are concerned with the geographic and departmental divisions within organisations – ‘a case of them over there, us over here’. Historically, this has always been the case within the health care system where doctors and nurses worked in the confines of their specialism in a designated part of the hospital. Most other professions are department based – either treating patients within their departments or acting as visitors in the various specialist areas. Physiotherapists treat patients within their own department or may visit the inpatient wards in order to treat patients in situ. Further specialist treatment of the inpatient may be carried out back in the Physiotherapy department.

Generational divisions are concerned with age and historical divides – ‘them from that time, us from this time’. Here, in the context of health care, older members of professions maybe more resistant to change – a kind of ‘old times were better’ lament – the surgeon who expects ‘his Sister’ to be on the ward when he does a ward round or the Sister’s allegiance to ‘her ward, her nurses’. The occupational/professional divide speaks for itself – ‘them that who do that, us who do this’. A professional identity, Parker argues, with its location partly outside the organisation, can be used as a ‘resource to resist change, as well as a claim for special understanding and consequent status privileges’ (p200). Figure 3 illustrates the links between role and working practice, the identity of the professions and
the individual's social identity. Role and identity are explicitly linked here in that change one and the other is affected. They cannot be viewed in isolation.

Figure 3: Exploring the links between role and practice, professional identity and an individuals professional identity within the organisation

Although health care delivery can be said to be fragmented due to the number of professions involved, the professions themselves have hitherto adapted to change by adjusting their position, rather than reinventing themselves. In doing so, their professional identities have remained intact. In turn this stability has afforded them privileged status within the health system as the key resource. The question is, do current changes in the role and scope of practice threaten this, and if they do what are the implications.
Conclusions

This chapter has explored the sociology of the professions literature and considered the concepts that underpin social and professional identity. In doing so, it provides a theoretical backdrop to some of the key terms used in this thesis – professions, role and identity. In addition, where appropriate, links have been made within the context of health care and the health professions. The primary aim of this chapter has been to ‘unpack’ these terms in order to inform the key argument of this thesis – the effects of change on health professionals in terms of role and scope of practice and professional identity. In attempting to determine the professionalisation process the chapter moves away from the old trait and functionalist sociological discourse. Drawing on the work of Larson emphasis is placed on the importance of securing monopoly over knowledge and expertise in order to secure professional status. The following chapter illustrates this theme by identifying how the health professions used their knowledge and expertise to construct very specific roles and tasks that became exclusive to themselves. Using Foucault’s philosophical stance of the ‘Le regard Medical’ where he links knowledge and power with surveillance we begin to see the importance to professions of being identified with specific practices and discipline. In using Scarborough’s concept of ‘expertise’ and the management of expert groups it can be seen that expertise can be resistant to change. The works of Larson, Foucault and Scarborough emphasise the interdependency between knowledge skills and expertise with a professions occupational identity within the workplace.

The early part of the chapter focuses on the corporate professional identity, one that is fostered by the professions outside of the workplace. In turning to the social identity literature we see how individual employees hold a number of identities through their relationship with colleagues, patients and their ‘out of work’ roles. However, the focus of
this study is not on all of the elements of social identity. In recognising that social location is defined in terms of group affiliations, links are made between the boundaries of professional role and scope of practice and professional/occupational identity – a central focus of this thesis. Thus, this aspect of the work of Tajfel and Turner is used to inform the data gathered in the one to one interviews found in chapter 6. Yet, today’s workplace is one of increasing flexibility where new methods of work practice encourage heterogeneous, transdisciplinary working. This approach encourages the notion of multiple and unstable identities and sits uncomfortably with the hierarchical, disciplined and homogenous nature of health care delivery. It is this mediation between professional/occupational role and social role that illustrates the complexities of identities within large organisations.

The following chapter examines the evolution of the health professions that are considered in this thesis. In doing so it makes an account of how the professions have developed their own role and scope of practice within the health care arena in order to enhance and protect their own professional/occupational identities. Through tracing the evolution of the professions, the unique nature and identity of the health professions is highlighted and the pluralistic nature of NHS delivery is emphasised. Furthermore, it allows us to see how the development of these professional/occupational identities is intrinsically linked with the particular context and history of the British NHS.
CHAPTER 3

THE DOCTOR KNOWS BEST? THE EMERGING ROLE AND SCOPE OF PROFESSIONS IN BRITISH HEALTH CARE

‘Finally, the surgery is empty and Dr. Graham washes his hands with coal tar soap. The smell reminds him of a time when he could understand what district nurses were talking about and they called him Doctor, not Trev’ (Addison De Wit, Sunday Times, 23/08/98).

Introduction

For health professionals, the beginning of the National Health Service in 1948 was a turning point in their history. Whilst their pre-existing skills and knowledge were important factors for the success of the new health service, the creation of the latter forced health professions to define their own role and identity, within a bureaucratic government system. In recent years, the functionalist viewpoint that professionals provide a value to society has been called into question, particularly in health care (Giddens 1989:287). The Thatcher years of government challenged the monopoly of public sector professions, such as teaching and medicine, making them more accountable for their actions. This view is not confined to Conservative political principles, and New Labour reinforced the importance of accountability and responsibility in their first White Paper ‘A New Health Service, Modern, Dependable’ (1997). Whilst the 20th Century saw a rapid growth of professions within the occupational structure, as a new Century begins the nature of professionalism is changing.

Parkin’s (1974) model of social closure as a process by which social groups maintain control over their resources to the exclusion of others, can be applied to the growth of the
health professions. *Exclusion* is the predominant form of closure in any system of social stratification. As the histories of the health professions unfold in this chapter it will be noticeable how the language of closure can be associated with the power of individual professional groups. In turn, this power can be linked to the status of the various professions and to how the hierarchical structure in health care has evolved. The medical profession, through its power, both scientifically and politically, ensured that the nursing profession, and as they came into being, the therapy professions, remained subordinate to themselves. The skills of the medical profession, acquired through sound scientific research, afforded them the power of exclusion, allowing them to exert pressure downwards by being able to prove themselves superior in terms of knowledge base. In turn, the inferior skills and knowledge base of the other professions, together with their female dominance and lower social status allowed this to happen. The control of professional boundaries by the nursing and therapy professions through their professional associations, is also associated with Parkin’s notion of exclusion. Furthermore, these groups exhibit a dual closure strategy in that they also take on the process of *solidarism* by maximising their claims to clinical skills and knowledge base that are deemed specific to themselves.

The process of social closure has helped to establish the uniqueness of the health professions in terms of role and professional/occupational identity. Parkin’s development of the Weberian/social action viewpoint links with the work of Larson (1977) discussed in the previous chapter. Her ‘professional project’ views professionalisation as an attempt to translate scarce resources, knowledge and skills in order to secure a monopoly over expertise. In doing so a profession creates a monopoly over status within the stratification system. Whilst Larson emphasises the link between education and occupation, Witz
(1992) focuses on the links between gender, class and social exclusion within occupational professionalism, stressing the influence of civil society in the 19th Century. This historical formation of the hierarchical nature of the health professions has led to an internal pecking order between them over the years. Parry and Parry (1975) compare the evolution of the medical profession with teaching. They conclude that a crucial factor for the achievement of self governing professionalism is the absence of state involvement in the formative stages of the profession. Whereas education and teaching had always been under the auspices of the state, the doctors had managed to establish themselves as a profession before the formation of a Ministry of Health in 1911. This professionalism was enhanced through their strategy of self recruitment from exclusive high status background. As a result, they secured their professional dominance before intervention from the state and this allowed medicine to be less dependent on government. As the chapter unfolds, we will see how this evolutionary process contrasts with that of the other professions.

In their essay on social closure and mobility Parry and Parry (1975) anticipated that the huge increases in public bureaucracy, through the welfare state, would considerably challenge the independence of professions. As professionals became increasingly employed in large organisations, sociologists such as Mills (1959) Esland (1980) and Oppenheimer (1973) argued that they would see their independent status limited. More recent work by Reed (2000), discussed in the previous chapter, suggests that this is not necessarily the case. Parkin’s ‘Strategies of Social Closure’ provides a framework for an understanding of how the health professions have developed. Through tracing each of their developments chronologically the struggle of all the health professions to define and raise their status becomes apparent. External social factors, such as class, ideologies of science and gender have provided medicine with a powerful basis on which to develop its
professional identity and autonomy. Furthermore, the non medical professions, having built their role around the medical model, struggle to break away from medical control. That medicine was already well established as a profession before the creation of the NHS, has further exacerbated this problem in the formative years of the other professional groups.

In Chapter 2, it was established that professional/occupational identity is grounded within the role and boundaries of practice of the individual professions. It identified the importance of exclusivity of knowledge and expertise and the interdependency between role and scope of practice and occupational identity. This chapter traces the evolution of these roles and practices. Four specific professions are examined: medicine, nursing, physiotherapy and occupational therapy. These four professions have been chosen for three reasons. Firstly, because they are the professions represented in the empirical chapters of this thesis. Secondly, because medicine and nursing form the two largest core professional groups. Finally, because the two smaller therapy groups are often neglected in the literature. The scope and depth of this literature is enormous. So, attempts have been made to confine relevant information specifically to the role and tasks of each profession, together with identifying the part each professional body has played in developing this. The order that has been taken does not reflect the order of importance of any one profession. Since the other professions have emerged in its shadow, it seemed logical to explore medicine first. As the other professions have created their own status and professional/occupational identity they have broken away from the paternalist nature of medicine. Chronologically, the Physiotherapy and Occupational Therapy professions are much younger and little researched and so are of particular focus here. Furthermore, the therapy professions literature tended to derive from the relevant professional associations.
through their own internal publications, rather than from the wider secondary literature. It is expected that this chapter will contribute significantly to an understanding of how these particular professions evolved within the NHS labour process.

MEDICAL PROFESSION

'Lampart had joined them almost at once, pulling off his green operating cap, peeling off his gloves. The room was small, clinical, seeming full of rushing water and the sound of feet passing in the room next door, of confident voices above the unconscious body of the patient. It was a temporary place, a room for quick clinical exchanges not for confidences. Dalgleish wondered if the ploy had been deliberate, a way of demonstrating the subtle power of his professional status...' (P. D. James A Taste for Death, 1987:371)

Introduction

As the dominant profession in the health service, medicine has exerted tremendous influence over the provision of health care. Although in recent years this dominance has been challenged through government reform of the health service, medicine remains, through its knowledge base, easily the most powerful of the health professions. The power of the medical profession's control over other health professions, and in particular nursing, has been enhanced by the doctor's legal responsibility to the patient. This responsibility has allowed the profession to determine its own professional roles and boundaries, whilst being able to secure its own professional/occupational identity and autonomy.

In Britain, medicine is a male dominant, upper middle class profession. Women were only admitted to the profession a little over a century ago, and even then were deemed inferior to their male counterparts (Versluysen 1981:182). Whilst women remain in the minority, university entrants are now equally divided between the sexes. What is probably still true
is the difficulty women have in making medicine a career. There remains a high percentage of men in the more glamorous specialties such as general medicine and surgery, whereas women are more heavily represented in fields such as general practice, psychiatry and occupational health. The demands of medicine as a career are huge and often difficult to adapt to family life. In a recently televised documentary programme tracing the careers of junior doctors, these facts were succinctly highlighted. Of the 7000 surgeons employed in the health service, only 488 are women, with a mere 239 of those, women with children. Women generally are more likely to make a decision of steering themselves toward specialities that are more family-friendly and sociable. A study by Allen (1998) shows three quarters of doctors are drawn from the upper middle classes of society. Although the study indicates an increase in the proportion of doctors from working class background, the figures suggest that medicine remains a socially exclusive profession. Armstrong (1990:691) attributes an increase in status amongst other health care workers, such as the therapy professions to strategies such as improved educational standards, improved registration and self regulation. Yet, whilst professions other than medicine continue to enhance their standing by such means, medicine still determines the overall division of labour.

**Initial formation**

The founder of the profession is acknowledged as the Greek physician Hippocrates in the 5th Century BC. Before this the population had considered illness to be due to the displeasure of the gods. Cure was generally perceived to be penance, often in the form of sacrifice – a view continued among ordinary people until modern times. Part of the social construction of any identity, be it nationalist or professional is to project it back into the midst of time, to make it seem an inevitable and natural phenomenon that is rooted in long
tradition. Medicine refers back to Hyppocrates and still today uses the Hyppocratic oath. One wonders how far this is an ‘invented tradition’ used to protect the status of the profession, rather than a genuine historical lineage (Hobsbawm and Ranger 1992:1-14).

The next big milestone in the development of the profession came in the middle of the second century when Galen, a doctor to the gladiators of the time, developed an interest in human anatomy. Although this anatomy was based on the structure of animals, it was an accepted and influential benchmark on the practice of medicine for more than 1,400 years.

In the 16th Century Vesalius questioned Galen’s work and became responsible for developing the study of anatomy as it is known today. In subsequent years medical science developed at a tremendous pace. New theories were postulated and developed. Although too many to mention, some notable discoveries include Pare who developed the technique of ligation; Harvey, with his work on the circulation of blood; Jenner who discovered the first vaccination (smallpox); Lister who pioneered the work on bacteria; and Fleming who discovered penicillin. The list is endless, but what is worth noting is how medical science and the practice of medicine developed through international collaboration. This is significant in helping to explain why the profession is so powerful today. Through research, new medical knowledge is an ongoing process, making the profession of medicine a continuous learning curve. And the links between medicine and science gives a powerful basis for expertise. Medicine is a universal profession and today enjoys a high status worldwide. This has not always been the case. In Victorian England, for instance doctors didn’t enjoy the status of lawyers and vicars.

Baggott (1994:43) suggests that the superior position of medicine is due to its effective political organisation. One aspect that makes the profession so powerful is its power of self-regulation. The body responsible for regulating the profession is the General Medical
Council (GMC), whose role is to maintain the register of practicing doctors and to regulate the fitness of doctors to practice. Founded in 1858, the organisation is dominated by doctors and has managed to resist radical change through the years. Other principle medical organisations include the British Medical Association (BMA) and the Royal Colleges. The Colleges, responsible for the training and accreditation of the various medical specialties, are consulted by the government on a wide range of health issues. By far the most powerful medical lobbying group is the BMA. As the main representative body of the profession, the BMA not only has a high public profile, but also has long been regarded as the major health pressure group. Whilst a voluntary organisation, its membership comprises more than three quarters of all practicing doctors (see Tables 2/3, p102 ). Founded in 1832, its espoused objectives were, firstly, for the advancement of medical science and, secondly, for the maintenance and respectability of the profession (Grey-Turner 1982). The strength of the BMA lies in its close and extensive political contacts. Its prime activity lies in the negotiation of issues such as pay and working conditions of doctors, and it enjoys close collaboration and consultation with the government on health issues (Baggott 1994:44). This will be explored later in a discussion on the possible decline of medical power.

The creation of the National Health Service

It is well documented that the creation of the health service led to a bitter dispute between the doctors and the government (Ham 1992, Seifert 1992, Foot 1975, Klein 1995). In the BMA’s official history, the creation of the health service is referred to as ‘the nationalisation of medicine’ (Grey-Turner and Sutherland 1982). Two major fears were openly expressed by the BMA – loss of renumeration and loss of autonomy. That the
BMA was well established by this time, both politically and professionally, forced far greater concessions from the government than was perhaps wise, in hindsight. Doctors remained all powerful. They had rights to have representation on all administrative committees and the rights to secure their clinical freedom and opinion. The price paid by the government was that virtually all other health professions were excluded from most major committees (Seifert 1992). This continued in much the same way until the reorganisation of 1974. Until the mid 1970’s, the BMA denied claims that it functioned as a trade union. Watkins (1987:243) disputes this suggesting the BMA has always acted as a trade union by protecting the rights of its membership,. When, through changes in the Health government’s 1971 Industrial Relations Act, the BMA found itself transformed into a registered trade union, it retained its status as a learned society and a company limited by guarantee. Watkins argues that it would be impossible to set up a body today with the advantage of all three statuses.

Medicine today

Brazier et al (1993:209) argue that doctors have endured more blows to their autonomy in the last ten years, than other comparable professions such as Law. However, Deakin (1991:14) suggests that doctors have suffered less than other public service professions. Whilst recent reforms have forced the medical profession to be more accountable, they are not alone in this and have ridden these pressures better than most. The relationship between the medical and nursing professions is discussed below. There is, however, evidence to suggest that the relationship between doctors and other health professionals is contradictory. In an editorial discussion in the first volume of The Lancet (1966:895), the medical profession deliberated over whether professions such as physiotherapy and occupational therapy should be regarded as ‘sister’ or ‘daughter’ professions, arguing that
fragmentation of medicine had gone far enough. Today’s argument is more about whether other professions should be seen as a resource. Accordingly, their work is essential for the provision of a service, which at the end of the day, will support the doctor’s responsibility for the treatment of the patient. Personal experience has shown how a doctor will campaign for the services of health professionals in order to develop their own service. However, this ‘resource’ can also be seen as a threat, particularly in the distribution of power and autonomy. This is particularly pertinent today as the blurring of professional/occupational boundaries becomes an increasing feature in health care. An added dimension to this, is increased specialisation inside the professions themselves. Within medicine, a qualified general surgeon or general physician is no longer truly ‘general’ in practice. The demand for quality in today’s health care system together with expanding technology, is such that specialisation in a particular field is necessary. This has led to a fragmentation of specialities such as general surgery and general medicine. Some argue that this has led to a decrease in the power base of medicine at local level. With other professions, the reverse has happened. Increased specialisation in nursing and physiotherapy, has allowed a further degree of autonomy in certain areas. Midwives, Health Visitors and District Nurses are an example of this.

Watkins (1988:17-24) outlines a number of characteristics of medicine as a profession. Firstly it sees itself as an embattled profession, a self image brought about by its refusal to share its role and power with other professions. Watkins argues that medicine’s defensive posture against the government and other professions helps to sustain the effectiveness of the BMA in the public arena. This assumption is questionable since the BMA lost the very public fight over both Griffiths and the 1990 White Paper government reforms. The second characteristic is that of a united profession. Doctors vary rarely criticise each other
in public. In the past, this concept of unity has restricted practice by protecting what they do. Much of clinical medical practice relies heavily on the individual clinician's personal experience and opinion over the years rather than rigorous evaluation of scientific research. Initiatives such as clinical audit and evidence based practice have made inroads into the problem of restrictive practice, but when criticism mounts, doctors unite in their own defence and in those of their colleagues.

This unity is beginning to erode, with doctors increasingly willing to make a public stance and judge the standards of colleagues. A recent televised documentary highlighting excessive child mortality rates in heart surgery, saw members of the profession openly questioning the competence of colleagues. As professional/occupational identity is based on the notion of equal competence of qualified professionals, the comparison of performance could serve to undermine. The notion of unity leads to a further characteristic of medicine - conformity. The norms of the profession are loyally followed and defended. That medicine is fiercely independent as a profession is never in question. Even though the value attached to a doctor's clinical freedom by the profession has been revised in recent years (certainly post Griffiths), this remains one of the predominant status symbols of the profession. The final characteristic centres around the idea of medicine as an ethical dominant profession. The essentials to this are the doctor's overriding commitment to the patient and the principle of confidentiality between patient and doctor.

The medical profession is well organised, with a number of groups representing the various specialities within the profession. Nevertheless, one of the characteristics of the profession is its strong overall sense of unity, and this can be seen in the way it presents itself through the professional bodies. It is very rare to hear either the Royal Colleges,
GMC or BMA openly arguing from within. This solidarity must help to promote the outward strength of the profession. Recent times, certainly post Griffiths, have seen difficulties between the government and the profession, and relationships between the two, particularly in the early nineties, had deteriorated considerably. The Thatcher government's general dislike for political pluralism and the rights of specific interest groups, led the medical profession to be snubbed over changes in health policy. For a time, it seemed that the profession might lose influence in the health care arena. Day and Klein (1992: 475) point to similar upheavals in history where the structure of existing health care was threatened and opposed by the profession, but went ahead anyway. Indeed, the creation of the NHS is an example of this. They also note that following this upheaval, the atmosphere returned to one of relative calm and co-operation. It would seem that this is again the case. Although local power may have been diluted by increased accountability the medical profession has been quick to counteract with the encouragement of clinical director positions and the use of clinical audit as a means of securing increased funding. On the national front, little, if anything, has changed. Medicine, through its knowledge base, remains the dominant health profession, and continues to enjoy the high profile and status that this disciplinary knowledge brings.

THE NURSING PROFESSION.

Introduction

As with medicine, the origin of nursing can be linked to an invented tradition, since the foundation of a nation, organisation or profession presupposes that there is a founder. Sometimes this person can be as much mythical as real and is usually a mixture of both, for example, Camelot or Boedicea. Conventionally, Florence Nightingale during the
Crimean Wars, is seen as the starting point for nursing as a profession. Before this time, however, there was always the acceptance of a specific person within the family community as a carer, a nurse. An added dimension to this, is that the specific role of carer within the family has nearly always been a female one. Whilst this thesis is not concerned with the specifics of gender, female dominance within the nursing profession (as with the rehabilitation professions) has done much to shape the identity of the profession. The image of nursing in the eyes of the lay person has changed little over the years, but the identity of the profession from within is changing rapidly. The largest profession within the health service, with over 600,000 Registered Nurses, it is still dominated by women. The result is a predominantly married workforce and a high percentage of part time workers (see Tables 2/3, p102).

**Initial formation**

Whilst the image of Florence Nightingale, the 'lady with the lamp', is iconised on the British ten pound note, the first thing that strikes the reader of nursing history is how little time, once back from the Crimea, she must have actually spent by the hospital bedside! Rather, she concerned herself in reforming nursing practice and education through the Nightingale Fund, and was most influential in her pursuit of changing the face of health care through hospital construction and new fields of public health. Although the most famous, she was only one of a number of nineteenth century women who dedicated their lives not only to nursing but to the beginnings of the foundation of the British health care system. The work of Florence Nightingale, Elizabeth Fry, Louisa Twinning and Sister Dora saw the change from 'unskilled and untrustworthy nurses to a kind that were useful and efficient' (Williams1980: 44). Prior to the reforming works of these eminent nursing figures, the duties of the general nurse were akin to those of domestic servants of the time.
— attendance of the sick at their bedsides, together with tasks such as cleaning and floor scrubbing.

Whilst early nineteenth century literature often depicted the drunken, illiterate nurse epitomised by Dickens’s Sarah Gamp, the latter half of the century saw the entry of middle and upper class ladies, who challenged the authority of the medical profession and hospital administrators. This particular breed of women became socially influential in their own right — not through paid work, but by being publicly involved in major ethical crusades and playing a decisive role in voluntary work (Himmelfarb 1996:104-106). At this time, the social prestige of the medical profession, though rising, remained below that of the clergy, the military and the law. Doctors at the time looked beyond themselves and their own organisations for someone to blame for their professional dilemma. The establishment of nurse education and subsequent increase in nursing numbers were seen as a positive threat to their autonomy and earning power (Moore 1993). This reflected Victorian domestic ideology whereby women were strongly linked to the ‘caring’ side of life and spoke with special moral authority in this sphere.

By the end of the nineteenth century, the growth in institutions caring for the sick and changes in attitudes toward sickness and those who cared for the sick, led to an increase in nurse recruitment. Since the largest field of female employment was already in domestic service (Himmelford 1996:106), a general shortage of female labour led to the introduction of a three year training scheme and written contract of employment. Although the recruitment age was between the ages of 25 and 35, there was no guidance as to what should be done between leaving school and starting training. Emphasis was placed on girls who were not only educated, but armed with the more practical skills of cookery,
needlework and household management (Maggs 1980:21). These entry requirements succinctly indicate the type of role these women were destined for once qualified. Successful entrants, living in dormitories at the hospital, found themselves under the strict control of the matron. As in teaching, where married women were forced to resign, recruits were expected to dedicate their life to the profession rather than to marry. Perhaps this is how the term 'vocation' became synonymous with professions such as nursing and teaching. Florence Nightingale herself stated that 'to be a good nurse one must be a good woman.' This emphasises the Victorian ideal that women were custodians of moral standards. Nurses were to be 'attendants on the wants of the sick and helpers in carrying out doctors orders' (Gamarnikov 1978:115). It can be seen from this early history how the status of nursing was beginning to evolve, from the lowly servant of the early nineteenth century to the educated workforce seen at the turn of the century. The challenge to the medical profession at this time should not be understated. If one looks at the power base that evolved over the twentieth century, this begs the question how did the status of the nurse change over the years?

Williams (1980:58-73) gives an excellent account of the changing status of the late nineteenth and early twentieth century hospital nurse. This account is well worth exploring for two reasons. Firstly it allows us to uncover the changing dynamics behind the role of the nurse. Secondly, it provides valuable insight in to how the power base of the nurse shifted in favour of the doctor. The account begins by identifying the structural features of the nursing system of that time. The early nineteenth century saw three offices of nurse: matron, sister and nurse. The overall internal authority belonged to the matron, who ruled with a rod of iron and spread a sense of fear throughout her domain - memories of Hattie Jacques in the Carry On films of the 1960s come readily to mind. All hospital personnel
were subordinate to this figure. The daily management of domestic and nursing ward
duties devolved under the ward sister. However, the ward sister took her orders and was
under close supervision from the physician or surgeon on whose ward she worked.
Williams (59) cites an article from the British Medical Journal (BMJ) at this time,

‘The control and the responsible charge of the ward rests with the sister as head
nurse, and the nurse has the more menial offices to perform.....The sister receives
the directions of the physician or surgeon.....She takes care that the nurse does her
duty...’ (Anon BMJ 1897 vol.1 p11).

With the introduction of a hospital based nurse training system the status of the nurse
began to change. The separation of domestic and nursing tasks, although still incomplete
by today’s standards, saw the emergence of skilled nursing tasks. Although still
subordinate to the ward sister, nursing duties of the trained nurse became more akin to that
of the ward sister. Despite this, the role of sister did not change. In practice, the ward sister
continued to take her instructions from the medical team for whom she worked. Yet there
are formal and informal patterns of social organisation here. Whilst formally, doctors
continued to be at the top of the hierarchy, hospital matrons and experienced sisters
exercised substantial de facto power over the more junior doctors. Nonetheless, the
practical training of the sister remained under the auspices of the medical practitioners. As
Williams (63) comments, ‘..the doctor, through his long standing relationship with the a
ward sister, controlled the status of nursing as a set of practical duties as defined by him’.
This relationship between the two had long lasting repercussions on the status of the
nursing profession. An added controversy centred on how the status of the nurses was
viewed by the two professions. The nursing hierarchy responsible for promoting the
training of hospital nurses, heralded the creation of a new profession that studied and
practiced new principles. The medical profession questioned this assumption and spoke of

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nursing as a skilled profession as defined by themselves, thus rejecting the altered status of nursing,

‘Anything which approximates the training of a nurse to that of a medical profession is to be avoided.......for the nurse a knowledge of the laws of life and health.....would leave her ample leisure to make herself proficient in those bedside duties on which depend the comfort and well being of the patient’
(from the Nursing of the sick in the Victoria era (author unknown)

The upsurge in the power and prestige of the medical profession in the 1920s, shifted further the superior/subordinate relationship between the nursing and medical professions (Hawker 1987:156-7). In addition, the image of women generally at this time, as property and belongings of men, did nothing to assist the nurses’ cause, as they were seen as handmaidens to the doctors (Rowbotham 1992:47). Detailing an account of the reorganisation of work, Rowbotham cites medicine as a profession where women, through their exclusion were ‘forced to be bottom’ (1992:3). Midwives of the time could only attend the poor, whilst their medical colleagues attended the rich and upper classes of society. Attempts by the midwives to protest, asserting the importance of their craft skills and experience against medicine, fell upon deaf ears. Medicine had achieved its power through its universal association with science. Craft and experience were not so highly valued. Although these thoughts are a far cry from society today, they have been instrumental in shaping the existing hierarchical nature of the health professions. The 1919 Nurses Registration Act saw the beginnings of the General Nursing Council and a register of nurses. Although by now there was mandatory syllabuses and common entrance requirements, the image of nursing remained in the image of Florence Nightingale and her lamp. Nurses were not highly regarded in terms of status, but were more readily seen as ‘pairs of hands’ rather than skilled workers. Only the matron had
established a position of autonomy. This authority, whilst primarily over her nurses, did partially extend over the lower ranks of doctor as well.

The creation of the National Health Service

With the creation of the NHS, there was discussion of the need for change of direction within the profession (Athlone 1938, Wood Report 1947, Horder Reports 1942, 1943). Much was made of the cloistered, somewhat institutional lifestyle of nurses of that time, together with long hours and poor pay. It was felt that these problems did nothing to help the nursing shortage problem. Interestingly, half a century on, similar factors are often cited in today's problems of nurse shortages. On reading the literature surrounding these reports, what is most striking is the obvious differences between the various committees responsible, about what action was needed in order to change the face of nursing. White (1985a:33) surmises that the arguments centred around two issues: whether all nurses should be regarded as generalists or semi skilled; or whether there should be an elite group of educationally qualified specialists.

At the founding of the NHS, all relevant parties had diverse feelings about the role of the nurse. The BMA, whilst accepting the need for an increase in nursing numbers, remained ambivalent about any rival professional status in relation to their own. Many doctors expected the handmaiden role to continue. Employing authorities, likewise, were preoccupied with the need for continued cheap labour and not with skill or professional enhancement. Of the nursing bodies themselves, the General Nursing Council (GNC) was primarily concerned with producing nurses who had the minimal level of qualification, whilst the Royal College of Nursing (RCN) was keen to preserve the image of the amenable gentlewoman. There was hostility to male nurses amongst the nursing elite since
it was felt that male nurses might threaten the culture of nursing at that time — hard discipline, total commitment and low pay (Carpenter 1997). Although the RCN considered themselves the dominant partner with the Ministry of Health in policymaking, they were in fact dominated by the Ministry. This in turn, suppressed any professional goals of the nurses. Decisions on how the profession should progress were short term, with no consideration to long-term effects on professional role and identity. Despite advances in medical technology, this short termism allowed the profession to become deskill ed. Little thought was given to the future of the professions in terms of accumulation of skills and enhancement of nursing as a profession. Proletarianisation of the profession served to drive out altruism and created a demand for solidaristic unionism from within the ranks.

As the Health Service became more bureaucratic, there was an increase in the numbers of nurse managers which generated a pluralistic structure within the profession. In research carried out with the King's Fund in the 1960s, White (1985 a:270), distinguished three subgroups within the nursing profession. There were: managers, whose primary role was to control nursing staff, within the constraints of budget and who upheld the status quo; generalists, or in sociological terms, functionalists, who saw nursing as a means of earning a living, and thirdly, specialists, or professionalists, who based themselves on seeking to improve their professional status through higher education and a specialised knowledge base. While nursing managers no longer necessarily uphold the status quo, many of these findings still hold today.

Despite being founded in 1916, the RCN did not institute open membership until 1960. Following this, the College amalgamated with the National Council of Nurses in 1963, becoming the largest nursing organisation in the country. As membership of the college
had been restricted in the early years, after 1960, the nursing profession found itself with many members having dual membership with trade unions, in particular the National Union of Public Employees (NUPE) and the Confederation of Health Service Employees (COHSE). Whereas the College was seen by many as a support mechanism for colleagues and theoretical exchange, it was felt that the unions gave stronger support within the workplace, and were stronger, less restrained at national level (White 1985a:261). This remains true today. The college found itself in an increasingly compromising situation. Whilst continuing to work alongside the ministry, it had to be seen to be active and independent in the eyes of the members, particularly with regard to raising demands for improved working conditions. As it dealt with increasingly complex situations and grew as an organisation, it became increasingly bureaucratic in its own right, but also gained confidence as the ‘voice’ of the nursing profession.

After 1961, the College attempted to counter the process of generalism and proletarianisation by drawing greater emphasis on the need for specialisation. Focus on specialisation allowed the College to stress the importance of nursing as a profession in its own right, though much ground had been lost. The Salmon Report in 1966 increased the managerial contribution of nursing by creating senior hospital managerial ranks for nurses. The Report itself was scathing in its assessment of the matron system of management, blaming the old structure for the loss of professional influence and status. Claiming that the traditional matriarchal system of management to be unitarist, the Report called for a nursing management system based on the industrial model of professionalised management (Carpenter 1977).
Increasing the management structure had a two fold effect on the profession. From a management perspective it improved the career prospects of the nurse. Whilst it was hoped that this would enable the profession to compete with other middle class occupations, the biggest impact was that it afforded male nurses the chance to carve out a niche for themselves in management. Whereas male nurses had been predominantly found in mental health, there was now an increasing percentage in the general fields. Although the RCN failed to accept male nurses on to the register until 1960, male nurses soon began to dominate many of the management and union aspects of the profession (Salvage 1985). Secondly, though the Salmon Report gave the profession greater influence over national policy making decisions, White (1985a:265) suggests that it drove the nurse specialists to the periphery of the profession.

Nursing today

A major problem for the RCN is that it has become the professional voice for a number of specialists, though the same could be said for the BMA. Few professions are truly homogenous. In a sense, the task of professional bodies is to create a sense of solidarity and identity between disparate elements (see Ackers 1994 for a similar argument with colliery deputies). Whereas, in more recent times the RCN has restructured itself into a number of associations and forums, and learned to delegate more readily to these specialist sections when decisions affect the whole College, Council still makes the final decision, for the ‘common good’. Again, the policy makers concerned with the needs of service provision, prevail. Thus the power of today’s RCN is very much determined by its membership, which is largely made up generalist nurses and managers. This may lead to
the professionals/specialists establishing their own specialist bodies as their voices for the future (White 1985b:20).

The two tier system of State and Enrolled nursing has been dismantled in favour of one state registered nurse. All pre registration courses are now either diploma or degree level and since 1993 have been based in institutions of higher education (see Table 4, p.102). There are calls for a move to full degree entry but this poses particular problems. Firstly, problems with recruitment cannot afford the profession the luxury of admitting degree status candidates alone. Secondly, student nurses have always provided a steady, cheap form of labour in the health service. The extra academic time needed would necessitate that students to spent more time away from the ward situation. As the basis of nursing is of a practical nature, there are fears that necessary practical expertise would be lost. The growth in NVQ training for nursing auxiliaries, now more readily called assistants, is undergoing rapid expansion. With this, the role and task variety of the assistant is changing to one that encompasses more of the basic nursing skills.

If asked to define the role of a nurse, the word that would come most readily to mind in the eyes of the public is that of 'carer'. Perhaps this has been one of the inherent problems for nursing as a profession. Their predominant task as carer has always come second to the medical task of 'curer'. More recently, these tasks are changing as professional boundaries become more blurred. Tasks taken on by nurses, such as administration of intravenous therapy, taking of blood, assessment of patients, were previously regarded as medical. The dilemma for today's nurse, lies in how to increase this task variety whilst achieving a distinctive role in health care which enables them to pull away from medical dominance. The RCN recognises that the values and strength of nursing lie in the 'professions
adaptive and generalist nature’ (RCN 1980:2) and warns against excessive specialisation and the need for a careful balance between the two roles. For the nurse on the ward this adaptability can often be seen as exploitation. The term non-nursing duties (paperwork being one example) is often banded around and used as an example of tasks nurses are expected to carry out in ‘the line of duty’.

The profession’s adaptive role leads to tension within it. On the one hand the fragmentation of work that accompanies the demarcation of professional role and boundary may limit the nursing process. On the other the exclusion of the more mundane non-nursing duties (bed pans, making beds, giving out meals) can be seen as an attempt to enhance nursing as a profession. At present there is much criticism about the academic nature of nursing from both within and outside of the profession. A university style academic training was expected to gain the profession a higher status. As the new era of graduate nurse now attends the patient it is said that nursing has moved too far way form its ‘caring’ origins (Phillips 1999). This lends credence to the social closure perspective that professionalism is predominantly a self interested strategy to raise collective social status. Conversely, it questions the functionalist assumption that professionalisation is automatically good, in health service terms for the patient. Finally, the advent of the role dubbed ‘super nurse’ in the media – New Labour have yet to determine the name – will allow senior ward based nurses to advance clinically rather than move into management. This consultant style nurse has received a luke warm reception amongst the medical fraternity, who fear that their own ward autonomy is threatened.
THE PHYSIOTHERAPY PROFESSION

Introduction

While the struggle of nurses to control their practice has often been viewed sympathetically, the therapy professions have been widely ignored. Parry (1995:312) suggests that the feminist movement has served the female professions poorly and argues that the professional associations have done little to redress the balance. Though the majority of their members are female, the associations have failed to 'articulate a feminist analysis of male dominated medical care and its consequences for the professions'. The following histories and developments of two of the Therapy professions gives an account of how predominantly female professions initially needed to evolve on the medical model and their struggle to break free in order to secure their own identity and professional autonomy.

The shifting sands of health care professionalism have continually impacted on the smaller professions, particularly in their search for a higher profile in society. 1994 saw an important landmark for the physiotherapy profession. Its centenary year not only allowed the profession the chance to reflect on its past, but also to identify its shape and direction as a profession for the future. Once more, this was a case of looking to the past in order to define the future. Whilst many elements of professional practice are shaped by outside agencies, other crucial aspects such as the identification and evaluation of core skills and practice come from within the profession. This identification and evaluation of core skills is as an integral part of continually redefining the profession in today's health care system. In May 1998 at the Chartered Society of Physiotherapy's (CSP) Annual Representative Conference, two motions of debate centred around the need for the CSP to
define core roles of Physiotherapists and Nurses in order to ‘eliminate any ambiguity in creating extended scope practitioners and in order to develop a useful working relationship’ (*Physiotherapy Frontline* April 1998:22). In a personal view of the emergence and development of the profession Parry (1995) urges the profession not to confuse tasks with skills. In order to maintain it’s identity, she calls for the need to identify what is unique to the profession. From ten original founders, the governing body of today’s physiotherapy profession, the CSP now has more than 29,000 subscribing members (CSP 1999). (See Table 2 p.102).

Initial formation

The primary objective for four women – all nurses – in 1894, was to ‘make massage a safe, clean and honourable profession’ (cited in Robinson 1994:8a ). This was a response to the publication of stories of ‘unscrupulous behaviour’ in the practice of massage, and the scorn of the medical profession who found it necessary to alert the population against the use of massage on the account of dubious persons practicing it. The formation of the Society of Trained Masseuses in 1894 was followed the next year, by the first examination of the Society when seven people were awarded the certificate of competency by its founders. Candidates were only allowed to enter once they had been vetted (which interestingly included two testimonials from medical practitioners), and successful candidates were only issued with this certificate if they agreed to certain rules and practice. The first rules of professional conduct were laid down and these sowed the seed that was to grow into the profession of Physiotherapy. That the profession allowed doctors to assess entry into the profession from its early days through to the early eighties – albeit not in the same form - shows the pivotal role that medicine has played in regulating the profession until recently.
The formative years of the Incorporated Society of Trained Masseuses (ISTM) – as it became known in 1900 – saw the early development of accreditation into the profession together with an escalating variety of practices which incorporated the profession’s two other core skills: electrotherapy and exercise. However, this was not without some opposition and much deliberation. After all, the Founders as nurses, had only founded the society in order to legitimise and defend the practice of massage in the treatment of the sick. Practice and examinations in the core skills of movement and electrotherapy were gradually established in the second decade of the century and training schools became widespread throughout the country. Examinations were still under the auspices of the Society and London based. A female dominated profession for much of its formative years, the Society was approached by the War Office in 1905 with a request to examine army personnel in massage. This began the long tradition and association between the Services and the Society which continued until the closure of the joint services school in the 1980s. Men were admitted to the Society in 1920, at the same time as the granting of the Royal Charter. At this time the IMST merged with the Institute of Massage and Remedial Gymnastics (a group based in Manchester) under a new name: The Chartered Society of Massage and Medical Gymnastics. The next twenty years, though interrupted by two world wars, saw the society continue to develop and consolidate its training and examinations. The three core skills - massage, electrotherapy and exercise - became established and synonymous with the profession. The role of its governing body, the CSP has done much to preserve these traditional skills. Every direction the physiotherapy profession has taken, has been guided by its professional body. Following the first examinations of the ISTM in 1895, a circular was sent out to ‘medical men, matrons of hospitals, surgical homes and a few private friends who have asked for fuller particulars’ (Page 82 of 299)
cited in Robinson 1994: 8a). The first paragraph of this circular contained the primary objective of the founders,

'The Society of Trained Masseuses has been formed for the purpose of improving the training of, and organising an independent examination for competent masseuses. It is hoped that this may establish a more uniform standard of proficiency and qualification' (Robinson 1994: 8a).

The granting of the Royal Charter in 1920 states,

'That the Incorporated Society was founded in the year 1894 in order to raise the standard of massage and to improve the professional position of women taking up that work' (Robinson 1994:8a).

Despite this declaration, as the Royal Charter was granted, men were admitted for the first time to membership. Most were trained in the Services as the existing schools claimed to have no facilities for the training of men. When the Second World War broke, little changed in the training and examination system, though men already in training had to be given an exemption from Service until completion (Thornton 1994:14a-15a).

**The Creation of the National Health Service**

The changing of the Society's title to 'Physiotherapy' happened in 1943, and with it a comprehensive revision of training in an attempt to broaden the curriculum. A three year training system was introduced to coincide with the creation of the NHS. As with many of the younger professions, the formation of the health service was seen as an opportunity, and perhaps, necessity to raise their status. Medicine, through its opposition to the NHS, had gained important concessions that served to enhance medical syndicalism. In return for their support, both General Practice and the hospital consultant had gained control over their own working environment and those who worked alongside them. Although large in
number, nurses were subordinate to medicine, through the power of control that medicine had been given. It was not until the 1974 reorganisation and the introduction of consensus management that nurses had any control over the provision of care (Strong and Robinson 1991:16-18). Being younger in their development and smaller in number, professions such as Physiotherapy had no voice, but continued to enjoy a higher status than nursing, in that the profession was seen less as an ancillary to medicine. Thus, for these professions, the impetus was given to consolidate the creation of a profession that would have a recognised place within the health care system. The new system of Physiotherapy training, which was to exist for thirty years, included three years full time study which incorporated all three core skills. This provided for the availability of bursaries and grants to assist the students. Students were to be not less than 18 years old and to hold the School Certificate or equivalent.

During the 1960s the Society set up a central clearing house in order to handle applications to the training schools. Moreover, this decade saw the first serious moves towards an all graduate profession. This continued to be high on the agenda for the next twenty years and was seen as necessary for the profession to prove its credibility with other professions. The need for credibility extended beyond the realms of health, but this also appeared to involve an attempt to shift from the medical model. Some schools began to move away from health authority control into higher education institutions, and with close collaboration with the higher education system and the CSP, began to formulate their own diploma courses.

The breakthrough for the Society on the issue of degree status came in 1976, when a four year degree course was approved at Belfast, although it took five more years before the
first degree on the mainland was approved at North East London Polytechnic. Helped by the massive expansion of Higher Education in the late eighties, opportunities to further enhance Physiotherapy training rose quickly. By 1989, the profession had a 50% graduate entry, which only three years later, had escalated to 100%. Now an all graduate profession, with a base in higher education, as with nursing and occupational therapy, the profession is working to enhance its stance within the research domain. Moves within the profession to a more evidence based approach to the provision of physiotherapy, are in line with other health care professions and government edict. Through the years there have been calls for an increase in male physiotherapists as a means of increasing the status of the profession, since it is felt that males are more likely to become autonomous independent practitioners as opposed to females who generally stay hospital based (Davies 1990). As a female dominant profession, this is understandably hotly debated in some quarters. Parry (1995) cites Wilkinson (1994), in suggesting that the blurring of gender demarcation is such that females now strive for the same autonomy as men. The current tendency of men to move into private practice and sports medicine appears to be pay related. Today’s gender figures obtained from the Chartered Society show that in numbers males are still a long way behind, though, as with the nursing and occupational therapy the numbers of male students continue to rise (see Tables 3 and 4, p.102).

Whilst the Society looked favourably on the trade union movement, as with the RCN a principle objection for not joining remained – the Society and its members would not countenance strike action. Although the CSP was listed on the special register of trade unions under the Industrial Relations Act 1971, this was not enough from some members of the profession. Calls to join a larger union such as NALGO were met with reluctance by the Society who saw their role as the voice of the profession as sufficient. This early
reluctance on behalf of the Society demonstrates the fear of losing control over their own membership in favour of a larger Union. In 1976 the Society gained a certificate of independence under the Trade Unions Act 1974, which meant that it had satisfied the regulations that the CSP could fulfil the role and functions of a union for its members. The appointment of an industrial relations officer at the Society in 1978 brought renewed interest in the trade unions and the Council recommended that the Society should be affiliated to the Trade Unions Congress (TUC). However, when ‘push came to shove’ the following year, the recommendation was defeated, with again the problem of strike action being the main opposition.

A long period of Conservative government, together with yet another health service reorganisation, that was to effect the delivery of health care and the individual professions like never before, are thought to be the two key reasons for the Society’s members voting overwhelmingly for affiliation in 1992. In recent years the CSP has become a lively force within the trade union movement and continues to develop relations with the TUC. Meanwhile the CSP’s Industrial Relations department has gone from a one-man-band in 1978 to one of the biggest departments at its headquarters with more than twenty five members of staff, demonstrating a shift of emphasis toward collective bargaining and industrial relations. Stronger links with the Department of Health have also been forged over recent years. The first Physiotherapy Officer was appointed to the Department in 1980. A liaison group made up of physiotherapists, speech and language therapists and occupational therapists meets on a regular basis with department officials to air views on wide ranging topics that effect the professions. In 1996, the Right Honourable Betty Boothroyd became its President.
Physiotherapy today

This outline history of the physiotherapy profession also serves to illuminate the changing role of the physiotherapist. Few physiotherapists would dispute that the original core skills—massage, electrotherapy and exercise—remain the basis of physiotherapy practice today. The CSP’s Annual Report of the Chartered Society of Physiotherapy regularly acknowledges the first objective of the Society as it stands today,

‘To improve the training, education and professional status of persons engaged in the practice of massage, medical gymnastics, electrotherapeutics, or kindred methods of treatment and to foster and develop the use of these and kindred forms of treatment’ (Robinson 1994:8a).

It is interesting to note the similarities between these statements that cover the span of the life of the profession in a 100 years of health care that has seen tremendous change. Rules of professional conduct that identify and dictate the scope of professional practice have been present in the Society since its beginning; and, whilst the primary objective of the Society may have changed little, the rules of professional conduct have become more readily debatable within the profession over the years.

One of the ‘hottest’ and perhaps most contentious debates that is relevant to this thesis, is the role that the Society has played in developing the relationship between medicine and the profession. As already discussed earlier, candidates were only eligible for examination on commendation from two medical practitioners. Furthermore, in a major re-write of the Society’s bye-laws in 1928, practitioners were restricted to undertaking work only under the direction of a medical practitioner. While actively supported by the medical profession, this rule of conduct brought much condemnation from within the physiotherapy profession. In a review of government reports during the lifespan of the
NHS, Armstrong (1976) noted that the Majority Report of the Committees of Medical Auxilliaries in 1951, stressed the need for medical control over paramedical professions. Medicine justified this control by stressing the primacy of medical knowledge. Only certain professions, including both physiotherapy and occupational therapy, were incorporated into this, which left them on a 'sticky wicket' since hitherto both had based their own existence on the medical model. Interestingly, professions such as dieticians and chiropodists, although paramedical, were too low a status to be considered. The professions' response tackled the indignity of being called 'Auxilliary' since it denoted inferior status. However, they did themselves little favour when the two professions in their own individual minority reports criticised each other over the boundaries of their own work.

The following years saw much deliberation over the issue of medical control and minor changes were made in an attempt to break the old ties. An example of this was the election in 1972 of the Society's first non medical chairman from its own ranks. The publication of a government report on the relationship between the medical and remedial professions, rescinded the outmoded advice that doctors should prescribe physiotherapy modalities and numbers of treatments, and acknowledged the professional autonomy of physiotherapists (HM(77)33). This had followed recommendations made by a working party set up by Sir Keith Joseph following outrage by the three remedial professions (Remedial Gymnasts, Occupation Therapists and Physiotherapists) over the Tunbridge Report (1972) that had done little to promote the professions. In 1978, the Society's Council approved a Bye Law change enabling physiotherapists to treat patients without prior medical referral.

Following a major review of the Society's rules in 1987, and discussion with the British Medical Association (BMA), the rules were changed. These new rules, together with
unabated interaction by the professional body with the government, have done much to establish not only the role of the profession, but also its status and standing in today's health care system. The rule below highlights the change in emphasis in the relationship between medical and physiotherapy professions:

‘Chartered physiotherapists shall communicate and co-operate with registered medical practitioners in the diagnosis, treatment and management of patients’ (Annual Report, CSP 1996).

The most recent revision of the rules of professional conduct took place in 1996. Most interesting to note is how the wording in this latest edition, rather than referring directly to the medical profession, takes into account the relationship with all fellow professionals:

‘Chartered physiotherapists shall communicate and co-operate with professional staff and other carers in the interests and with the consent of their patient: and shall avoid any criticism of them’ (Annual Report CSP, 1996).

This illustrates the more collaborative relationship with other health care professions, not just the medical profession, and succinctly demonstrates the achievement of the professional body in breaking away from medical control. It could also be argued that it shows the profession's rejection of the historical hierarchical structure of authority prevalent in the health service, by moving away from a satellite system revolving around medicine to a pluralist system of equal but different professions. A recent article in Physiotherapy Frontline (May 7 1997) - the official magazine of the Chartered Society - highlights the debate over the revision made by the BMA on the 2,500 year old Hippocratic oath. Contributors have criticised the revision for being 'too vague' and called for the adoption of the more adaptable World Medical Association statement. Comments from the Society on the issue surrounding the new oath, suggest that the CSP would be happy to suggest a different approach.
Membership now includes students of physiotherapy (as from 1986) and physiotherapy assistants (as from 1995). Security of the profession’s status in the health care arena is an ongoing issue. Issues such as Protection of Title continue to be addressed. In 1996 the Society launched a major strategic review, Towards 2001, with a final report expected at the end of 1997. The review has been the Society’s most comprehensive since its formation. It encompasses the views of its membership through postal survey (random sampling of 16,000 of its members), seven focus groups on wide ranging topics (members from all walks of life from within the profession), consultation at regional level through the regional boards together with specific clinical interest groups and occupational groups, and finally from external individuals and organizations with whom the Society has dealings with on behalf of the membership. One of the reviews major findings has been the importance that membership places in the role that the Society plays in promoting Physiotherapy as an ‘important and unique profession within health care’ (Annual Report 1997: 19). This reflects the high % of state registered physiotherapists that are also members of the Chartered Society (see Table 2, p.102).

**THE OCCUPATIONAL THERAPY PROFESSION**

**Introduction**

Although one of the fastest growing health professions, the number of Occupational Therapists is still comparatively small (see Table 2, p.102). Historically, Occupational Therapy too has been linked with the medical model. Turner (1992a:8) suggests two major reasons for this: a desire to gain respectability and recognition, and a lack of adequate resources to carry out its holistic philosophy independently. As with both Physiotherapy
and Nursing, Foster (1992:365), acknowledges that the history of Occupational Therapy ‘demonstrates the consequences of basing a profession on a weak theory base’. This lack of theoretical basis obliged the profession to ally itself more closely with other professions, such as medicine, which not only had a sound theoretical base, but which were also more esteemed by the public. These links with the medical profession are firmly embedded in early definitions of Occupational Therapy.

**Initial formation**

Although George Barton, a 19th Century American doctor first used the term Occupational Therapy, one of the earliest definitions in this country can be found in accounts of the history of the Association of Occupational Therapists. The first meeting of the Association’s Council in June 1936 defined an Occupational Therapist as ‘a person who is appointed as responsible for the treatment of patients by occupation and who is qualified by training and experience to administer the prescription of a physician or surgeon...’(Macdonald 1957a:30). In 1945 Colson defined the aims of Occupational Therapy in purely physical terms within the medical model of treatment. And in 1946, Howarth and Macdonald emphasised the importance of Occupational Therapy being carried out only on prescription of the medical practitioner. There are strong similarities here with the Physiotherapy profession. Only in recent years, as the profession has gained greater credibility, has the profession attempted to define the basis on which Occupational Therapy is practiced (Turner 1992a:5).

Although not acknowledged as a profession until after the second world war, the earliest theoretical base for Occupational Therapy can be attributed to Egyptian, Roman and
Greek philosophy. Practices of music, games, conversation and exercise to alleviate melancholics and troubled minds can be found in early Egyptian and Roman writing. Macdonald et al (1970) cites the Greek physician Galen, who advocated occupation as treatment. In the 19th Century Pinel, a French physician, wrote of a Spanish hospital where recovery rates were higher amongst those patients who occupied themselves than those who were 'idle'. At the same time, William Tuke, an English Quaker established a retreat in York where emphasis was based on occupation for the mentally ill (Turner 1992 b:12). By the early 20th Century the treatment of mental illness using activity and occupation was well established. As with Physiotherapy, early Occupational Therapy treatment was not entirely performed by people whom we would now recognise as Occupational Therapists. In a review of a Memorandum on Occupational Therapy for Mental Patients published in 1893, Hume (1992) notes that Occupational Therapy in the asylums was almost entirely organised by nursing staff. In addition to this, medical staff were themselves encouraged to adopt occupational techniques in their own treatment. The Second World War heralded the expansion of Occupational Therapy in the field of the treatment of the physically injured, and the move toward specifically trained personnel to carry out the role. On reading the literature, it is clear that the growth and acknowledgement of the profession is embedded in the history of the Association of Occupational Therapists. As with the physiotherapists the professional body has helped to form the profession.

The founding of the Association of Occupational Therapists in England took place in 1935 when a handful of Occupational Therapists sought to establish a professional association for themselves. A similar Association had been founded in Scotland a few years earlier. Other than formally defining the term Occupational Therapist, the main work of the first
Council was to establish an examination framework together with the publication of a professional journal. By the outbreak of the Second World War in 1939, these two aims were achieved (Macdonald 1957b). The Second World War was a turning point in the recognition and standing of the profession. Rapid expansion in numbers was needed to cope with the demand by the services for Occupational Therapy. In response, the Association drew up an emergency syllabus for Occupational Therapy Auxiliaries. Interestingly, at this time, discussions took place with the Chartered Society of Massage and Remedial Gymnastics (now the Chartered Society of Physiotherapy), as to the possibility of joint training and practice, but these proved fruitless. The major reason cited for failure was that both were too heavily involved with extending their own work and services in response to increasing demand (Macdonald 1957b:16). However, a further consideration might have been that closer collaboration at a time when both professions were working to advance their own identity and status could have served to blur the boundaries that each were aiming to establish.

During the war, work of the association fell into three categories – general domestic policy, training considerations and future plans. Regulations for professional practice were drawn up and the establishment of a Charter sub committee group in 1943 saw the profession’s ultimate aim of gaining a Royal Charter. Again, discussions with the Physiotherapists took place, which led to the formation of an Advisory Committee on Rehabilitation but no definite action followed. Training considerations revolved around wartime courses. At this stage, qualifications fell into three categories: the full diploma, a War Emergency Diploma for those with some medical background, together with two styles of Auxiliary Certificate.
The creation of the National Health Service

The advent of the NHS saw continued expansion and recognition for the profession in terms of both the number of practitioners and professional identity. The need for a national representative body became increasingly apparent in order to cope with the demands of government policies and legislation. To this end the Scottish and English Associations merged in 1974 to form what is today recognised as the British Association of Occupational Therapists (BAOT). In 1978 the constitution of the British Association changed significantly. It became an independent Trade Union, whilst the educational and professional aspects were maintained by a separate College of Occupational Therapy. At this time a new category of membership was introduced, allowing non-professionally qualified staff to become associate members of the profession (Jay et al 1992). In 1980, an Officer from the Association was elected to the Department of Health. More recently, the Association, while maintaining its status as a Trade Union has affiliated with Unison, the largest public service trade union. Meanwhile, the College of Occupational Therapy has overseen a rapid expansion in educational development. As with the other health professions the shift away from hospital based schools to Higher Education has provided the opportunity for the profession to become all graduate.

Occupational Therapy today

One of the smallest health professions there are now just under 20,000 registered Occupational Therapists (CPSM 1999). It is clear to see that the role of Occupational Therapy in health care has been very much shaped by events in history. The earliest theoretical base of the profession was founded in the belief that occupation and activity are essential requisites for good health. In the immediate post war years, partly in attempt
to deal with the increasing use of Occupational Therapy, two distinct roles were defined: a
general role was to prevent depression and maintain morale for long term patients; and a
special role involving the prescription of treatment which had some remedial purpose, for
example, the ability to dress unaided. This separation of Occupational Therapy into what
is now known as *diversional* (general) and *therapeutic* (special) branches has plagued the
profession for a number of years. Through time the diversional role has been much more
identified with Occupational Therapy than the therapeutic role, and Occupational
Therapists have had to work hard to dispel the myths that their main role is to keep
patients occupied with craft activities.

The history of Occupational Therapy from the 1970's to present day draws many parallels
with the Physiotherapy profession. This is not surprising, especially following the
Professions Supplementary to Medicine Act of 1960, which provided the mechanism for
the establishment of the Council for Professionals Supplementary to Medicine. To some
extent from this time forward, they have worked together in the political arena,
particularly on issues such as the right to clinical autonomy and control over the scope of
professional practice. The latter has, in recent times, precipitated heated debate, both from
within the professional associations and on an individual level. There are unanimous calls
for the profession to not only define their boundaries but to defend them from other
professions (Golledge 1998, Johnson 1995).

**CONCLUSION**

**Professions in the New Workplace**

Professional identities undergo periods of stability and consolidation interspersed with
times of great change precipitated by both changes in work organisation and state policy.
Today, health professions face a time of great turbulence affecting their boundaries and professional/occupational identities. In a speech delivered in July 1992 at a conference entitled ‘Nurses and Skill Mix’, Christine Hancock, General Secretary of the RCN, considered that much of the association’s work is committed to demonstrating and promoting the value of nursing. She argued that ‘Whilst it was legitimate to ask whether nurses were giving value for money... clearly nurses don’t want every Health Service job going’. Recent years have seen much greater attention paid to skill mix issues in the health service workforce, particularly via initiatives such as patient focused care and hospital re-engineering. Skill Mix exercises not only address the balance between professionally qualified staff and other members within a particular occupational group, but also serve in some instances, to examine skill boundaries between differing occupational groups.

Interestingly, Rogers (1991:49) notes that since the foundation of the NHS, there has been little change to the either the number or boundaries of health care professions, citing the emergence of clinical psychologists as the only exception. Indeed, change and flexibility in the workforce is inhibited by the self regulatory structure that has evolved in many of the professions. As public and management policy threatens to recast the roles of the professionals in the NHS, the professional associations face new challenges to maintaining established identities and boundaries - a central focus of this thesis.

Some nursing literature suggests that such exercises should be seized upon as an opportunity for nurses to prove their worth. But usually negative feelings prevail (Bradwell 1994, Hancock 1992b). The latter view suggests that skill mix exercises are, at worst, another example of attempts at downsizing, and at best, an attempt at deskilling the nursing profession (Sylvester 1992, Bagust 1992, Moore 1993). RCN guidelines (1992) arm the profession with information regarding the aims of skill mix initiatives. The
guidelines not only set out action checklists for its members, but also advice on the importance of skilled and thorough negotiation. A briefing paper by the BMA (1995) on the issues surrounding the restructuring of tasks calls for further evaluation of the benefits in terms of standards, outcomes and efficiency. The paper acknowledges that in some instances service to the patient has been improved and that quality of service has not been adversely affected. Whilst warning of the potential problems of competency and accountability, the paper further acknowledges that the skill mix exercise may often help to formalise practices that already exist. These two documents alone highlight the differences between the two professions. On the one hand, the RCN encourages the need for care and skilful negotiation, in order to protect the profession from the adverse affects of skill mix initiatives. On the other, the medical profession sees the issue as one where more onerous tasks can be passed on and views such initiatives in terms of quality care to their patient. It seems clear that status and hierarchy continue to play their part in the acceptance of restructuring of work.

The creation of Unison in 1993, following the amalgamation of the three public sector unions, led to one of the biggest unions in the country. Representing the interests of more than one million workers (including the British Association of Occupational Therapists), Unison has, in the past, been accused of ‘militant defence of the status quo’ (Brindle 1997:17). However Bryson et al (1995:128), suggest that the NHS members ‘stand to gain significantly in terms of resources’ through the merger. In 1994, its guidelines reflected the more negative views of skill mix exercises that led to restructuring of the workforce. Concerns of cost cutting, deskilling, and decreasing quality are all voiced in the guidelines, with much evidence to support their cause. Since 1997, however, there appears to be a change of direction in policy. This not only reflects the new government
and TUC policy on social partnership (see Ackers and Payne 1997) but also echoes the main thrust of the NHS new White Paper, *A new NHS Modern, Dependable*, which advocates collaboration and partnership rather than competition. Together with the King’s Fund, a respected independent body which works in close collaboration with NHS Management, Unison announced details of a new initiative involving management and staff from six NHS Community Trusts. The project is aimed at ‘harnessing the skills and expertise of staff in order to foster a joint approach to work force planning in the health service’ (Unison 1997). Stressing the importance of collaboration between unions and employers as a way forward for the future, Unison is quick to point out that it will not be at the expense of those delivering the service. Hailed as a major paradigm shift all parties involved are being encouraged to commit themselves to think beyond traditional relationships and assumptions (Brindle 1997). Findings from the empirical chapters of this thesis contribute to this debate.

A strategic review has recently been undertaken by the Chartered Society of Physiotherapy. It is allowing the Society to identify the key issues surrounding the delivery of a quality service in today’s new health service. There have again been calls to identify what is uniquely theirs and to consider how they can best collaborate with other health care professions in sustaining a workforce that could deliver appropriate patient care in the future (Friend 1998). Acknowledging that core physiotherapy skills are at risk of being provided by others, CSP is being urged by the Association of Physiotherapists in Management - a special interest group within CSP - to take the lead in researching the pros and cons of a seven day week (Hiller 1998). Meanwhile a motion to look at closer working relationships between therapies was put forward by the same group at a recent conference. Arguments for and against the possibility of forming a Royal College of
Therapy are increasingly beginning to appear in physiotherapy literature (Rosen 1998). That this is being debated is a huge step forward for the professions. As this chapter has shown, through history the Physiotherapists and Occupational Therapists have been reluctant bed fellows. The launch of the Alliance of Health Professions in 1998 is expected to bring a more powerful voice in Industrial Relations (Physiotherapy Frontline 1998). As the professions meet these new challenges, we can see how past experience has shaped their responses.

A central theme in this has been the struggle of professions populated by working women to break free from control by a male, medical social elite. As Rich (1980:21) wrote, ‘There is no discipline that does not obscure and devalue the history and experience of women as a group’. Professions such as dentistry, and in more recent years, osteopaths and chiropractors have managed to evolve without medicine dominating their practice. As they are predominantly male professions, we must assume that gender has played an important part in creating the hierarchical health care structure we have today. Furthermore, by limiting their scope of practice, these professions have benefited by being able to define their knowledge base with more freedom. After examining the evolving role and scope of professional practice, it is evident that external social factors such as class, ideologies of science and gender have played a part in the histories of the today’s key health professions. This links back to the work of Foucault in chapter 2 which stresses the relationship between increasing knowledge and increasing power his conceptual link of using power to secure human surveillance/subjection. As the nursing, physiotherapy and occupational therapy professions emerged, they could do little about these three external factors. Medicine through its universality, class and gender was already the power force in health care. Moreover these professions agreed to take on the supplementary role to
medicine. In their formative years they were happy to trade autonomy for orthodoxy and the backing of the medical profession. The therapy professions were reliant on the goodwill of the doctors to endorse what they were accomplishing. Indeed, their recognition and esteem in the eyes of the public depended on it. With the founding of the NHS, their evolving status and identity continued to be propelled by the status and power of medicine. Only in the last twenty or thirty years have the professions had the courage to break away and become their own independent force.

This chapter has contributed to the argument of this thesis by identifying and exploring the uniqueness of the individual health professions within the NHS organisational context. It demonstrates how professional roles and scope of practice were actively constructed by the professions themselves through competition, co-operation and imitation. What is evident in this chapter is the close relationship between the health professions and the NHS and the entrenched nature of the professions within it. Through examining the traditions of the role and scope of practice within health care, it recognises and emphasises the importance placed on professional/occupational identity by the professions themselves. In tracing the traditions and evolutions of the professions it not only confirms the hierarchical nature of the health professions but demonstrates that some professions, namely medicine and nursing, are more firmly established than the smaller, younger professions.

Business Process Re-engineering is one of the general management change programmes currently employed in the NHS. A programme that has skill mix and job redesign at its heart. The empirical work of this thesis takes place in a large NHS Trust which had undergone a radical change process under the auspices of Business Process Re-
engineering. Therefore, the early part of the chapter focuses on the specific form taken by health care BPR. It introduces the reader to the background information concerning the nature of the programme, the mode of implementation and the general nature of the organisational changes made. The chapter then reflects on BPR as a management led, organisational cultural change programme, identifying and exploring the key concepts that underpin BPR as a general management theory.
### Table 2: Showing number of state registered professionals and number of individuals that are members of the main professional associations.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Registered</th>
<th>Member of professional assoc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>18,030</td>
<td>111,630 (BMA)</td>
</tr>
<tr>
<td>Nursing</td>
<td>634,229</td>
<td>310,000 (RCN)</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>29,523</td>
<td>29,470 (CSP)</td>
</tr>
<tr>
<td>Occ. Therapy</td>
<td>19,692</td>
<td>16,117 (BAOT)</td>
</tr>
</tbody>
</table>

(numbers correct at June 2000)

### Table 3: Showing the % of registered male and female health care professionals.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>127,493</td>
<td>60,537</td>
</tr>
<tr>
<td>Nursing</td>
<td>79,000</td>
<td>799,000</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2,826</td>
<td>26,703</td>
</tr>
<tr>
<td>Occup. Therapy</td>
<td>889</td>
<td>18,803</td>
</tr>
</tbody>
</table>

(numbers correct at June 2000)

### Table 4: Showing the degree status of individual professions

<table>
<thead>
<tr>
<th>Profession</th>
<th>Degree status</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>Yes (6yrs) Full</td>
<td>Always</td>
</tr>
<tr>
<td>Nursing</td>
<td>Part – approx 75% diploma 25% degree (3yrs)</td>
<td>1993</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>(3 or 4yrs) Full</td>
<td>1992</td>
</tr>
<tr>
<td>Occup. Therapy</td>
<td>(3 or 4yrs) Full</td>
<td>1992</td>
</tr>
</tbody>
</table>

(Source: Individual Professional Associations)
At the heart of re-engineering is the notion of discontinuous thinking – of recognizing and breaking away from the outdated rules and fundamental assumptions that underlie operations. Unless we change these rules, we are merely rearranging the deck chairs on the Titanic.

(Michael Hammer, ‘Re-engineering Work: Don’t Automate, Obliterate’ 1990:107)

Hospital Re-engineering: The Management Programme and Organisational Context – An Introduction

The research for this thesis took place in one of the largest University teaching hospitals in Britain. Employing more than 4,000 staff it encompasses 1,100 beds. With a budget of £130 million per annum, it has 400,000 out patient attendances, 120,000 accident and emergency attendances and 103,000 in patient and day case episodes each year. In addition, more than 80% of its in patient admissions are emergencies. Rather than concentrating on top down structural redesign, the programme was to focus at the delivery of patient care. The programme sought organization-wide change as opposed to initiatives confined to specific specialties or clinical directorates. By 1997, 140 separate projects had begun, so that that re-engineering efforts had become increasingly indistinguishable from the day to day operational activities of the hospital. Figure 4 and Table 5 illustrate the structural redesign of the hospital. This structural redesign moves away from the clinical directorate functional and speciality based model. Instead, the approach adopted focuses on the development and enhancement of speciality focused teams and healthcare/patient focused processes. Table 6 illustrates some of the hidden benefits that the new specialty-process model created following its implementation, together with anticipated outcomes.
for the future. Finally, Table 7 gives examples of a number of improvements that the Trust suggests can be empirically demonstrated.
Figure 4: Direction of re-engineering change at the Trust hospital
**Table 5: Organisational configurations at the Trust hospital**

<table>
<thead>
<tr>
<th>Speciality - function</th>
<th>Speciality - process</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate management of ward, outpatient and daycare as functional units.</td>
<td>Process Manager accountable for the entire “end to end” journey of a group of patients defined by speciality i.e., ENT; Gastroenterology.</td>
<td>Process Manager accountable for the entire “end to end” journey of patient group defined by process characteristics, i.e., disease grouping; planned/unplanned; short/medium/long stay.</td>
</tr>
<tr>
<td>Managed as a centralised resource, separate from other clinical specialties or patient processes.</td>
<td>Clinical support functions/ specialities involved in setting process based targets</td>
<td>Clinical support services integrated into processes with joint accountabilities for process targets.</td>
</tr>
<tr>
<td>Teams on uni-professional basis, chiefly by function, i.e., ward nurses, clinic clerks, ENT doctors</td>
<td>Multi-professional teams grouped around the activities of individual clinicians or groups of patients managed by these clinicians.</td>
<td>Multi-professional teams grouped around patient process.</td>
</tr>
<tr>
<td>Functional targets and systems of activity measurement, not “owned” at a service delivery level.</td>
<td>Measurement and target setting at the level of the individual clinician and clinical team</td>
<td>Measurement and target setting at the level of the individual clinician and the patient process.</td>
</tr>
<tr>
<td>By Functional Directors with input from Clinical Directors.</td>
<td>Jointly by Clinical Directorate leaders/Functional Directors</td>
<td>By “Supra” Process Directors, supported by Functional Directors.</td>
</tr>
<tr>
<td>Directorate Senior Nurse as line manager for nursing staff and leader of professional nurse development.</td>
<td>Separation of line management and professional development responsibilities. Professional development by the Clinical Team Leader/Centre for Best Practice.</td>
<td>Extension of nursing and care roles. Organisation by process rather than specialty.</td>
</tr>
<tr>
<td>Project title</td>
<td>“Hidden” benefit</td>
<td>Anticipated outcomes in performance at future date</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Introduce clinical teams (medical)</strong></td>
<td>Team based performance management and problem solving.</td>
<td>Reduction in error rates, duplication and waste through team based problem solving. Improved productivity and potential for reduced operational costs through direct service improvements and fewer supervisor/managerial layers of staff.</td>
</tr>
<tr>
<td><strong>Menstrual clinic process</strong></td>
<td>Improved teaching through the application of evidence based diagnostic and treatment protocols. Improved research opportunities through the collation of quality life indicators.</td>
<td>Better clinical outcomes which represent potential for both improvement in service quality and clinical cost reduction.</td>
</tr>
<tr>
<td><strong>Medical physics</strong></td>
<td>Improved working relationship with the Children’s Hospital; increasing number of scans and reduced waiting time.</td>
<td>Reduction in ‘turnaround time’ for patients, reduced length of stay may result in generalisable benefits.</td>
</tr>
<tr>
<td><strong>Process and skills development (surgical)</strong></td>
<td>75% of ENT nursing staff have patient recovery skills (previously 0%).</td>
<td>Enhanced service quality through reduction in number of ‘hand offs’ between staff and subsequent reduction in error duplication and delay.</td>
</tr>
<tr>
<td><strong>Prioritise emergency (theatre) demand</strong></td>
<td>Formal communication channels ensures support across the entire process and leads to improved working practices and patient care.</td>
<td>Leads to improvements in quality of care for patients through joint problem solving and perspective which matches patient experience.</td>
</tr>
<tr>
<td><strong>Cellular Pathology</strong></td>
<td>Team based working amongst consultant histopathologists.</td>
<td>Impact on the ‘turnaround time’ for diagnosis supports the development of further single visit clinics. Improved productivity in reporting specimens.</td>
</tr>
<tr>
<td><strong>Musculo-skeletal rehab/discharge</strong></td>
<td>Implementation of agreed performance measures which are patient focused and owned by the multi-disciplinary team.</td>
<td>Achievements of targets in terms of quality and efficiency as a result of on-going performance monitoring.</td>
</tr>
<tr>
<td><strong>Focus on clinics (Information Services)</strong></td>
<td>Facilitation of clinical team based performance management.</td>
<td>Achievements of targets in terms of quality and efficiency as a result of on-going performance monitoring.</td>
</tr>
<tr>
<td><strong>Organisation design-macro</strong></td>
<td>More coherent link between strategy and operations leading to greater effectiveness and cohesion of decision making. HEIGHTENED focus on clinical issues, improved and more timely senior management decision taking.</td>
<td>Linking performance goals at a micro level with the overall goals of the organisation. Prioritisation by managerial/clinical leaders of achievement of efficiency/effectiveness targets. Increased potential for achieving corporate objectives.</td>
</tr>
<tr>
<td><strong>Trust Pay and Conditions of Service</strong></td>
<td>Greater job satisfaction and career opportunities reflected in reduced levels of sickness and more stable workforce.</td>
<td>Likely to impact on service quality, patient satisfaction and improved productivity.</td>
</tr>
<tr>
<td>Category</td>
<td>Baseline (previous arrangement)</td>
<td>Current position</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Service Management</strong></td>
<td>Separate management of ward outpatient and daycase as functional units. Separate spans of responsibility for clinical Head of Service and functional ward or outpatient manager(s). Changes commenced October, 1995.</td>
<td>Process manager accountable for entire “end-to-end” journey of a group of patients, typically grouped by specialty. Span of responsibility for Head of Service and Process Manager coincide.</td>
</tr>
<tr>
<td><strong>Performance Management</strong></td>
<td>Functional targets and systems of activity measurement, not ‘owned’ at the level of service delivery. Changes commenced September, 1995.</td>
<td>Measurement and target-setting increasingly at the level of the individual clinician and clinical team. Corporate performance management strategy reflects drive towards process based targets.</td>
</tr>
<tr>
<td><strong>Performance Reward</strong></td>
<td>Use of Whitely Council terms and conditions does not allow performance reward for team and individual performance. Changes commenced February, 1995.</td>
<td>Implementation of Trust terms and conditions has provided the flexibility and framework for team and individually based performance reward.</td>
</tr>
<tr>
<td><strong>Team based working</strong></td>
<td>Teams typically operated on a uniprofessional group of individuals i.e. ward nurses, clinical clerks, ENT doctors, physiotherapists. Problems passed up the managerial hierarchy and decisions passed down to staff. Skills restricted to professions and grades. Resourcing issues dealt with by managers. Changes commenced November, 1995.</td>
<td>Move towards multi-professional teams grouped around particular patient processes that can extend across Directorate boundaries. Teams beginning to resolve own problems and make decisions about their own processes. Skills required to meet the needs of patients within defined processes being identified and shared by team members. Teams beginning to deal with own resourcing issues.</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Corporate leadership agenda largely managed by (functional) Directors’ Group with input from Clinical Directors. Changes commenced August, 1996.</td>
<td>Corporate leadership by Clinical Directors/Process Directors (who represent process) and (functional) directors. Process defined as the natural unit of management within the hospital. Leadership development (for both clinical and managerial leaders) identified as the key corporate priority for 1997.</td>
</tr>
<tr>
<td><strong>Managing the joint operational and change agenda</strong></td>
<td>Re-engineering projects typically led by the central re-engineering programme team. Clinical Directors largely focused on operational agenda or localised change projects. Changes commenced September, 1995.</td>
<td>Process redesign projects managed by Clinical Directorate leaders. Organisation wide projects are headed by corporate leaders. Operational agenda and change are wholly integrated. Both are represented in Directorate and corporate objectives.</td>
</tr>
<tr>
<td><strong>Ongoing capability for change</strong></td>
<td>Change methodologies “owned” by central re-engineering programme team with support from external management consultants. Development strategies operate on a discrete basis (i.e., teaching, research, audit, quality, professional development). Professional development roles typically combined with line-management roles in the guise of Ward Manager or Senior Nurse. Changes commenced May, 1996.</td>
<td>Clinical Directorate staff are experienced change practitioners. Support and guidance on developments in clinical effectiveness, research, education, professional development and process change provided by the hospital’s “Centre for Best Practice”. Development strategies are co-ordinated and managed through the centre. Separation of process (line) management roles from professional development roles.</td>
</tr>
</tbody>
</table>
A number of factors contributed to this particular Trust hospital undergoing such radical change. Nationally, the increasing political pressure on the capping of public spending, together with an explosion in new and often expensive medical technology, had led to demands for achieving improved quality of patient and purchaser services throughout the health service within ever limiting budgets. An added incentive for the individual Trusts had been the government led focus on clinical outcomes and the introduction of league tables. On a local level, there was the potential movement of focus from large city teaching and general hospitals towards community and primary care and the introduction of the quasi market within the health care system, following the 1989 White Paper. This had necessitated that organisations within the NHS look competitively at the service they delivered in order to meet the demands of the various potential customers. These circumstances led the Trust to embark on a radical BPR programme, with its goal to become the ‘best hospital in the country’ (Trust Corporate promotional Video 1994). Small, incremental changes, though successful, no longer seemed far reaching enough in the eyes of the Senior Management team.

The Trust aspired to a strategic direction which required quality targets beyond those set down in the national Patient Charter. The hospital’s Management saw the BPR programme as an important initiative, focusing on improving the quality of its services, teaching and research in order to achieve its strategic direction (Trust hospital management report 1994). Dramatic improvements in critical measures of performance were to be expected in quality, service, speed, outcome and cost. The programme was carried out over a two year period and primarily funded by the NHS Executive and Trent Health. A number of other organisations provided further support, including the local health authority, the Audit Commission, the two of the regions universities.
The primary objectives of the re-engineering programme were four fold:

- The re-alignment of key healthcare processes so that different ways of working could be delivered and the managerial paradigm changed from managing inputs to managing outputs
- Achievement of levels of service of quality hitherto not realised
- Achievement of levels of efficiency and cost reduction hitherto not realised
- the provision of a working environment where staff could maximise their skills and abilities

(Bevan et al 1997)

The Trust had embarked on a number of innovative quality initiatives prior to the start of the re-engineering programme. The most successful of these was the neurology single visit clinic. Designed around the concept of value to the patient (customer), this sought to reduce the number of patient visits to the clinic. Previously, patients had waited for up to eight weeks and attended the Out-Patient department four times, before diagnosis and eventual treatment plan was discussed. By redesigning the clinic into one, five hour visit, the patient was seen by consultant, investigations carried out and a final consultation with the consultant and the investigation results concluded, before leaving the hospital. The process time had been reduced from a matter of weeks to hours and the administrative activity by 40%. The reduction in the number of hospital visits had not only reduced the inconvenience and costs to the patient, but also reduced anxiety levels in the wait for confirmation of diagnosis. To the Trust, the single visit clinic had illustrated the basic re-engineering principle of looking at a process, redesigning it, and achieving a radical
improvement at no extra cost to the organisation (Trust Hospital Corporate promotional video 1994).

Few departments and staff had not been untouched by the BPR programme. Some significant successes had been achieved in the first six months. An example of this can be seen in the reduction in length of patient waiting time in the outpatient department. This is in line with Government targets set in the Patient Charter - a 30 maximum waiting time in Out-Patient Clinics and waiting times in some other clinics have been significantly reduced. Instances of this include a Gynaecological clinic where before re-engineering only 61% of patients were being seen within the 30 minute time scale, as opposed to 100% post-engineering; and in Ophthalmology, where percentages have increased from 50% to 96%. In achieving these results the Trust had jumped from near bottom of the Government league tables to near the top. A 'near patient test centre' transformed how diagnostic tests are carried out and how the test results are delivered to the clinician. Within the centre, tests can now be performed by one person, as opposed to the patient visiting a number of departments dotted around the hospital site. As a result, 80% of tests can be performed within this system and results dispatched to clinicians within one hour. Symptom specific clinics have also been designed allowing for a greater diversity of specialty and increased throughput of patients (Bevan et al 1997).

In-Patient services were also in the process of being radically re-designed. This re-design was to focus on the development and enhancement of speciality focused teams (i.e. teams based around one particular speciality) and patient care processes (i.e. crossing the boundaries of care, taking a hospital wide approach, rather than inter department). Process speciality boundaries were to be defined according to patient need. In achieving this there
is to be further enhancement of the multidisciplinary 'team based' approach to patient care, which, alongside challenging existing hierarchical structures, allows for clearer accountability and responsibility of patient care processes to the speciality teams. The advantages of the team based approach were seen as three-fold.

1. **Patients:** Specialist expertise will be available at an earlier stage of the patient's hospital stay. Multidisciplinary teams will develop around the needs of a particular patient grouping. The concept of 'access for all' will be enhanced.

2. **Business:** It allows for the focus of business around specialities, i.e. Gives clearer responsibility and accountability for managing the speciality, focuses attention on contracting and marketing, allowing heightened awareness, and increases the potential for increased revenue through efficient management of throughput, waiting lists, etc.

3. **The Health Care Professional:** Provides the opportunity for employees to gain expertise within a defined speciality. Allocates teams to workload more equitably. Improves communication networks between disciplines.

(Medical Directorate Briefing Paper 1995)

The aim of the re-engineering programme was to transform patient care, teaching and research activity. As with any form of re-engineering, the importance of senior management commitment is paramount to its success. In a letter addressed to Trust employees, the Chief Executive stated that he would be expecting to devote 30% of his time to the initiative. It is often the case that change programmes are dealt with by a small number of individuals who are still engaged in their normal role within the organisation. In order to secure the level of radical change needed, the Trust has seconded as many as 30 employees at various stages of the programme and resources have been made available to educate and enhance the skills of those seconded. During the observation phase of the research, it was clear that some secondments had caused a certain degree of resentment in the early stages of the process. This was particularly apparent in departments which are below staff quota, where although it has allowed for a certain amount of 'acting up', those
seconded have not been replaced in number. Even so, those seconded expressed a considerable sense of empowerment.

The management re-engineering team believed that many advantages have come from the re-designing of health care using an organisation wide approach within the Trust (Bevan 1997). Firstly, they believed it had led to better solutions, by optimising the potential within the hospital. Secondly, the organisation wide approach had led to more rapid and effective benefits. This was an important issue since the re-engineering efforts had to be shown to be delivering success stories in order to maintain momentum terms and encourage commitment of the Trust staff. Thirdly, it helped to balance the management of a partly re-engineered organisation alongside the 'normal' day to day running of the hospital. Certainly the 'big bang' approach of the early days gave credibility to the re-engineering programme. Results and quality improvements, such as reduced clinic waiting times and enhanced Out Patient services, could easily be seen and appreciated by patients and health care workers alike. This third advantage was openly disputed by some middle managers, who suggested that the time and effort needed in the re-engineering programme was not always worthwhile, when there are more pressing and immediate matters that more adequately reflect their true role and job description. There had been a strong emphasis on communication and Human Resources throughout the programme. This had been deemed highly important by senior management in order to secure commitment to the programme and allay the fears of the Trust staff. A Communication Task Force, involving more than 60 staff, is in place with the objective of ensuring that as much information as possible is distributed hospital-wide. Individual views and concerns were welcomed. A Human Resource Strategy Group has been developed for the purpose of
assessing necessary changes in roles and responsibilities and instigating revised training and development needs in light of these changes.

The early phases of the re-engineering programme, had been highly positive - particularly in the Out Patient services. It had provided an opportunity to examine long standing working practices and evaluate possible change mechanisms. In doing this it had achieved a number of successes and high profile acknowledgement. Due to it being a national pilot there has been an opportunity to enhance the Trust's Public Relations (PR) with its customers - the patients and the purchasers of health services. PR outside the hospital had generally been favourable, with improvements in patient services well publicised in local and national media. There was a sense of political kudos associated with BPR together with a notion of 'doing something to ourselves before being done to'. This reflects the more general sense of seemingly never ending change that has affected the Health Service in recent years. With so much money having been invested in the programme it had to be seen to be successful. This has perhaps in itself caused some resentment amongst employees.

Internally, there seems to have been a detrimental effect on morale and there are a number of factors contributing to this. The streamlining of processes had brought with it some reorganisation of departments, necessitating some health professionals to reapply for their own jobs. Understandably this evoked a certain amount of stress and worry over job security, not only within the departments undergoing the reorganisation, but also in other departments who see it as 'their turn next'. This sense of insecurity led to open criticism of re-engineering. Communication strategy also came under fire. There was a general feeling that communication was limited and that the leadership had not been open enough. A
report compiled by members of the re-engineering team twelve months after the official two year programme, commented that one of the benefits of the re-engineering programme has been that it has acted as a catalyst for change within the Trust and that change is now being seen as a natural phenomenon. Additionally, hidden benefits have included enhanced career opportunities, increased professional skills for some, and improvements in team based working and communication channels (Bevan et al 1997:2). In short, this was a programme that had been a radical attempt at changing a working structure that had evolved historically through national health policy and a fixed professional agenda.

In terms of defining whether the project has been successful, two differing perspectives were outlined in a report published by the re-engineering team in 1997. The first perspective relates to the achievement of tangible improvements in performance, which relates to quality improvement, an increase in productivity, cost reduction or a combination of these. The second perspective relates to the development of a 'change capability' enabling the organization to continue to change and improve. In order to cover both perspectives the outcomes of the programme were described in a framework encompassing three headings:

Outcome Criteria
- achievement of original goals
- cost/benefit analysis
- evaluation of achievements across a range of indicators
- impact on users and key stakeholders

Empirical demonstration
- extent to which re-engineering projects have been implemented
- extent to which organization has moved from functional to patient process based modes of working
- syntheses of the learning into a change methodology which is generalisable to other health care organizations
Process Criteria
- ability to maintain the energy and momentum for change
- ability to create an ongoing capacity for change across the organization
- creation of methods of health care delivery which are unique in a health care context and which offers models of organization to other healthcare bodies

In its report published in 1997, the Trust explained 'whilst the timescales for creating change are longer than originally envisaged and there is variability in the depth and speed of change, analysis demonstrates that the Trust is meeting this broader success definition' (Bevan et al 1997:3). The final two tables of this chapter illustrate this success. Table 8 demonstrate the percentage of projects citing benefits in terms of specific categories. Table 9 demonstrates the overall cost improvements of the programmes.

Table 8: Categories of benefits specified for re-engineering projects

<table>
<thead>
<tr>
<th>Category</th>
<th>% of projects citing benefits in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality improvements</td>
<td>64%</td>
</tr>
<tr>
<td>Capacity increase</td>
<td>30%</td>
</tr>
<tr>
<td>Generalisable benefits</td>
<td>12%</td>
</tr>
<tr>
<td>Cost improvements</td>
<td>8%</td>
</tr>
<tr>
<td>&quot;Hidden&quot; benefits</td>
<td>57%</td>
</tr>
</tbody>
</table>
Having introduced the hospital site and the re-engineering programme this chapter now explores the literature on BPR in order to provide a broader critical perspective on this management phenomenon. In doing so, it gives an understanding of the general theory behind the hospital programme.

**BPR: The limitations of a general management panacea**

The literature on BPR appears to display much confusion as to the terms used to describe the theory. Many different terms are used that relate to the management and improvement of processes, including business process improvement, business process redesign, core process redesign and business restructuring. These concepts cover a range of activities from the continuous improvement of processes to the complete restructuring of organisations. At the centre of BPR are two concepts: organisations must view themselves in terms of processes instead of functions, divisions or products; and organisations must think inductively instead of deductively (Hammer and Champy 1993). All agree that re-
engineering is about an organisation's processes, but some lead on to argue that re-thinking one small process within a business is not fundamental enough and that re-engineering should entail a radical rethink of the whole organisation, not just a part.

Romney (1994) suggests that BPR does not attempt to make marginal improvements, but rather that it ignores how work is done currently and starts from scratch. As a revolutionary process that challenges all the old organisational structures, work flow, management procedures, controls and organisational values and culture, it discards those that make businesses underperform and replaces them with more effective and efficient processes. Hence BPR is seen to be a re-invention of business processes rather than an improvement or enhancement. There is general consensus in the literature that a narrow approach to re-engineering cannot produce the kind of widespread result expected and that many re-engineering efforts can fail because of insufficient process breadth. Process breadth is important for two reasons. First, the more activities that are included in the process, the more likely the improvements will extend through the entire company. And second, if a process includes interrelated activities, a company may be able to identify incremental opportunities that would not surface in single function performance improvement efforts. Having noted this, re-engineering efforts can fail because of a too broad, almost indiscriminate approach. This highlights the need for a preliminary 'diagnostic phase' where key elements can be identified that combine customer value with what defines the organisation's competitive advantage. A 'clean slate' or 'starting from scratch' approach allows organisations to avoid the classic re-engineering pitfall of focusing on fixing the status quo. Starting over, allows organisations to plan and build a new infrastructure which will enable them to realise their new goals (Patching 1994).
Proponents of BPR herald the initiative as the organizational change paradigm of the future. Yet, despite this, BPR's unpopularity amongst academic commentators cannot be understated. Much is made of its ambiguities and the tensions and contradictions these create. Attempts to define BPR lead to a debate on its acceptability as a new approach when it overlaps with a number of earlier management theories and more recent employee involvement initiatives (Marchington et al 1992, Hill and Wilkinson 1995, Wilkinson et al 1997, Wilkinson 1998, McCabe and Wilkinson 1998). Several writers link re-engineering to the traditional management thinking of Taylorism (Grey and Mitev 1995, Conti and Warner 1994, Tinnaker 1995). The name itself can be associated with Tayloristic notions of the work study engineer and with technical expertise and scientific rationality. Even so, Grey and Mitev (1995) argue that BPR represents the unwinding of traditional modes of organisation based on bureaucratic structures and Taylorized work systems. Unlike Taylorism which places emphasis on the division of labour and divides processes into tasks, BPR reintegrates tasks into processes using present day Information Technology. This re-division of labour reduces the number of steps in performing a given task and implies not only a flatter hierarchy but also a 'delayering' of the workforce. However, the move away from task fragmentation toward process simplification using IT, implies a technocentric approach (as does Taylorism) to working practice. And this gives rise to the suggestion that the theory underpinning BPR is within the same engineering traditions of management thinking such as Taylorism.

In contrast, Mumford and Beekman (1994, 1995) claim Socio-Technical Design (STD) as an early form of BPR. Even so, they acknowledge the humanistic, more prescriptive approach of STD, in contrast to the technology dependent perspective of BPR (Mitev 1996). At the same time, BPR's perspective of strong leadership and a committed
workforce, together with its emphasis on employee involvement techniques such as empowerment, echoes themes within the popular Total Quality Management (TQM) initiatives of the late 1980s (Johansson et al 1993, Conti and Warner 1994, Morgan 1995, Wilkinson 1998, Wilkinson et al 1997). Harrison and Pratt (1992), and Davenport (1993a) state that together, TQM and BPR could form an integrated management system within an organisation. It is true, that certain aspects of the management of processes are considered vital to both TQM and re-engineering. These include benchmarking, cultural change and performance measurement (Zairi and Sinclair 1995). In common with TQM, BPR draws heavily on notions of empowerment, and ideas of shared values and strong cultures are prevalent in the literature. All in all, these suggested links between BPR and other management initiatives of recent times, both at a theoretical level and practical level within an organisation, raise the question of whether BPR is just another management fad.

In a discussion on four various streams of management literature, Francis and Southern (1995), question the legitimacy of rendering BPR 'just another management fad', and trace back the management initiatives since the early eighties. These include the 'aspirational' descriptive work of Peters (1988) and Peters and Waterman (1992), the quality literature associated with Japan, the management of strategic change literature best exemplified by Kanter and the most recent developments in the idea of the 'learning organisation'. All are seen as part of a cumulative process in the development of knowledge about organisational management and its change, of which BPR is one more contribution. BPR is seen by Francis and Southern (1995) to 'embrace' other management initiatives gone before it, with the added bonus of going part way in offering a methodology for producing radical change.
That BPR can be linked to so many past management philosophies not only fuels suspicion of its claims to novelty, but also lends credence to the view that that the BPR phenomenon is full of contradictions. It could be argued that such links are partly justified through the common intent of supplying the needs of the customer. Alternatively, these common themes may indicate that BPR is just another instance of management cultural change rhetoric thought up by gurus and management consultants, and this is one argument considered below. On the relationship between managers and management gurus, Jackson (1996: 587) concludes that ‘...managers tend to be ambivalent in their attitudes toward management gurus, yet substantial book sales and far reaching organisational change efforts suggest otherwise’. That management gurus and consultants have reaped the benefits of the re-engineering phenomenon is never in doubt. In exposing what he calls the ‘secular motives’ at work in the BPR literature, Case (1999:13) writes that protagonists and consultancy groups are ‘suspended between two worlds one of the acknowledged hype, the other of material practicality and suggests that they are ‘hostages to a contemporary epoch that would have them commodifying their every last thought’. Many management gurus and consultancy firms selling the re-engineering concept acknowledge that re-engineering ‘...has always been an important part of their product line’ (Thakray 1993:41).

Another debate concerns whether BPR should be labelled a ‘soft’ HRM initiative or a ‘hard’ technique like Statistical Process Control. For Morgan (1995:187) BPR is ‘a structuralist theory that seeks to change processes ... a ‘hard’ philosophy with its roots in scientific management’. Wilkinson et al’s (1992) work on TQM defines a ‘soft’ approach as an open management style, delegated responsibility and increased employee involvement and autonomy, together with senior management commitment. This emphasis
on ‘hard versus soft’ echoes the debate surrounding HRM. Whilst the ‘harder’ side of HRM (Storey 1987), including workforce reductions and restructuring, is visible in many organisations, the ‘softer’ issues of commitment and valuing employees can be more ambiguous. In questioning the relationship between HRM rhetoric and reality, Legge (1995: 127) writes ‘it is difficult to know where rhetoric ends and the extent to which compliance with the normative ‘soft’ version HRM model is really sought’. With its radical and ruthless approach to work redesign, the same could be said of BPR. A major reason for BPR’s apparent unpopularity centres around its alleged lack of human dimension (Willmott 1994, 1995, Grey and Mitev 1995). Indeed, Grey and Mitev (1995:11) describe BPR as ‘distinctive in the scale of human misery it promises to produce’. The overwhelming message found in most of the critical literature is that whatever short term benefit may arise from re-engineering, is at the expense of long term damage to human resources. Indeed, the sheer ruthless efficiency of BPR may be the source of this opprobrium. From this perspective, BPR does threaten existing roles and jobs in the workforce, precisely because it is not a cultural hot air phenomenon. In short, BPR does make a difference.

Academic literature is swamped with calls for a more holistic, sensitive and people focused approach, and even Davenport, one of the architects of BPR, now openly admits that the effects of re-engineering programmes on employees has been overlooked (Mumford and Hendricks 1996:25). Downsizing of the workforce has been one of the major effects of BPR programmes. Introducing such initiatives that are aimed at gaining worker commitment in such an atmosphere surely leads to cynicism of the ‘survivors’. Of this organisational paradox, Foy (1994:79) writes ‘at the same time as they are downsizing...they are also trying to achieve the open, trusting, flexible, communicating,
empowering, people orientated culture that we all say is necessary for their future survival’. Rather than being given freedom or choice, the loss of substantial numbers of workers forces survivors to take on extra roles and tasks. Thus, the labour process view is that this form of work intensification is directing compliance rather than commitment to new working arrangements. This is further confounded by what McCardle et al (1995:166) describes as workers being committed to their own exploitation through ‘their willingness to resist increased intensification of work which is displaced by a solidarity with the interests of management’.

The Three ‘C’s - A Perspective on BPR

In practice, most companies aim for the ‘patchwork quilt’ approach. Instead of re-engineering the whole company in one plan, individual processes are identified for improvement. Over time the separate pieces of the quilt are joined to create a wholly re-engineered organisation (Bartram 1994). Stern (1994) argues that re-engineering is required to establish the leanest and most responsive business processes, suggesting that the recession has encouraged this thinking pattern, with fashionable phrases such as ‘rightsizing’ and ‘downsizing’ being euphemisms for talking about redundancies. In Hammer and Champy’s rendering of BPR, the cornerstone of both the rationale for BPR and the re-engineering task itself is the question ‘why do we do what we do at all’. This rationale takes the form of the ‘three C’s - Customers, Competition and Change.

In their view, the aspirations of to-day’s customer continue to rise. Customers are becoming more demanding in their expectations of product, service and price. A fundamental precept of re-engineering is to focus all redesign activity on the needs of the customer. Patching (1995) comments that this not only helps to distinguish between core
business processes and those that are concerned with non-productive support functions, but can also result in a clarification of business aims and performance standards leading to more effective processes. Despite the BPR assumption that organisations should be arranged to satisfy the customer's needs, this logic does not necessarily follow through. Organisations in the private sector also seek profitability rather than simply 'what the customer wants'. Public sector organisations are often operating under governmental financial restraints. Although they may primarily have the interests of the customer at heart, especially in these days of Citizen and Patient Charters, limited resources must play a significant role in the re-engineering of either a department or organisation. Furthermore, the concept of the 'customer' can be problematic for the public services. Can the 'patient', 'client' or 'student' be classed in the same bracket as retail customers. The importance of consulting the customer is now widely accepted within the Health Service. Patient satisfaction questionnaires and suggestion boxes are abundant, and there is a move toward the concept of consumerism. Consumer health care groups, with their own support mechanisms, a supportive media, and their own brand of 'professional autonomy', can now be accessed at local and national level (Williamson 1995). However, standards and values of professionals and consumers are often at odds with each other whatever the service. These difficulties must surely stem from different perspectives resulting from differences in background, interests, power and position?

If organisations are to meet the demands of today's customer, they need to develop new patterns of working practice that encourage innovation and flexibility. Competitive restructuring, together with quality improvement and new concepts of service and quality provision, are part and parcel of an organisation's strategy for meeting customer needs (Hendry et al 1987). This value placed on the customer in current programmes of
organisational change also serves to create relationships within the organisation which would normally only occur on the interface of the organisation with it's customer. In other words the customer-supplier relationship can now be found between one department and another (Du Gay and Salaman 1992). If one key rationale behind BPR is indeed customer focus, it could be again argued that BPR is intrinsically linked with Quality Management theory, such as TQM.

The idea underpinning the rationale of competition in BPR is one of market forces, that is, good drives out bad. Because of competition companies must continually improve or disappear - a notion of survival of the fitness. It could be argued that it is the advocacy of competitive theory, such as BPR, which constitutes the competition which then, in turn, creates the problem that companies must address (Grey and Mitev 1995). To substantiate this criticism, in their book, Hammer and Champy (1993), recommend BPR not just to companies in difficulty but also as a chance to strike against competitor companies who have not re-engineered. Following the 1989 white paper Working for Patients, the notion of competition was introduced into health care through the 'quasi market'. Trust hospitals were encouraged to be more value and cost conscious in order to secure contracts for surgical procedures and out patient services from the health authorities and fund holding general practices. With already limited financial resources Trusts became more innovative in their approach to the delivery of health care. By the mid 1990s concepts such as TQM, BPR and its health equivalent PFC (patient focused care) were beginning to be introduced into the health arena.
Because of both customers and competition, change is seen to be faster and more challenging than ever. In today’s society the idea of change is fast becoming a ‘normal’ phenomenon within the culture of the organisation. BPR advocates that organisations should regard normality in this way. Change programmes are disruptive, which requires an increase in the capacity of an organisation to accept disruption (Peters 1988). Change programmes also require commitment at a time when the disruption is most acute. Organisational disruption and employee commitment can be difficult to balance. There are two key elements of successful management of change in a BPR programme. Firstly, there is senior management commitment. Secondly, there must be timely communication of why change is necessary, the vision of what is being attempted, and the rationale behind the proposed change and the implementation process itself. The more fundamental the change, the more important it is to manage the change well. Fundamental reappraisal of why an organisation does things demands major changes in the organisation’s culture, and in the expectations, attitudes and commitment of staff. Again, what is interesting to note here is the link between successful key elements in a BPR programme with the key themes of most management initiatives since the late eighties.

The three C’s have helped to create a new image of the business world, yet organisations designed to operate and succeed in one environment will not work well in another. Hammer has suggested that organisations designed to cope with mass production, stability and growth (is this not the public sector?), can’t expect to succeed in a world where customers, competition and change demand flexibility and quick response. Public services have, and are continuing to, undergo government induced rapid change mechanisms, the aim of which is to achieve customer focused organisations that are run at an acceptable cost. If this is the case, then BPR might be considered a viable proposition. However, it
still begs the question of how easily the BPR change model can be translated into a public sector, health care setting.

**BPR and the role of Information Technology**

In BPR, emphasis is placed upon the potential of Information Technology in enabling a transformation in the design of working practices. It is identified as a means of radically ‘re-engineering’ organisations in order to achieve optimum response to market forces whilst reducing labour costs. Despite the prominence of Information Technology in business re-engineering it has a role that can sometimes be misconstrued. For organisations embarking on a re-engineering programme the difference between re-engineering and automation needs to be made clear. The use of computer software as a means of solving a business problem is not seen as a solution in a re-engineering situation. Applying Information Technology to business re-engineering requires inductive thinking, the ability to first recognise a solution and then find the problem it might help to solve. This is seen as a complete reversal of the deductive manner in which organisations usually apply themselves where problems are first defined and evaluated before finding an answer. To assume that Information Technology is the only essential element of a re-engineering programme would be wrong, since strong leadership together with an empowered and committed workforce are also crucial in the quest for a successful re-engineering programme. These issues will be examined next.

**Commitment and Empowerment in BPR theory**

Ensuring employee commitment can prove problematic for any organisation embroiled in a programme that is destined to bring about change in work circumstance. Change often
provokes feelings of uncertainty - a fear of the unknown. Despite this, exponents of BPR cite employee commitment as one of the major factors in the implementation of a successful programme. It is argued by Grey and Mitev (1995) that downsizing, and the inevitable consequence of work intensification for those who are left, is detrimental to the cause of gaining employee commitment, leaving only mute compliance for fear of job security and unemployment. Indeed, Hammer himself advocates that fear should be used as a powerful, persuasive emotion with which to encourage commitment (Hammer and Stanton 1995:52) Whilst acknowledging that fear exists through uncertainty of how change will affect the individual or the department within which they work, this theses will question the general assumption that re-engineered employees commit themselves through fear of job security.

Empowerment, like BPR is a concept difficult to define. Work carried out by Denham et al 1997 and Denham 1998, demonstrates that the ambiguity of the concept allows for different interpretations between those doing the empowering and those being empowered. Whilst managers expect empowerment to fulfil their ideals of an involved and committed workforce, employees expect empowerment will promote autonomy, feelings of self worth and equity. But is this mere rhetoric? What differentiates empowerment from earlier ‘quality’ initiatives is the proposed importance of the management intention behind the initiative. Some writers feel that rather than offering beneficial effects, empowerment is more about management’s attempt to direct further control and exploit the workers (McArdle et al 1995, Sewell and Wilkinson 1992). That management consciously uses empowerment to subvert the workforce and exploit the ideas of employees, leads to the argument that the inevitable consequence of this is an increase in workload with no accompanying discretion or authority. Indeed, in a study of empowerment policies in the
In most cases, empowered employees are given the responsibility of performing more operational tasks than ever before, while the standardised computerised procedures restrict to a great extent the amount of discretion that could be exercised. What comes across in the empowerment literature then, is that, rather than viewing empowerment as 'organisational utopia', it serves only as a policy aimed at gaining the compliance and commitment of employees. Empowerment may result in a greater degree of individualisation amongst workers leading to increased anxiety and stress, or may heighten self esteem gaining commitment.

Hammer (1990) argues that employee empowerment is pivotal to the success of re-engineered organisations. Although empowerment is linked with securing commitment as important contributory factors in successful organisational performance (Cunningham et al 1996), many academic commentators take a more negative stance on BPR's claims. Willmott (1994:42) argues that the type of empowerment that BPR advocates is 'equated with the integration of tasks made possible by the development of expert systems...rather than the expansion of discretion or even an increase in task variety'. The notion that the meaning of empowerment in BPR is 'banal' (Grey and Mitev 1995:14), is backed by the argument that the empowerment is bestowed rather than acquired, and therefore can be seen as a form of control, with an emphasis on top-down leadership. Willmott (1995) also suggests that employees are expected to accept the increased responsibility that BPR brings, regardless of whether it is perceived as either delegation or dumping. Characteristics of the empowered organisation include multiskilling, job variety and responsibility – all of which play an important part in the overall perspective of BPR. Yet, Panteli (1995:5) suggests that organisational change programmes such as BPR focus on the need of the customer, at the expense of work simplification, intensification and
standardisation. In this view the introduction of new technology and work processes in empowered organisations serves to regulate and control employees behaviour. Although BPR is seen to encourage responsibility and multiskilling the fact that it has failed to develop an anthropocentric form of work organisation, gives rise to the question of whether BPR is essentially driven by short term cost cutting rather than long term human resource development.

The literature on organisational commitment is enormous but it is worth noting the links between empowerment and organisational commitment. Matthieu and Zajac (1990) found autonomy to be positively associated with organisational commitment, which Iverson (1996) suggests has a positive impact on the attitudes to change. Iverson, Deery And Erwin (1994), suggest job stress is composed of three basic factors – role ambiguity or lack of role clarity, role conflict or inconsistent demands of the role and role overload – and support the theory that all have a negative impact on organisational commitment. Aranya and Ferris (1994), suggests that the professionals can be committed to both their profession and their organisation. Research continues to stress the importance of employee well being in order to be fully committed to organisational change (Beer et al 1984, Cordery et al 1993, Iverson 1996). These dimensions of empowerment and commitment are explored, alongside changing professional roles and identities in chapters 6 and 7.

The NHS Context

So far, BPR, as a general change programme, has been both a success and a failure. Hammer, in the early days of this phenomenon, gave a guesstimate failure rate of between 50 and 70 %. A study carried out by Hall, Rosenthal and Wade (1993) identified two factors – breadth and depth - that are critical in translating short-term, narrow focus
process improvements into long-term profit. Firstly, the process to be re-engineered must be broadly defined in terms of either cost or customer value in order to improve performance across the company. Secondly, re-engineering must penetrate to the company’s core, fundamentally changing six deep and crucial organisational elements - roles and responsibilities, measurements and incentives, organisational structure, information technology, shared values and skills. So how does BPR translate into a public sector, health care setting?

Storey (1989) argues that the translation of private sector change initiatives into the public sector is limited by the continued bureaucracy found in large organisations. And, Kinston (1994) states that the ‘values of the existing public culture can degenerate into a bureaucratic nightmare’ if not mastered correctly. In later work, Storey (1992) argues that the ‘mere weight’ of the values of the public sector leads to new initiatives being pushed to the fringes. So far in this chapter, it has been shown how the general term BPR belies a great variety of highly specific management change programmes on the ground. This thesis is a case study of BPR in practice, within a health care setting. The programme in the case study is a substantive and specific management initiative that has had a dynamic impact on the workforce involved. This in itself challenges some of the generalised cries of ‘cultural hot air’ that arise from some management theorists. The rest of this chapter places BPR in the context of the NHS.

As the largest public sector organisation in our country, the NHS has undergone several major upheavals in its relatively short history. And as the country’s largest employer, the reorganisations and changes have done much to shape the nature of the professions working within it. Chapter 1 examined the impact of politically imposed health service
reform at national level on the key professional groups investigated in this study. The Griffiths Report (1983) saw a shift in emphasis from a consensus based multiprofessional management style to one of general management based on the principles of the private sector. The introduction of the internal market in 1991, following the government White paper *Working for Patients* (1989), further enhanced the focus on improved performance, efficiency and consumerism which ensured increased responsibility and accountability of the health professional, whilst strengthening managerial control over the delivery of care. Although not directly eroding professional autonomy, the reforms created a need to define professionalism and professional autonomy within the health service (Dent and Burtney 1996). The health service is unique in the number of professions working within it, each with their own professional bodies and membership, which determine the rules of conduct and standards to which the health professional must adhere. There is an undercurrent of change in the issue of overlapping of responsibilities and designing of procedures, not confined to those undergoing re-engineering programmes. Prospects of more flexible workforce in terms of multiskilled or generic health care workers is under scrutiny by many of the professional bodies, not least because of its effects on the professions in terms of responsibility, accountability and autonomy. Although a sense of collective responsibility is rarely in doubt in terms of patient care, this does pose a problem for the health professional in terms of commitment to the organisation in which they work and the profession to which they belong. In addition, the hierarchical nature of health care and the pluralistic and functionally fragmented way in which health care is delivered, creates a politically motivated atmosphere which can compromise any change management initiative. This chapter so far has suggested that change programmes such as BPR which advocate a clean slate approach to changes in work design sit uncomfortably with the pluralistic nature of health care delivery. Buchanan (1997:51) argues that with its 'lack of
precision surrounding focus and methodology', this is particularly pertinent in the case of BPR.

Chapter 2 outlines the links between role and scope of practice and a profession's occupational identity within the work setting. Occupational roles can be defined as self categorised and scripted behaviours which enable us to act in a consistent manner. In health care these roles are determined by the scope and type of practice that we perform and through our identification with a specific professional grouping. An example of this is found in the Rules of Professional Conduct of the Chartered Society of Physiotherapy. In defining scope of practice the rules state 'Chartered Physiotherapists shall only practice to the extent that they have established and maintained their ability to work safely and competently' (CSP 2000). The professionalisation processes of these groups has afforded them the opportunity to create a significant source of norms and values with which they can exert considerable influence in the work setting. In tracing the evolution of the health professions Chapter 3 illustrates how role and occupational identity has traditionally been jealously guarded by each of the professional associations. This role demarcation has led to a fragmentation of the workforce within health care which has created a number of problems for the delivery of service. This fragmentation takes two forms in that there is a wide range of occupations and separate specialisms within the occupations. At local level, Trusts and other agents of health care have to plan and manage a huge number of occupations, while inflexibility and a lack of clarity in accountability has led to delay and confusion for patients. In addition inflexibility has also prevented the workforce from responding to troughs and peaks in workload nationally. There has been little means by which the various streams can work together from a wider perspective in health care planning. However, there is a significant amount of role and skill overlap between the
professions. There is much talk of harnessing some of these skills in order to make a more adaptable and flexible workforce for the new millennium (see White Paper Working for Patients 1989, White Paper Modern, Dependable 1997, The Future Healthcare Workforce report 1996). Change programmes such as BPR and its other health guise, Patient Focused Care, with their emphasis on multiskilling and empowerment seem suitable mechanisms for achieving these goals. Indeed, until initiatives such as these had arrived, generic working has arisen predominantly through change in role of unskilled staff. More recently, Lloyd and Seifert (1995) note that prospects for the management of health labour focuses on widespread changes in skill mix. The reduction of costs by having a smaller percentage of skilled workforce supported by a larger number of multiskilled support workers, as described in the case studies by Lloyd and Seifert, is already apparent in the health service of today. It is expected and hoped that this will continue. In this respect BPR appears to meet some very specific needs of current NHS change.

Skill Mix is defined as ‘identifying the range of tasks and responsibilities involved in providing care within a particular speciality, what levels are involved, and therefore who is appropriate to carry them out’ (Bevan 1991). Placing more of an emphasis on team working, the term implies a process of review, leading to changes in roles and responsibilities. The problem in identifying ranges of tasks is that overlap does exist, and this is particularly so between the smaller professions allied to medicine. At the lower end of the skill spectrum the tasks are easier to analyse and less contentious to delegate. These might include who supplies crutches, simple wound care, washing and dressing practice. Calls for a more patient centred approach to skill mix overcomes the stereotyping associated with ‘who does what’ within health care. It can also be argued that in turn it allows for more flexibility within multidisciplinary teams. The report The Future
Healthcare Workforce (1996:79-80) recommends a ‘generic carer’ be responsible for the majority of care, with roles being designed around specific workload requirements. This, of course, calls for not only a huge shift in the training of the professions but also a loss of the core identity that the professional associations have striven for since their own inception. Latterly, there has been a move toward both clinical and shared governance, that is, devolving authority to grass roots professional employees. As with the issues surrounding skill mix, work done so far has centred primarily on the nursing profession. Much is being written about the benefits to those involved, in the form of empowerment, increases in job satisfaction and motivation (Geoghegan 1995, Geoghegan and Farrington et al 1995). In a recent professional physiotherapy article Hunter (1999) argues for generic therapists to cover core skills and more advanced clinical specialists who would have more specialists roles within health care. Whilst on the surface this may seem a massive step forward for the professions, the government funded Exploring New Roles in Practice (ENRiP) study (1999) highlights some significant problems with this approach. It warns that further expansion of physiotherapy and nursing roles is likely to heighten professional tribalism rather than break down barriers between staff groups. When examining new roles, the researchers found that practitioners had ad hoc training and preparation, and complex lines of accountability. And although they enjoyed their new roles, they were experiencing particular difficulties in being accepted by other health care professionals. The study concludes that these tensions are a particular problem in restructuring the health service. These findings are corroborated in a report carried out by Southampton University on behalf of the Department of Health. The report concludes that a ‘them and us’ culture of rivalry still exists with ‘turf protection and trench attitudes hampering moves towards flexible working practices’ (Meikle 2001).
In their review of published material between the years of 1991 and 1993, Tinnaiker et al (1995) cited only two of 248 academic articles on this theme. Similar findings were suggested by Burke and Peppard (1995), who put forward an agenda for academic research in BPR. One specific area was that of the effects of re-engineering programmes on the workforce. There was little doubt that something as radical as BPR was going to have a far reaching and significant impact on the workers in this Trust hospital. This impact was not confined to the issue of downsizing. In giving an overall perspective this chapter has highlighted the debate surrounding the human values associated with BPR - increased responsibility, empowerment, multiskilling and job variety. In light of recent political changes and prospects for changes in the makeup of the health workforce in the future, this study sets out to answer some of the debates surrounding the impact of change programmes such as Business Process Re-engineering on the role and scope of professional practice and effects on professional/occupational identities.

To conclude, BPR is a popular, if controversial general management change programme. The case study hospital has applied BPR to a very specific health care setting. In their own assessment BPR has brought major benefits for customer services. The empirical core of this thesis considers the implication of BPR for professional roles and occupational identities in a health care setting. Before considering the effects of these changes in working practice on professional employees themselves, the following chapter explains the methodology used.
CHAPTER 5

METHODOLOGY

‘He possess two out of three qualities necessary for the ideal detective. He has the power of observation and that of deduction. He is only wanting in knowledge and that may come in time.’
(Sherlock Holmes, The Sign of Four)

Introduction

The author this thesis worked both as a clinical physiotherapist and physiotherapy manager in the health service, and, for a period of time, worked at the Trust hospital used as case study in this research. Although now in academia, the author retains membership of the Chartered Society of Physiotherapy. This personal and professional immersion in the culture of the NHS influenced the research for this thesis. As a member of one of the smaller health professions, the debates surrounding the role and identity of the physiotherapy profession had always been of interest – both as a clinician working in a multidisciplinary environment and later as manager of physiotherapy services. This professional background gave insight and in depth experiences of health professions working within an ever changing working environment. The dichotomies and dilemmas faced by professions during periods of organisational change can be seen both as a potential threat and opportunity. On the one hand, change threatened the comfortable status quo; on the other it afforded the opportunity for some at least to improve their service, and their status. This research evolved through a personal interest in the effects of local change on professional role and scope of practice and on professional autonomy and identity. Through the use of 39 interviews and four focus groups the research data focuses on professional attitudes to three inter-related themes: attitudes to the change process, attitudes to changes in workload delegation and responsibility and the issue of
multiskilling. In using these three themes it was not the objective to glean insight into individual orientation to change in general terms. Rather, the themes were used to gain insight into a context specific change process and on how this process affected existing working practice and professional/occupational roles.

There is a long standing debate over the relative value of quantitative and qualitative research. Whilst the quantitative approach allows coverage of a wide sample and can be relatively fast and economical, it is criticised for being inflexible, artificial and unable to account of the social meanings by which people act out their lives. Qualitative research, on the other hand, allows people to be studied in a given situation over a period of time. It also tends to be exploratory in nature. In this study for instance, we need to explore how different professionals perceive the changes that have taken place in their role and scope of practice and how this affects their professional/occupational identities. Thus, this type of research allows for 'the different constructions and meanings that people place upon their experience' (Easterby Smith et al 1991:71). This chapter explains the methodologies used in this research. Using a phenomenological approach, the study has attempted to facilitate an understanding of how, why and what has happened to particular groups of professionals during a change process. This approach, also referred to as 'interpretivist' (Cassell and Symon 1994) is committed to observing and understanding social phenomena from the person's own perspective. The important reality is what people perceive it to be. This is in direct contrast with the traditional scientific, positivist viewpoint that research is about discovering an external, an objective reality. Thus, adopting a natural science model of research the positivist searches for answers through methods that produce data amenable to statistical analysis.
The methodology used in this thesis is qualitative and as such is based on the interpretative notion that 'social life emerges from the shared creativity of the individual' (Cassell and Symon 1994:4). Many different qualitative methods afford the researcher the opportunity to gain insight into people and organisations. Van Maanen (1983:9) is quoted in Easterby Smith et al (1991) as defining qualitative methods as 'an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world'. From this definition certain points emerge. Whereas a positivist perspective views subjective research as tainted, subjective meaning is at the heart of qualitative research (Bryman 1998, Cassell and Symon 1994, Burrell and Morgan 1979), from the identification of the research of the question through to the process of analysis and dissemination. Furthermore, this emphasis on subjectivity leads to relationships between the researcher and respondent. This relationship is based on participation, co-operation and recognition, emphasising the human-ness of the research process (Hagan 1986:352). In this context, the author's prior immersion in an organisational culture becomes an asset not a liability.

Secondly, there is the issue of the process of what Weick (1995:4) terms 'sense-making' and how individuals 'construct what they construct, why and with what effect'. This process, based on reflection and grounded in the social construction of identity, Weick argues, does not aim to reveal the nature of objective 'truth', but provide insights into the conceptual frameworks that people construct in order to 'comprehend, understand, explain, attribute, extrapolate and predict'. Thirdly, whereas the positivist stance is to see truth as single and unseamed, qualitative research sees social life and its context, agency and structure as inextricably linked (Giorgio 1970). This holistic approach is central to
qualitative research. This research was not just about peoples' perceptions but also concerned actual changes in work organisation. To this end, there is an element of collecting factual information within the research too.

Therefore, a qualitative approach was used for this study for a number of reasons. The ideas underpinning the research were not driven by a specific, clear cut hypotheses. It arose as a result of a number of discussions with health service colleagues. Whilst listening and joining into the lament and dismay about having to participate in a change programme that threatened the role and identity of the health professional, a number of emergent themes of interest had become apparent to the author. The research was exploratory in nature, as themes continued to emerge through its early stages. In essence, what was needed was an approach that accommodated movement and change, thus allowing flexibility. As Cassell and Symon (1994:7) state, '... the responsiveness to the individual's...conceptualisations of themselves is also related to a willingness to formulate new hypotheses and alter the old ones as the research progresses, in the light of emerging insights'. Hammersley and Atkinson's (1983:206) notion of progressive focusing succinctly highlights this: 'ethnographic research should have a characteristic 'funnel' structure, being progressively focused over its course. Over time the research problem needs to be developed or transformed, and eventually its scope is clarified and delimited, and its internal structure explored. In this sense, it is frequently well into the process of inquiry that one discovers what the research is really about; and not uncommonly it turns out to be about something rather different'.
The Research Process in this Thesis

Bell and Newby (1977:9-10) argue for a more pluralistic approach to data collection in sociological research, commenting that there ‘can be no longer one style of social research with one method that is to be the method. Rather there are many....We also suspect that here are no clear ways of choosing between them’. Their argument that no one style of method should necessarily be adopted holds true in this particular piece of research. As a case study of one organisation undergoing a change programme, this study is about balancing depth and breadth, and so in order to achieve this a number of research methods were used. An advantage of using a multi method approach is that it enables some ‘triangulation’ to take effect between methods and viewpoints, which allows a greater degree of confidence in the findings (Saunders, Lewis and Thornhill 1977). Each method used has its own unique strengths and weaknesses yet all have contributed to the richness of the data.

Weber claims that it is misleading to imagine that people can be studied using purely scientific measurement since humans attach meaning and significance to what they do (Giddens 1993 :710). This research was all about the health professional’s opinion, attitudes, and acceptance of a particular local change process, both from an individual and professional perspective. It began with ideas and issues drawn over time from my own experiences of working in the health service. New innovative approaches to work design, initiated by managers in line with national political policies had far reaching consequences for the professional working within that change process. Having experienced this at first hand, both as a clinician and as a manager, the potential limitations and advantages were very apparent. On reading the secondary literature on NHS change and Business Process Re-engineering, questions and themes began to emerge that were pertinent to the issues
that were to be addressed in this research. Informal, exploratory interviews, six in total, were carried out with managers from around the hospital site. These managers included those who were directly involved with the re-engineering programme and departmental managers who were members of the professions. These informal interviews were particularly valuable for two reasons. Firstly, they helped to establish some provisional research questions that were to be used in the research interviews. Secondly, this one to one contact, provided internal documents, specific to the re-engineering programme, that on reading provided valuable backdrop and insight into how the programme was being fostered and implemented (see previous chapter). Next, a relatively structured interview schedule (see appendix) was designed. The need to gain access and be economical with professionals time militated against a very loose, unstructured approach to the interviews. In addition, the structured interview allowed for consistency in the one to one interviews, but also afforded the interviewee and interviewer scope for digression, expansion and their own viewpoints and feelings. Thus, a qualitative approach heightened the responsiveness to the changing nature of the research. In addition to using information from hospital documentation, views were sought from the national professional associations on issues such as multiskilling, accreditation of skills and extended scope of practice. This gave insight into the official viewpoint and stance of the professions at national level (see chapter 6). Following this, focus groups with individual professionals were carried out in the hospital order to ascertain and explore further the local professional perceptions on how they adapted to and regarded the change happening around them.

Finally, in following a current organisational change process, the fieldwork took more than eighteen months to complete and the thesis over four years. Given the pace of NHS change, this proved a substantial period. A strength of longitudinal research is the
capacity it has to study change and development over time. And so it was with this research. The change initiative had been a two year pilot site. Although this research did not start at the outset of this two year period it did incorporate three different stages of the two year pilot.

Why a Case Study?

Single case studies have a mixed reception in the literature. Buchanan (1998:7) notes that much organisational research that focuses on change is evaluated through the single case study approach. Criticisms of this approach centre on the generalisability of such research findings. Whilst it is true that what is found in one organisation can not necessarily be representative of another, Buchanan argues that the case study choice is not based on 'representativeness, but as an opportunity or potential for learning'. This is pertinent to this particular case study for two reasons. Firstly, as a national pilot site for whole hospital re-engineering it was likely to (and in fact did) generate a tremendous amount of interest. Secondly, as a national pilot site it created a huge potential for learning. Indeed, the Trust held a number of national and international seminars on their experiences. Although this site was a 'first' at whole hospital re-engineering, smaller restructuring processes are happening around the country under the auspices of 'patient focused care' (a health orientated pseudonym for Business Process Re-engineering). Furthermore, health is universal and the NHS is a nationwide organisation. The nature of the case study and the workers being researched, afforded the opportunity for results of this research to be considered reproducible. Thus, this research is prototypical in that as an exemplar of the way NHS change is likely to be directed in the future. As such it is likely to be of especial learning value.
Bryman (1989:173) states that case studies are a useful means of providing an understanding of areas of organisational life that are not well documented. As a pilot site for whole hospital re-engineering this notion too fits well with this particular case study. In order to gain an understanding of the context of the research and the social processes being enacted, it was appropriate to conduct a case study of an organisation that was undergoing a radical change process that had hitherto never been attempted in health care on such a large scale. Sensitivity to context is the big strength of case study research. This research is about the specific organisational context of professions working with NHS change at local level. The case study approach has the ability to generate answers to the questions ‘why’ as well as ‘what and how’, which tend to be the questions addressed more in quantitative research. In the introduction to his book *In search of management* (1994:6-7), Watson argues that getting close to managers in one organisation can be a means by which generalisations can be made about specific processes rather than about ‘all managers and all organisations’. This has been so in this particular research. The case study about one organisation has clarified distinctive features of one highly particular change process. Yin (1984) makes the point that the case study should be evaluated in terms of the adequacy of the theoretical inferences that are generated. Although this is a single case study it involves professional groupings that work in hundreds of sites across the country, and who by the nature of their professional background carry out similar tasks within their own working structure. This case study will enable patterns and linkages to be inferred across the field of health service research about professional roles and identities.

**Negotiating Access**

Having been employed by this particular hospital previously, access was simple to arrange and organise. Knowing personnel from within the organisation and having a number of
named contacts helped the researcher gain access with ease. Knowing managers within the organisation facilitated access not only to staff willing to be interviewed, but also to documentary evidence about the programme. Little more was needed other than an appointment with the head of the re-engineering team who directed the author to key personnel within the organisation who it was felt would be willing to participate. Buchanan et al (1998:58) suggest that 'when negotiating access it is helpful to offer a tangible product in return for co-operation'. This was offered by the researcher in the form of a feedback session on the outcomes of the research, to staff who had been willing to be involved.

**Documentary Data Collection**

In stressing the actual research process adopted in this thesis earlier in the chapter, the value and importance of documentary evidence was highlighted. The strength of this method as a research resource is that documentation obtained from both the hospital and the professional associations gave an institutional view from above. Interviews and focus groups countered this with a view from below. Information provided in the documentation from the hospital gave insight into how the re-engineering programme was being implemented by management. The historical perspective outlined in Chapter Two emphasised how and why health professional roles evolved and provided a platform for interpretation of why health professionals feel the way they do about their particular role, occupational identity and professional standing. Without the views upheld by the professional governing bodies, evidence gathered through individual interview and focus group could not effectively be interpreted. Hospital management and external professional organisations are essential contextual elements of this case study.
Collecting documentary material is, on the whole, largely unobtrusive. Visits to professional libraries, and letters to particular associations proved a good source for material that supplemented other information, gathered through visiting clinical department and specialities within the hospital. Organisational documents obtained came in a number of guises, including working documents, policy statements and PR style press releases. The documentation gathered provided a rich source of data, giving insight into the stance taken by the associations and unions on the issue of healthcare re-engineering, and in particular on the effects of issues such as multiskilling. They helped to add strength to the data being collected through other methods and means. It could be said that the information collected was biased. Again, this was a positive feature for this thesis since the research is about opinions and views of professionals working with change. As mentioned there were significant advantages in collecting documentary evidence from both the case study site and the professional associations. For example, using data from the case study organisation provided an 'official' unobtrusive account and measure of what was actually happening. There was an enormous amount of top down communication from the re-engineering team in all stages of the process. Notice boards were awash with re-engineering information. Circulars passed around in all areas of the organisation – both in the form of discussion comments and in the way of general communication about the programme and its progress. Open meetings were held by the re-engineering team, where information was freely given. Individual departments held information folders in staff rooms containing all distributed communication. In addition a number of videos were produced by the re-engineering team which highlighted the benefits of re-engineered departments and which used 'real life' professionals to explain them. The information collected for the research gave a 'live' feel to what was happening and provided an invaluable backdrop to the case study. However, as this thesis has
emerged, it has not just been about one organisation. At the national level professional associations have done much to shape the unique identity of the professions working with change at local level. Documentary evidence was needed from them that explained the professional strategy behind that identity. Thus, information was gleaning from working papers, policy statements and press releases from many of the professional associations and health unions. Once more, this gave an ‘official view’ to be set alongside interviews and focus groups.

**Observation**

Observation as a methodology heightens the researcher's awareness of a particular social process. As a researcher who is well versed in the values that underpin many of the professionals working within the health service, this has had both a negative and positive impact on the thesis. On the plus side, ‘inside working knowledge’ built up through years of practice has lent valuable insight into the existing working relationships between the professionals involved in the research. Twenty years of working in a variety of health settings both as a clinician and a manager ensure a clear understanding of the work process, how professions interrelate with each other within that process, the technical language used and the organisational symbolism that is present in the health service. This existing knowledge however, can also be viewed negatively, increasing the potential for bias and subjectiveness. Awareness of this dilemma was really the only way to tackle this conundrum.

Waddington (1995:120) suggests that observation places priority on personal qualities that are to be acceptable to the people being observed. As the researcher was an established health worker, acceptability never posed a problem. The research was always carried out
in a clinical setting which allowed the researcher to gain a ‘feel’ for what was happening. Participant observation is described by Saunders et al (1997:187) as ‘where the researcher attempts to participate fully in the lives and activities of subjects and thus become a member of their group, organisation or community’. In order to carry out the field work the author used the role of participant as observer. Through knowing various managers and professional colleagues access to the hospital site had been straightforward. Moreover, personal contacts in the Physiotherapy department allowed me to shadow physiotherapists working within the specialities in which I was carrying out my fieldwork. My role as researcher was revealed to the staff. Whilst walking around the Trust to get from place to place there was plenty of ‘wall space’ covered with ‘re-engineering updates’. This was obviously one of the many management attempts to improve awareness and understanding of the initiatives happening around the Trust. Therefore, news was readily accessible. When update meetings were advertised, it was possible to attend as a health worker, but also to glean documentary evidence as a researcher. Documentary evidence was also readily available within the various departments. Thus, the easy access gained, the ready acceptability by workers involved in the research, and the direct manner in which it was possible to obtain information, can be argued to have outweighed any disadvantage of ‘bias’.

Selecting the professionals

As a large acute teaching hospital that encompasses a comprehensive range of health specialities, the hospital has 1100 beds and more than 4000 employees. The size and complexity of the organisation necessitated a very deliberate research design and selected sample. It would have been impossible to interview all 4000 employees, so particular slices of the organisation were taken as a representative sample. Representation has not
been about quantity in number. If this had been the case, a questionnaire would have been
the preferred method for collecting information, rather than an in depth interview
schedule. An approach commonly used in within case studies is that of ‘judgment’ or non
probability sampling, which typically allows the researcher to use their own judgement in
choosing a sample purposively in order to achieve a particular purpose (Robson 1993).

This research is about particular health professionals working in a variety of settings and
dealing with specific issues arising from a management led change programme. To this
end, the interviews for the research have been carried out in three very different
specialities/processes across the organisation in an attempt to create internal comparisons
about organisations and work groups within larger organisations. The health professionals
included in the interviews incorporated key members of the multidisciplinary team in each
of the three settings. These included doctors, nurses, physiotherapists, occupational
therapists and their assistants. In choosing research sites from both in and out patient
settings, they differ in terms of speciality and environment. The interviews had sliced the
organisation in terms of multidisciplinary professionals working together in teams. The
focus groups added a further dimension to the research in that it allowed the sample to be
‘sliced’ by professional grouping.

As this particular research involves a single case study undergoing a national pilot site
programme, it was important to place an emphasis on breadth. Reasons for choosing the
type and number of health professionals centred around the nature of the professions
involved and their closeness to the issues surrounding the research topic. Having a feel for
which professions would be most suitable for exploring responses to the changes
happening around them is most associated with purposive sampling as described by
Robson (1993) above. However, this did not mean that professions not involved would be unsuitable or not affected by the changes. Clearly the nature of the pilot scheme meant that all staff were affected in some way, but there had to be some limitations in order to focus the research design. In addition to purposive sampling, the issue of convenience affected the choice of interviewee. Often, and particularly among the doctors and nurses, it would be dependent on 'who was available' at the time. The volume of work and general day to day havoc on the wards necessitated this.

The Interviews

The health care professionals who were interviewed included doctors, nurses (registered and nursing assistants), physiotherapists and occupational therapists, together with their assistants who are unqualified members of their respective professional associations. In addition to this, a group of Integrated Testers from the Out patient department were interviewed. These employees were chosen as a loose 'control group' where BPR was implemented without any of the 'traditional' health professions being involved. So, issues of professional/occupational identity linked to role and scope of practice were not at stake. Here, there were similarities to a 'greenfield' site in Industrial Relations terms – starting from scratch without tradition. In all, thirty nine interviews were conducted throughout the three chosen sites. All were taped and lasted in the region of one hour. King (1995:33) argues that one of the greatest uses of qualitative interviews is in studying 'organisational and group identities in large organisations such as the Health Service where a complex pattern of organisational, work group professional and interpersonal loyalties exist'. The end goal of the research interview is to achieve information about the research topic from the perspective of the interviewee. By choosing to do one to one interviews with members from a number of health professions, the central themes of this thesis were addressed. The
views and attitudes of health professionals involved in the management led change programme, were captured through a mixture of relatively open ended questions and gentle probing of relevant and interesting themes, as they arose. It is well documented in the research literature that a key feature of the research interview is the nature of the relationship between the interviewee and interviewer (Cassell and Symon 1994, Easterby Smith et al 1991, Burgess 1984). Whilst the interviewee is seen as having an active role in the shaping of the research process through their participation, the interviewer is guiding the conversation in order to obtain the necessary research information.

Creating an interview guide allows for a degree of continuity in the questions asked, and the topics discussed in each individual interview. And so it was in this research. A question schedule was designed that used structured clear research questions organised around key themes that had emerged from a combination of the literature discussed in previous chapters, the informal interviews with managers, and the own experiences of the researcher. There are, however, a number of time constraints in any interview process. Setting up of interviews can also make demands on time. Personnel are not always free and available when it suits the interviewee. This was the case in this instance. Health service personnel seem particularly difficult to pin down. This problem was not confined to the medical fraternity. A number of times, interviews were set up only to be cancelled for reasons of heavy work commitment. Rescheduling of dates was never an easy option. Valuable time was wasted hanging around ward and out patient departments waiting for people to become available. On the surface, it seemed a viable and reasonable objective to schedule a number of interviews over a specifically identified couple of days. Although this was believed to be achievable in theory, reality posed a number of difficulties. Interviews over ran, they were often interrupted and staff were occasionally absent or
called away to an emergency. This experience reflects what Buchanan et al (1998:53) suggest as a need for an opportunistic approach to research in organisations and who argue that 'field work is permeated with what is theoretically desirable on the one hand and what is practically possible on the other'.

The Focus Groups

One regularly ignored, yet valuable method of qualitative research is the use of focus groups. Their attraction and strength lie in the ability to study an established and cohesive group of people (Easterby Smith 1991, Cassell and Symon 1994). This allows a relatively large number of people to be interviewed at one time (usually 6-12 people), saving time and resources for both the researcher and the organisation. Commonly used in market research, focus groups in this research were used for the very specific purpose of gaining insight into the changes in role and scope of practice and their implications for identity from a professional group viewpoint. The interviews had been constructed around multidisciplinary teams whereas the focus groups were by profession. Focus groups are essentially group interviews but differ in that it is the interaction between the members of the group that is most important. As Rubin and Rubin (1995:140) write 'the goal is to let people spark off one another, suggesting dimensions and nuances of the original problem that any one individual may not have thought of. Sometimes a totally different understanding of a problem emerges'. And so it was in the context of this research. Although I used the same question schedule as in the one to one interviews, this questionnaire was only a guideline for a less structured group discussion. 'Group think' is one of the recognised disadvantages of focus groups, yet, paradoxically here, this was exactly the main purpose of the focus groups in this research. Their value was to be in establishing what local professionals actually felt as a professional group: a quite different
perspective to the view from hospital managers, national professional organisations and isolated individual professional employees.

Four particular professional groups were taken from around the Trust. Physiotherapists and Occupational Therapists were chosen because of their unique identity within the Trust. Also, they are professional groupings that are generally under researched. Nurses were chosen as they represent the largest number within the health labour process and also because they work most closely with the change process at grass root level. A focus group on the managers, however, brought a new dimension to the research. Previously, only a few had been spoken to in an informal atmosphere, in order to gain an overall perspective into the re-engineering initiative. By arranging a manager-only group, the intention was that more substantive data could be extracted on the issue of job redesign and blurring of professional practice and impact on identity, from a purely management perspective. Again this provided another perspective on professional/occupational identity, partly from outside and partly from inside (as often former professionals themselves). Doctors were the one professional group who had been interviewed on an individual basis, but excluded from the focus groups. In conducting the one to one interviews, whether of a junior doctor or of a hospital consultant, it became apparent that answers given were fairly uniform in nature. It was further felt that Junior doctors, although fairly vociferous when voicing opinions to other health personnel - including managers - were unlikely to be so in front of their consultant bosses! It was not practical to focus on junior doctors alone as it was clear from responses given in the one to one interviews that they were merely ‘passing through the organisation’ so were not directly involved or affected by the changes happening around them. Since doctors focus groups were especially difficult to organise, and unlikely to add much to the interviews, it was decided not to conduct them.
The composition of the group and the specific role of the moderator/facilitator, are two important factors that contribute to either the success or the failure of the focus group interview. Sim (1996:191) argues that ‘respondents should have common experiences, interests and understanding and that there should be a shared set of definitions ... although a degree of diversity may be beneficial in some cases’. All four focus groups served these criteria. The focus groups shared a common interest through their professional identity and individual role within the Trust and the researcher set out to observe to commonalities. Diversity within the three clinical groups took the form of the different grades and different levels of seniority. The manager’s focus group involved different tiers of management level from within the Trust and also different disciplinary backgrounds and allegiances. Group dynamics and power hierarchies are two particular problems in the composition of any group. In the event, these problems were not particularly apparent, as the occupational groups chosen were of fairly equal status and power within them.

The role of the moderator is pivotal. Too little involvement in the group discussion may leave the group without direction, too much may guide the conversation toward what the interviewer wants or expects to here. Hague (1993) suggests that input from the interviewer should be between one tenth and one twentieth of the transcript. This posed a particular problem for the researcher. In having a substantial knowledge base on the subjective of re-engineering and professional role and identity (clearly more than certainly the more junior members of the groups), it proved difficult not to be seen to be ‘leading’ the conversation. The actual running of a focus group can pose a number of other potential problems, some of which were pertinent in this piece of research. It is suggested that the focus groups should be carried out in an informal fashion, free from distractions and with
careful consideration for seating (Easterby Smith et al 1991, Sym 1996). Preliminaries such as a general introduction of the proceedings by the interviewer, and possible ice breaker activities are thought to make the participants more comfortable with the situation. Reassurance that there is no right or wrong answer, that data collected is confidential and that anonymity is assured further contribute to making the participants feel more comfortable. The provision of refreshments is also suggested as a welcome enticement, although in reality it is questionable whether this is really the case. The group discussion itself should last in the region of one to two hours and ideally be taped.

In reality these ideals were difficult to achieve. In a work situation, it is often difficult to find a free room and even more difficult for it to be free of distractions. This is perhaps most difficult in a hospital where it may be possible to avoid the ringing of a telephone, but difficult to avoid a bleep going off. In one particular one hour group, a participant had to deal with the distraction of a bleep going off four times. In another, a piano playing at times overrode the tape when attempting to transcribe it. Time constraint was also problematic. Often participants were giving up lunch time in order to participate, which in some incidents proved difficult to accept, especially when they had been volunteered by their manager. The guilt of taking up personal free time puts pressure on the moderator to be economical with the time. In the researcher’s own experience, the enticement of either free sandwiches or biscuits to munch, did little to either make people come, or encourage them to stay. The taping of the group may cause alarm and vulnerability in some incidences, but it was generally found that when explanation and reassurance was given, the taping of the conversation was not seen as a threat, and certainly did not curb attitudes or opinions.
What constitutes the strengths of the focus group can also be its weaknesses (Sym 1996). As mentioned above, much depends on the skill of the interviewer and the interaction of the participants. Whilst it is important for the interviewer to be able to identify and facilitate divergent views, it is relatively easy to fall into the trap of leading the group into endorsing certain views, thereby suppressing others - particularly the less dominant members of the group. This is an important fact to consider when analysing the conversation. Whilst a divergence of views underlie difference of opinion, the absence of diversity does not necessarily suggests consensus. Group dynamics may play a part in this. Group polarisation needs also to be taken into consideration and is particularly pertinent when analysing data from groups very similar in nature. This above all else causes a quandary, in that whilst the success of a group depends on its relatively homogenous nature, this homogeneity can cause polarisation. Yet, this was exactly why focus groups were used in this research. Strong themes had emerged from the interviews that were very profession specific, and as such needed exploring further within the professional group setting. An example of this is the issue of multiskilling. Whilst highly significant to all interviewed, the importance and emphasis was found to be different according to which profession the respondent belonged to.

Analyzing the Data

The need to create a full record of the interview is seen as a means of controlling bias and producing reliable data for analysis (Saunders, Lewis and Thornhill 1997: 227). Miles and Huberman (1994:51) comment that ‘raw field notes are usually fairly illegible and contain private abbreviations’. Interviews in this research were taped and fully transcribed as soon as possible after the interview – normally within 24 hours. Although extremely laborious, transcribing of the interviews allowed the researcher to ‘immerse’ herself in the data. In addition to the transcripts, notes and memos were made on emerging themes and
significant issues. This research has followed a relatively structured case study approach driven by research questions derived both from the literature and the process itself. As the interview schedule was structured it was possible to weigh directly the balance of evidence surrounding each theme. The focus groups were less structured and because of this needed more content analysis. However, given the size of the sample it was possible to do this manually, through the use of highlighter pens, and ‘cutting and pasting’. This said, care was taken to present an accurate balance of evidence whilst at the same time using richer quotes to illustrate the actors/professionals social meaning within the context of this case study. The fieldwork for this thesis looked at a specific process. Interpretation of the data was by means of unearthing themes and issues as they arose in the course of the interviews and focus groups. The work of Tajfel and Turner (see chapter 2) was used to give further insight into this interpretation.

Quantitative research seeks to ensure rigorously that findings by more than one researcher will produce similar results or reliability. King (1994:31) argues, however, that in qualitative research ‘the interviewers sensitivity to subjective aspects of his or her relationship with the interviewee is an essential part of the research process’. In a qualitative context, reliability concerns the researchers interpretation of data and to what extent this interpretation reflects on what the interviewee was actually saying. To this end, King suggests, researchers should acknowledge their own prejudices and assumptions and ‘should allow themselves to be surprised’(31). This said, a further way in which it is possible to check on the accuracy of understanding is to cross check with the interviewees themselves at the time of the interview in order to avoid making incorrect assumptions.
Validity is concerned with whether the research findings are 'really' about what they appear to be about – does the data relate to the concept that it is claimed to measure. Miles and Huberman (1994) argue that internal validity is measured by ascertaining whether or not events have been uncontrolled and unmodified by the researcher's presence and action. In this research, the anonymity of the participants and the individual independence of the researcher has been emphasised at all points in the research. In spite of this it is still difficult to ascertain if this has been achieved. External validity or generalisability refers to the extent to which research findings are more generally applicable, for example in other contexts, situations or times, or to persons other than those directly involved. As discussed earlier in this chapter, it is not claimed here that this one organisation is representative of any other. However, the nature of this case study and the workers being researched means that the findings should have wider application to other NHS professionals, at least.

Conclusion

Methodological purity may be weakened by the need to fit in with the practicalities of organisational life. As Buchanan et al (1998:54) acknowledge in their own work ‘...whatever carefully constructed views the researcher has...the process of theory development, of data collection methods, or of the status of different types of data, those views are constantly compromised by the practical realities, opportunities and constraints presented by organisational research’. Buchanan et al (1988:59) argue that ‘needs, interests and preferences of the researcher...are central to the progress of fieldwork’. This quote is pertinent to this thesis for two reasons. Although no longer a practicing clinician, the role and scope of professional practice and professional/occupational identity remains of interest. As a previous health care manager, the effects of management practice has led
to questions regarding the impacts of change in the work setting. This research has allowed the researcher to facilitate a greater understanding of how and why. The results of any research are affected by the method and design adopted. This research design has taken a multi method qualitative case study approach where each has been used for a different and specific purpose. Thus, it can be argued that each method has contributed to the overall strength of the thesis. Finally, in advocating single case study research Butler (1997) talks of the importance of the ‘richness’ of the story. This case study, through its personal anecdotes and quotes gleaned through the various methods, attempts to explain the perceived professional dilemmas in their own words. The following chapter, Chapter 6 focuses on the one to one interviews. Chapter 7 gives an account of the focus groups.
CHAPTER 6

THE INTERVIEWS

*It is far more difficult to be simple than to be complicated, far more difficult to sacrifice skill and cease exertion in the proper place, than to expend both indiscriminately.*

('Modern Painters', John Ruskin)

Introduction

The research contained in this thesis is from three very different sites within the Trust hospital. Each site chosen incorporates a very different speciality and work setting. The specialities included two from an in patient and one from an outpatient process. The specialities chosen offered three very different insights into the change process. The first case study took place in the musculoskeletal process. Based in the Surgical Directorate, work was considered to be acute, with a faster rate of patient turnover. In addition, this particular process had been part of the early re-engineering programme. Traditional mixes of health service professionals were interviewed including doctors, nurses and members of the therapy professions. The second setting took place within a very specific part of the out patients process – the ‘near patient testing centre’. Within this centre a brand new working environment had been established, again in the early part of the re-engineering process. Here, professionals interviewed were not members of the traditional health professions but more concerned with the technological, investigation occupations such as phlebotomists and cardiology technicians. The final setting moved to another inpatient setting known as the rehabilitation process. This time the speciality dealt with the longer term inpatient. This allowed for a very different view of ward life in terms of patient recovery and stay. However, types of professionals interviewed remained the same as the first inpatient setting, that is members of the medical, nursing and therapy professions.
This chapter now looks at the particular themes that arose during the semi structured interviews held in the three different sites within the Trust Hospital (see Tables 20-22 p. 213). Evidence for the interviews will be discussed under three related headings. These headings are *General attitudes to the hospital re-engineering change programme, Attitudes to Changes in Workload, Delegation and Responsibility and Attitudes to Multiskilling*. These three themes are used because they relate to the purpose of this thesis. That is, to consider the impact of local organisational change on professional employees in terms of effects on role and scope of practice and professional identity. Each theme is considered separately within each of the three sites. The interviews involved members from multidisciplinary teams working within these sites. Although some of the evidence is pertinent to the individual within the team, there will also be comparisons with the individual’s particular profession.

**THE MUSCULOSKELETAL PROCESS**

The first of the three research sites took place within the hospital’s musculoskeletal process. This process deals with any type of orthopaedic condition. The range of patient age and type of condition on these wards is enormous – from elderly fractures of the hip to young football players breaking legs, from traffic accidents to the less severe, but equally debilitating slipping and falling over, breaking arms, legs and backs. Four previously mixed acute/rehabilitation trauma wards were restructured in order to accommodate two wholly acute and two wholly rehabilitation wards. Previously on admission, patients had been admitted to one ward for the duration of their stay. Following the restructuring this no longer happened (see diagrams 1 and 2). The acute wards accepted the patients on admission to the process. It was from these wards that the patients went to theatre and subsequently spent the initial few days of their post operative recovery. The rehabilitation

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wards, as their name suggests, served to accept the patients thereafter for their rehabilitation and preparation for discharge. Patients were only considered for transfer on attaining a score of twelve points or more on a specially designed rehabilitation criteria score sheet. This meant that there was no defined time scale for the transfer of patients from the acute to the rehabilitation setting. The thirty bedded wards were not the dismal and traditional Nightingale wards. Based in a newer part of the hospital, they were designed to incorporate four, six bedded bays together with a number of side rooms which tended to house patients who were either very sick, very noisy or very rich - those willing to pay for their privacy. Nursing staff worked in teams (two teams per ward), but all other health professions involved in the research treated patients on any of the four wards.

Diagram 1: The Musculoskeletal patient trail; pre re-engineering
At the time the research was carried out, the only job formally redesigned on the wards was that of the traditional ward sister. As a direct result of the BPR programme this role no longer existed, having been replaced by Key Workers (rehabilitation wards) and Team Leaders (acute wards). These two newly created roles incorporated new job descriptions, which saw an extension in the roles and responsibilities, from those of the traditional nursing sister. This extension in role centred round an increase in day to day general management duties within the reorganised musculoskeletal unit. Other than this the traditional team based nursing existed. That is, nurses were organised into teams comprising of a mix of seniority and skill. Each team had responsibility for the welfare of a fixed number of patients. As far as possible, the workload was organised such that patient allocation was based on bays. Each team took on the workload of two bays together with a set number of side rooms. Each patient had a named nurse on admission to the wards. Formal job descriptions of all other nurses within the teams remained the same, but it will be seen that in practice, their role did change substantially after the reorganisation.
Nursing skill mix between the wards was similar, with the ratio between qualified and unqualified 50/50. However, the acute wards had a higher total number of nurses. This was due to the perceived higher turnover of patients from the acute to the rehabilitation setting. Each team on the ward was responsible for half the total number of patients admitted at any one time. The ward layout was such, that each of the teams covered two six bedded bays and three side rooms. For the research, two nursing teams were identified - one from the acute and one from the rehabilitation setting. In all, 20 nurses were interviewed. This number incorporated a wide range of skill mix - team leader / key worker, senior and junior staff nurses and nursing assistants. Other health care professionals interviewed included members of the medical staff, physiotherapists and occupational therapists together with their assistants. These professionals were not directly attached to the nursing teams but, through working on any of the four wards, liaised with any member of the nursing staff at any given time and were very much part of the 'multidisciplinary' team.

The physiotherapists and occupational therapists interviewed in the research though attached to the ward, were actually based within their own departments in another part of the hospital. Located within their own small teams, both professions worked on the wards and in the gym adjacent to the wards on a daily basis and for much of the day. Each team comprised of a senior therapist who had specialised within musculoskeletal work and who was based within the speciality full time. In addition, junior members rotated on a six month basis to the speciality, along with the assistants. Both of the rehabilitation professions treated patients both on the ward and from within their own individually designated specialised area away from the ward. But this area was still situated within the
musculoskeletal process. This is described in more detail below. Both took a daily report from the nursing teams discussing the patients under treatment. Treatments were not necessarily prescribed by the doctors, but there was close collaboration between the doctors and the two therapy professions. There was close communication between all the professions on how therapy treatment regimes were progressing—both verbally and in writing within the patient notes. Both the doctors and the nurses referred patients to the therapists. The therapists took responsibility for their own treatment regimes, liaising when appropriate and when the patients were removed from treatment. In this respect this did not differ from any other part of the hospital.

A new initiative had been the introduction of newly designated therapy treatment rooms within the musculoskeletal unit. This had very real advantages to the therapy professions and their patients. It provided them with their own base close to the ward setting, from where they could treat patients without taking them to the main department. The nature of the musculoskeletal work was such that the therapy professions were heavily involved in the recovery of the patient. The therapists saw all the patients at least once prior to discharge, but usually treatment was over a period of time. Each medical team was led by a consultant who had a number of doctors working for him/her. They ranged from Registrar down to Houseman grade. There were eight teams in total—two per ward. The doctors were not always present on the ward as time was spent between theatre, outpatients and the ward setting. The doctors interviewed ranged from consultant to junior doctor.
General Attitudes to the change programme

Acceptance of change was more evident in those who experienced a sense of enrichment in their roles following re-engineering, which, for the nurses interviewed, tended to be confined to those jobs who had been formally redesigned. Amongst the group of nurses interviewed, the higher up the ladder they were, the more positive the attitude to change and the more emphasis placed on the importance of success with the re-engineering initiative. For the nurses especially, this acceptance also reflected on how well individuals had adapted to the changes imposed on them by management. In a discussion on the new ward layout and patient redistribution, one team leader acknowledged that the changes had brought about a degree of unrest amongst her staff. Almost despairingly she commented, "It's still early days following the changes and there's lots of scope for development. That's exactly what a lot of the staff don't recognise. As a team we need to be more aware of this than we are - staff need to acknowledge that we need time to settle into our new working practice and be more readily able to accept where we are going". Similar comments were voiced by some of the staff nurses, "It takes time to get used to change. There's bound to be hiccups and people are bound to be unsettled by them". And another, "Change can be difficult to handle, especially when you are not sure that its right. It gives you a sense of uncertainty".

In general, the more junior the nurse, the more negative were the feelings toward the organisation's attempt at re-engineering the work process. There was evidence of increases in workload amongst those whose formal job description had not changed following restructuring, but who were experiencing change in role as a result of changes in the ward hierarchy. There was an acceptance that the traditional nursing tasks had to some extent been taken over by the nursing assistants, whilst the general patient management
duties such as booking appointments and ambulance transfers home were being carried out by the qualified nurses. Discussing her daily duties one staff nurse commented, ‘I haven’t even seen a patient today, let alone touched one, as I have been busy on the phone all morning arranging transfers and discharges’. This type of response was common among the nurses.

The perceived change in role varied from individual to individual. Some saw the changes in terms of similar tasks but more intensity. This was more apparent for the qualified nurses, particularly those who were working on the acute wards. Here, there was a higher turnover of patient, as the patients admitted were more acutely ill and more dependent, therefore needing more ‘all round’, intensive nursing before being suitable for transfer to one of the two rehabilitation wards. All nurses interviewed recognised the increase in workload. As one staff nurse commented ‘Because this is the acute ward where we take all the admissions, our work is therefore more intensive. Patients are more nurse dependent on this ward’. All saw it in terms of additional, wider range of tasks. This category included many of the nursing assistants, who felt that as the work intensified they had taken on more of the basic nursing duties of the qualified staff. Nursing assistants unanimously spoke of how their role was changing. Although the traditional tasks of assistant such as ‘bed baths and toilet runs’ were still being carried out, they were also performing basic nursing duties that had previously been in the realm of the qualified nurse. These included tasks such as wound care, dressings and changing of intravenous drips which had previously been qualified nursing duty work.

The depth of acceptance to change in work design depended very much on the individual’s perception of their role within the new work process. When asked about how
or if their role had changed one staff nurse commented, ‘The workload has almost doubled which has had an impact on how stressed we feel. Added to this there is much more of a feeling of being on our own - more answerable for our own actions without the back up of the old nursing sister, who used to support us if there was ever a problem. You feel as if you have lost the support of your superiors - especially as they seem so much more upbeat about the changes, which in turn makes you feel more vulnerable and questions your own commitment, not in terms of the patient but certainly in terms of work generally’. This comment not only emphasises the increase in workload but also the feeling of lack of support within the new working structure.

This loss of support was a very real issue for the nurses and was attributed by many to their own feelings of low motivation and a lack of control over the new situation. When one junior staff nurse was asked how she might influence the new working practice she said, ‘I doubt that I’d be able to. We were told this was a pilot scheme but nobody told us how long it would be for. Also nobody asks us how we feel about it. People have shown that they are unhappy by leaving which has stretched the remaining staff even more as they haven’t been replaced, but nobody seems to be questioning why they have left.’ And when discussing her views on multiskilling, one nursing assistant commented, ‘It may be okay for the experience and increase in responsibility and, of course, to the patient, but you have got to have a feeling of being appreciated in order for you to have the incentive to be committed to the idea. Incentive would come if you were appreciated, it doesn’t have to necessarily be a financial incentive’.

A change in physical layout with the siting of a new physiotherapy gymnasium nicely demonstrated the need for employee involvement when redesigning the workplace as
means of promoting well being and acceptance of change. Prior to the restructuring, the physiotherapists and occupational therapists had used their own department gymnasium in a part of the hospital some distance away from the wards. This involved both the transferring of patients from ward to physiotherapy department regularly through the day and transporting often bulky and expensive equipment from physiotherapy to the wards in order to carry out specific treatments on the wards. These longstanding procedures were both time consuming and inappropriate in terms of quality patient care. During the setting up of the new working structure the physiotherapists had negotiated an onsite physiotherapy gym in a small room adjacent to the wards. Although small, it not only gave them their own designated space within the musculoskeletal process, but it allowed them to treat patients in a more effective and efficient manner. They agreed that this had aided their general acceptance of the changes. The senior physiotherapist explained, ‘They (management) asked us what we would like and we said we would like a gymnasium and be much closer to the patients, which is what we now have. It’s great as we can now work much closer to the ward team and feel much more integrated. Staff can see more readily what we do and share in it a lot easier. We feel much more part of the team now and the fact that they have acknowledged our worth by ploughing resources into us gives us added incentive to make it work’. Another said, ‘It’s a huge bonus for us as we no longer have to take patients downstairs to our own gym which means we don’t rely on porters and waste valuable treatment time’.

For junior members of the medical staff acceptance of change wasn’t an issue. Their loyalty continued to be placed with their consultant team for whom they worked. Whilst working arrangements had changed around them, little had changed for them in their own work circumstance. Ward rounds, operating theatres and out patients continued wherever
their patients happened to be. In a discussion on workload, one senior house officer commented ‘Our workload is whatever wings our way from casualty the night we are ‘on take’. That’s the way it is. It’s irrelevant who’s where, and what’s happening. I just do as I’m told and work through it, I am only here for six months anyway and am not likely to be back’. For their bosses, the consultants, there was similar ambivalence directed at the change, other than to complain that they could never ‘find a nurse’ or that they ‘had to walk further now as I have patients on all four wards instead of one’.

**Attitudes to Changes in Workload, Delegation and Responsibility**

Whilst all the nurses claimed to have experienced an intensification of work as a direct result of the re-engineering process, few expressed a sense of being ‘empowered’ and few were enjoying an increase in job satisfaction. There was little doubt that there had been an increase in tasks and task variety, particularly among the nurses. The more senior the staff nurse, the more the tasks were less about nursing and more about patient administration and the co-ordination of treatment with the other professionals working on the wards. In a discussion on her working day one staff nurse said, ‘I have to be honest and say that I preferred things the way they were. Things seem much busier now. There is a definite increase in workload. I know we are short staffed and that doesn’t help the situation. I can’t honestly believe this is a better way of working. We’re all more stretched than before and that causes unhappiness on the ward’. A nursing assistant who was discussing how her duties had changed said, ‘There has been a noticeable knock-on with our work. The nurses are busier and so are we. We have taken on more of the basic nursing skills whilst they (nurses)do more administration. I would say we definitely have more responsibility but unfortunately without the recognition – either financially or otherwise’.

The reorganisation of the work process in this particular setting, appeared to exacerbate
some of the problems inherent in today's health service - staffing difficulties, and ever expanding patient demand in terms of both resources and expectations. As one nurse commented, 'There are deficiencies in staffing levels and although some I'm sure will associate this with the changes - particularly those who are unhappy - but these problems are inherent within the service anyway. There is much more stress because we are more accountable not only to the patients and their relatives but also to management'.

It is interesting how this intensification of work has been perceived according to type of role being played in the new structure. More senior nursing staff whose jobs had been formally redesigned, though they had difficulty describing their new role in terms of responsibility and acceptance within the newly created ward team, did have a sense of being empowered to do more within the organisation as a whole. This was due to the fact that, once appointed to the new posts, individuals were allowed to create and develop their own working practice as the post evolved. Typical comments from a team leader and a key worker explain this point, 'My job is changing as I go along...and I'm not entirely sure what my new role is as it is expanding all the time. I'm supposed to be the team leader, but how can I lead the team if I'm off doing other things all the time'. 'Off doing other things' referred to her increase in managerial tasks in the general running of the musculoskeletal process. And from the key worker, 'My new role is certainly dynamic and the boundaries seem to change all the time at the moment'.

More junior nurses and nursing assistants whose actual jobs had not been redesigned as a result of re-engineering, still recognised an apparent change in role as a direct response to what was happening higher up the nursing scale. Whilst they acknowledged an increase in task variety and responsibility within the team, for example, nursing assistants carrying
out more basic nursing duties such as dressings, these increases were seen to be more about intensification of work rather than positive notions of changes in responsibility. Furthermore, this intensification of the work process was directly associated with an increase in feelings of stress, rather than a notion of being empowered. This particular group of nurses attributed the blame for increases in workload to increases in work stress, with blame for both being apportioned to the change in working environment. One nursing assistant said, ‘We’re expected to do more now. We appear to have more responsibility for basic nursing duties than ever before. There is definitely more stress amongst us now. Shortage of staff is one problem, but the change in the way we have to work hasn’t helped the situation and staff are disillusioned’.

Rather than attributing the blame to the restructuring, those whose jobs had been formally redesigned more readily acknowledged that increases in workload and stress were part and parcel of working for the health service. The marked difference in attitude toward intensification of work and their sense of empowerment highlights the fact that positive feelings towards restructuring and the willingness for restructuring to succeed, lay primarily in those whose jobs had been redesigned. This may be due in part, to acceptance that their new role may be temporary if the restructuring fails. However, it does show a form of organisational commitment not evident in those who viewed the process as merely ‘more work, more stress’. This suggests the importance of participation and ownership in the change process.

For the other professions working within the new structure, intensification was not an issue. There wasn’t a sense of ‘working through lunch breaks’ or ‘longer hours’. Nor was
there a sense of change in range or variety of tasks that they were expected to carry out. Instead, the changes had brought for them sense of unity and belonging with the nurses, as they had become more readily ensconced into ward life with the creation of the new gymn adjacent to the musculoskeletal unit. Hence, although their tasks had not changed, for them, their role within the unit was perceived to be much more in their own words 'dynamic' and 'up front' and 'more of a presence'. Nurses popped in to the gym to see patients being treated, thus becoming much more aware of the role and part played by the therapists. Commenting on the importance of this, one occupational therapist enjoyed the idea that it helped them to be recognised as doing something other than 'basket weaving'.

For the doctors there had been little change to either their role or scope of practice. As one senior house officer commented, 'Work is whatever appears on the ward or in theatre and I am here until it is done'. Criticism from them was not about their own workload but which of the nurses was responsible for their patient under the new structure. As one consultant reminisced, 'Gone are the days when you arrived on the ward, you did your weekly ward round with your sister (who was always on duty that day). You gave her your instructions and she wrote them down and passed them on to her nurses. Then you and your team had tea and biscuits in sisters office. Now you arrive on the ward, you look for your own patient notes and then try and hunt down the nurse looking after your patient who is more than likely not on the ward anyway'. Whilst this consultant admitted he was thinking very much in the past, his comment highlighted both the change in hierarchical nature of the ward nursing team and the changing role of the nurse in terms of delegation and responsibility.
Attitudes to Multiskilling

Nursing staff viewed the issue of multiskilling and flexible working practice more positively than any other of the professions included in the research. Much was made of the benefits, in terms of meeting the needs of the patient and providing a more comprehensive level of care. Although enhancement of skills was viewed favourably in terms of patient care, it was generally not viewed as a means of extending the professional boundary of the nurse. Nurses in general feared the possibility of being ‘taken for granted’ and, perhaps not surprisingly, this was especially the case amongst the lower grades, who were already viewing their experience of intensification of work and increases in task variety more negatively than those higher up the scale whose jobs had been formally redesigned. 'Although I’m in favour of it in terms of benefits to the patient - and I can certainly see its value for patient care - I’m not convinced about the benefits to me as a nurse. I can see it being pushed forward without thought to our existing workload'.

Another comment, ‘Its great for the patient – but for the nurse I’m not sure. I mean they talk about extended role but is it about that or just more cost cutting and more work’.

Interestingly, few nurses could give any stance of the Royal College of Nurses (RCN), which suggests that responses in the interviews were direct personal feelings on the issue.

The doctors demonstrated a much more hostile approach to the whole issue of flexible working practice and multiskilling. This hostility was not prompted by a fear of deskilling, but focused on the criticism of other professions with which they worked. The notion of ‘clock watching mentality of other professions’ was a collective viewpoint of those interviewed. The concept of multiskilling wasn’t seen as either a means of enhancement of other professions or as a means of deskilling for themselves. As one consultant said, ‘At
the end of the day, the patient is under the jurisdiction of the consultant whatever changes are made to the way in which they are treated and by whom'. Another similar comment came from a more junior member of the medical staff, 'Whilst I accept that there are several sticky issues - accountability, responsibility and perhaps worries about what would happen to our own accreditation and training. I can't see a problem with, say for instance, a nurse taking bloods, or assisting the surgeon in theatre, as at the end of the day we are still in control of what happens to our patient. I can't honestly see us deskill but I can foresee problems with our own accreditation and training procedures.'

The rehabilitation professions demonstrated a more fixed approach to the issue of multiskilling. Physiotherapists were more likely to view multiskilling as a means by which their own assistants skills could be enhanced rather than nursing staff, suggesting that loss of skills by their own profession in favour of nurses would potentially lead to demotivation of the rehabilitation professions, 'I would rather see multiskilling as a means by which the skills of my own assistants can be enhanced. Nurses are being asked to do so many things these days. Although multiskilling could be favourable, we must as a profession voice concerns over factors such as training of skills, assessing competencies, monitoring standards and accountability. We need to protect our own status first and foremost'. One occupational therapist said 'Multiskilling is one thing but we need to be able to assess who is capable of taking on our role'. This suggestion reflects the profession’s fear of losing their own professional identity and autonomy within the health care setting. Adapting the skills of the profession’s own assistants, rather than enhancing the skills of other professions acts as a form of safety net in the preservation of professional roles and identity. The occupational therapists shared similar views and concerns, accepting that though the issue of multiskilling had encouraged them to
acknowledge that some skills could be shared, the professional thinning that multiskilling may cause would ultimately have a detrimental effect on their professional autonomy, 'I think that there is a genuine feeling that others can do our job particularly in areas such as home assessments, assessing washing and dressing practice etc. However, whilst these may seem simple tasks from the outside what other professions should remember is that we have three years training in these skills and that things may not be as straightforward as they seem'.

Summary and analysis of the interviewee responses

Changes that had taken place within the working structure of the musculoskeletal process had created winners and losers amongst the nurses. The 'winners', illustrated in figure 5(a), are those who are experiencing a sense of job enrichment in their new working environment. For the nurses this was confined to those whose jobs had been formally redesigned. This new role had presented them with new challenges and a stronger sense of identification with the organisation/management. Their responses were more upbeat, they tended to be less critical about their new role, and more in tune with management objectives. Whilst they remained nurse by profession, there was acknowledgement by both themselves and the nurses on the wards that their role and activities were more managerial in nature. Chapter two introduced the concept of the professional triangle arguing that it is important to understand where employees are 'located' within that triangle in order to gain insight into the success or otherwise of changes in working practice and role. A change in working practice has impacted on their role by relocating away from their original work group towards a new managerial/organisational role within the new work process. The picture was less than rosy for nurse lower down in the nursing structure. Responses from the rest of the nursing team (those whose jobs had not been formally redesigned) suggest
that changes in working practice had led to work intensification. Here, increases in task
variety had not been associated with job enrichment, more of a sense of ‘more for less’.
Change in working practice had not enhanced their professional role and occupational
identity and had in fact increased their affiliation toward their own work group (see
fig.5(b)). Responses suggest that they were less than enthusiastic about the effects of the
change in work practice on their own role within the organisation.

For the therapy professions working with management to secure a designated area within
the musculoskeletal process had improved their working environment in terms of
resources and given them a stronger sense of social identity within the new work process.
Their enhanced social identity had afforded them the opportunity to build stronger and
closer working relationships within the new structure. Figure 5(c) illustrates on the one
hand their affiliation towards their work group and to the organisation/management, but
also depicts new tensions between the organisation and their professional association.

Overall the responses suggested that initiatives such as multiskilling created tensions and
dichotomies within the workplace. The professional role of the therapy professions was
fostered outside of the workplace through their professional associations. This role created
a special occupational identity within the organisation. Any change in work design that
impacted on this professional role/occupational identity was seen as detrimental to
themselves professionally. However, exactly because this identity was fostered outside of
the organisation, the therapists realised that change could only go so far. As we turn to the
work of Tajfel and Turner in light of the interview responses further illustration will show
the impact on them as a group.
The work of Tajfel on the concept of social identity, discussed in chapter 2 of this thesis, brings further insight into this winners/losers argument. Self categorisation is the process of seeing oneself as a member of a social group - 'I' becomes 'we', 'others' become 'we', and 'others' become 'they'. His work tells us that group belonging and identification gives us a basis or anchorage for how we think, feel and act. Based on Tajfel's work the following tables attempt to illustrate the process of self categorisation, pre and post re-engineering, for the team leaders/key workers, nursing group and therapists.

**TEAM LEADERS/KEY WORKERS**

As winners in this change process these workers had utilised their skills knowledge base to become more managerial in their actions. Their new roles within the organisation supported their occupational identity as a nurse manager.
PRE RE-ENGINEERING

<table>
<thead>
<tr>
<th>Social category + self</th>
<th>Ward sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I’</td>
<td></td>
</tr>
<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup Ward sister and Nursing team</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup Nursing team and management</td>
</tr>
</tbody>
</table>

POST RE-ENGINEERING

<table>
<thead>
<tr>
<th>Social category + self</th>
<th>Nurse manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I’</td>
<td></td>
</tr>
<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup Nurse manager and management team</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup management team and nursing team</td>
</tr>
</tbody>
</table>

TABLE 10. Group affiliations – Key Workers/Team Leaders, musculoskeletal process

NURSING TEAM

As losers in this change process, notions of work intensification, a sense of loss of the old nursing structure, more tasks but same skills, left these workers with the same occupational identity as nurse carer.

PRE RE-ENGINEERING

<table>
<thead>
<tr>
<th>Social category + self</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I’</td>
<td></td>
</tr>
<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup Nurse and nursing colleagues</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup Nursing team and management</td>
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</tbody>
</table>

POST RE-ENGINEERING

<table>
<thead>
<tr>
<th>Social category + self</th>
<th>Nurse</th>
</tr>
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<tr>
<td>‘I’</td>
<td></td>
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<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup Nurse and nursing colleagues</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup Nursing team and management</td>
</tr>
</tbody>
</table>

Table 11. Group affiliations – nurses, musculoskeletal process
THERAPY PROFESSIONS

The professional role and skill base of these workers had not changed, leaving their occupational identity intact. Their social identity within the musculoskeletal process had been enhanced. They were no longer perceived as an out group within the new working practice.

| PRE RE-ENGINEERING |
|---------------------|------------------|-----------------------------|
| 'I'                 | Social category + self | Therapist                   |
| 'Others' become 'we' | Social category + ingroup | Therapist and therapy departments |
| 'Others' become 'they' | Social category + outgroup | Therapist and ward staff |

| POST RE-ENGINEERING |
|---------------------|------------------|-----------------------------|
| 'I'                 | Social category + self | Therapist                   |
| 'Others' become 'we' | Social category + ingroup | Therapist and ward staff |
| 'Others' become 'they' | Social category + outgroup | Therapist and ward staff |

Table 12. Group affiliations, Therapists, musculoskeletal process

In chapter 2, Turners six shaping factors were applied in order to depict what made an occupational identity accessible (see figure 2 p52). From the responses given by members of the therapy professions we can see that whilst the temporary situational factors had changed, long term stable factors remained intact. Their occupational identity remained unchanged. In a change process looking for change in working practice, this has proved to be a double edged sword. On the one hand, the type of role and scope of practice that these professional employees perform has led to a unique role that is fostered outside of the workplace. In a sense, they were winners in becoming part of a new ‘in group’ and they no longer saw themselves as an ‘out group’ minority member. On the other, new working concepts such as multiskilling lead to new tensions and dichotomies, with the
potential for inter group conflict if new working practices attempt to transgress professional boundaries. The therapists run the risk of continuing to be an out group member if this tension cannot be resolved.

AN OUT PATIENT PROCESS

The Trust’s Out Patient department occupies a considerable part of the ground floor of the hospital. Prior to the start of the re-engineering programme the Trust had embarked on a number of innovative quality initiatives. The most successful of these was the neurology single visit clinic. Designed around the concept of ‘value to the patient’, BPR sought to reduce the number of visits to the clinic. Previously patients had waited up to eight weeks, and attended the Out Patient department up to four times before diagnosis and eventual treatment plan was discussed. By redesigning the clinic into one five hour visit, the patient was seen by the consultant, appropriate investigations carried out and a final consultation with the consultant already in possession of the investigation results, before leaving the hospital. The process time had been reduced from a matter of weeks to hours and the administrative activity reduced by 40%. This reduction in the number of hospital visits had not only reduced the inconvenience and cost to the patient, but helped to reduce anxiety levels in the wait for confirmation of diagnosis. To the Trust, the single visit clinic had illustrated the basic re-engineering principle of looking at a process, redesigning, and achieving a radical improvement at no extra cost to the organisation (see diagrams 3 and 4).
Diagram 3: Out patient testing trail; pre re-engineering

Diagram 4: Out patient testing trail; post re-engineering

The success in this particular redesign process directly led to a number of other out patient redesign initiatives, one of which, the 'Near Patient Test Centre' has been used for this research. This particular test centre has transformed how diagnostic tests are carried out and how those results are delivered to the clinician. Within the centre, tests are performed by one person as opposed to the patient visiting a number of departments spread around the hospital site. As a result, 80% of tests can be performed within this system, with results being dispatched to the clinician within one hour. The centre has won a number of prestigious awards, and has received considerable recognition within the health world at both national and international level. Notable awards include the Silver Award from the Association of Quality in Health Care (1996), and the Hewlett Packard British Golden Helix Award (1996) which led to the runner up award in the European competition. Based
within the out patient setting, the centre is equipped with all the necessary diagnostic tools. In addition, there is a designated pathology room and an x ray room.

At the time of the research, health care personnel attached to the centre included three full time and one part time integrated testers, two senior radiographers and one pathology technician (see Table 21 p213). The four integrated testers had previously been employed as technicians based in either the Trusts cardiology or phlebotomy departments. They had volunteered for the newly created roles within the centre. Two had been there since the beginning of the centre and two had joined subsequently as the workload had increased. These newly created roles were employed on a Trust salary scale as opposed to any other professional scale, but their previous salaries had been taken into account when negotiating their new Trust contracts. Training for these new roles was dependent on previous experience. For example, the volunteer from the cardiology department, whilst being highly trained in taking echocardiograms (tracing of the heart beat), had to become sufficiently competent to take blood. Thus training and competency assessments took place within the relevant departments. However, both the pathology technician and the radiographers were seconded to the centre on a rotational basis from within their own departments. Their job descriptions and salary scale remained unchanged.

General attitudes to the change programme

In the early stages of the change process, there had been some apprehension particularly regarding the newly created role of integrated tester. As one commented, 'There were problems to start with. Our new roles did seem to create a 'them and us situation'. It made us feel isolated. Especially as we were so positive and everybody was so negative generally about both the re-engineering and also our new role'. In spite of these feelings
of apprehension, the integrated testers were upbeat about their new role within the Trust hospital. A very different ethos towards the changes came across amongst those interviewed, to that of the inpatient processes. What was most striking was the affinity between those being re-engineered and those doing the re-engineering. Comments typical from the integrated testers, "We were all volunteers, which was a bit of a risk really. But I can honestly say it revolutionised my work. Because we were a new role in health care the re-engineering team really wanted us to work – we had so much help and support in the early stages, it was reassuring to know that the support was there to see us through the early stages". And another, "...the excellent team building that we received from the re-engineering team helped us on our way". The views of the radiographer and the pharmacy technician were similarly upbeat. Although their professional role and job content had not significantly changed on joining the centre, each demonstrated positive feelings toward the centre's work and its role within the organisation. One radiographer said, 'My role within the organisation itself has not changed as such, but I am enjoying work within the centre. There is a good working atmosphere and a lot of support generally'.

On discussing the role of the integrated tester within the organisation, their level of commitment outreached the confines of their own working practice to encompass the whole re-engineering philosophy within the Trust. Thus the level of organisational commitment was high. As one of them said, 'What's especially nice is the fact that what re-engineering has done for us is to put us in these new roles that don't exist anywhere else. If you like we are like the leaders in the field in this kind of work. If I had not been here, I wouldn't have been part of it'. And another, 'It gives us a tremendous amount of scope to move further. For example if they set something similar up in another hospital they can come to us for advice. They don't just come to the re-engineering team
they talk to us as well ...’. Although not quite so vociferous, the radiographer and pathology technician held similar viewpoints, ‘It is nice to be part of something successful and to be considered part of the team in that success ...’. And, ‘The rewards and national recognition have been great. It makes you feel very part of the team and organisation that have created this centre ...’. These comments suggest that the overall success of the centre together with the national and international recognition that had been received helped to consolidate the commitment of those working within it. Furthermore, this recognition notably enhanced the role of the Integrated Testers in particular, and served to increase role satisfaction and secure job enrichment, ‘At the moment there is no professional body for us – we are the pioneers, and with generic roles looking to increase within health we have a big vantage point. Working for the first Trust to do this gives us a nice feeling of being first and foremost in the field.’ Being newly defined jobs within health care there was obviously no external reference point for the integrated testers as with the other professions. Their roles and skills were very organisation specific. What was most notable in this particular setting was that all seemed happy with the changed working environment. There appeared to be no winners and losers. The ‘newness’ of the situation and awareness of its uniqueness were important contributory factors for this.

**Attitudes to Changes in Workload, Delegation and Responsibility**

During the interviews for this research, the integrated testers came across as the epitome of fully empowered workers. The newly created role of integrated tester had brought an increase in task and task variety to those who had taken on the role. These increases were viewed most positively by all the integrated testers, ‘It has enhanced our work no end. We have total job satisfaction now. There is much more to do and we have a new role within the organisation that is well respected. Also, its relatively stress free, especially now the
teething problems are sorted out'. And another, 'I can’t see any disadvantages in our new role'. When asked about the concerns regarding the new role one commented, 'I don’t have any concerns on how we work now. We can very much manipulate our own work as a self managed team and sort out the best way to sort things out'. This notion of a self managed team is an interesting one. The centre’s immediate manager was based in another part of the hospital. When the particular manager was approached for permission to interview the staff within the centre, the response had been to ask the staff directly if they would mind being interviewed. The day to day running of the centre was solely organised by the centre staff, in particular the integrated testers. There appeared little interference from management. In addition, the integrated testers had equal status in the decision making process. They had managed to create a team that was self motivating and autonomous and there was an air of unity.

This unity encompassed the other two professionals working within the centre, but not to the same extent. When discussing the issues surrounding workload the pathology technician commented, 'I wouldn’t say it has enhanced my work or empowered it, but it has changed it from the point of view of being more team focused. However, I still feel very much part of pathology because at the end of the day my job hasn’t changed. I’m only seconded and belong with the pathology department. It has new pressures sometimes especially when we are busy. Sometimes I think we are victims of our own success. Others seem to expect so much more from us'. The comments again highlight the differences between those whose jobs had been formally redesigned and more whose jobs had not changed. Those whose jobs had been formally redesigned more readily expressed the positive feelings toward increases in job variety, were more fulfilled in their role and were experiencing job enrichment. In this particular example of work reorganisation, success or failure of the process held different connotations for the various health care workers.
within the process. The pathology technician and radiographer, were attached to the centre on a secondment basis and remained employed by their individual departments. Their role in terms of task variety and intensification of work had little changed. They had neither gained nor lost from the initiative. If the process failed, their role and professional identity remained intact. The role of integrated tester had created personnel who had experienced a positive increase in task variety through enhancement of role and autonomy within the wider organisation. Their newly created skills had awarded them recognition and achievement not only from within the organisation, but within the health care arena generally. This recognition and achievement must surely be an incentive for the process to be a success. Failure and return to their old roles and identity would mean considerable loss in status. In short, they had far more to lose.

Attitudes to Multiskilling

The integrated testers saw the issue of multiskilling in favourable terms. When considering the role and scope of the integrated tester this was not surprising. Much was made of the practicalities of having a multiskilled diagnostic worker. Few disadvantages were expressed concerning multiskilling as a concept in itself. However, much was made of the problems faced in attempting to further extend this new role. Two comments form the integrated testers that support this view were, ‘The work we do is very fulfilling, but I would like to go further still’ and “Because our role is new, there is some ambiguity of role at times. This doesn’t necessarily cause conflict, but sometimes I think I would like to go further.....’. These comments highlight the limitations of multiskilling in a health care context. Because so many of the professions are accredited by individual associations, there will always be limitations on how far extensions of skills can go. Again, it was a member of the paramedical professions, the radiographer, that demonstrated a more fixed
approach to the issue of multiskilling, 'There can be a bit of a problem over this at times. They think that because they know how to prepare a patient for x ray that they should be able to push the button as well when really there is more to it than that...'. And from the pathology technician, 'They (the Integrated Testers) do the bloods, it is still my role and part of my work to correlate the results. There are still things they cannot do'. Whilst appreciating why their roles were limited and probably as far as they could go, positive feelings were expressed about how their roles could be developed. As one of the integrated testers commented, 'At the moment there is no professional body for us, there's no association or body that supports what we do. Perhaps this is our way forward. We are the pioneers in this, and with generic roles looking to increase within health we have a big vantage point'.

Summary and analysis of the interviewee responses

This part of the field work highlights the more positive aspects of the re-engineering programme. This newly created working environment had proved beneficial for both the organisation and the staff working within it, in terms of both success and prestige internationally, and employee moral and well being within the workplace. The newly created roles had allowed the workers to feel empowered and had also given them a sense of uniqueness and self worth. As a self managed team they were left to make their own choices and decisions about their work process. In these new working roles the benefits of worker participation and ownership can be appreciated. Furthermore, team unity, especially amongst the integrated testers adds an extra dimension to the success of change. The lack of traditional professional roles and boundaries in this working process added to a sense of team unity not felt elsewhere.
Newly created occupations had been developed. As such, there was no tradition, no perceived hierarchy. As these workers were considered to be first in the field of healthcare, it emphasised the importance of being ‘unique’. It nicely demonstrates one of the key principles underpinning BPR - that starting with a clean sheet approach can work in practice *in some instances*. These workers were winners within the organisational change process as their identity as an occupational group was enhanced and secured within the organisation (see figure 6). This security and the fact that they were self managed ensured that they endorsed the change management process. However, on a wider scale outside of the organisation, they would need to acquire recognition of their role within the health service. To do this they would have to adopt some form of occupational strategy for professionalisation and legitimacy.

For the radiographer and pathology the picture was much more mixed. Whilst enjoying the new working environment and experiencing the benefits for the patient, there remained a sense of loyalty toward their professional standing (figure 7).

**Figure 6: Illustration of Location of Integrated Testers within Organisation**
Again using Tajfel's theory of self categorisation, the following tables give further insight into the responses given by the interviewees. The integrated testers through their new role had secured themselves a new identity and new occupational grouping within the organisation. For the radiographer and pathologist, as with the therapy professions in the musculoskeletal process temporary situational factors had allowed the professions to be part of the 'in group'. Long term stable factors, which determined their occupational identity also remained intact, but rendered them susceptible to becoming an out group minority member.

**Integrated Testers**

<table>
<thead>
<tr>
<th>PRE RE-ENGINEERING</th>
<th>Social category + self</th>
<th>Technician</th>
</tr>
</thead>
<tbody>
<tr>
<td>'I'</td>
<td>Social category + self</td>
<td>Technician</td>
</tr>
<tr>
<td>'Others' become 'we'</td>
<td>Social category + ingroup</td>
<td>Technician and department</td>
</tr>
<tr>
<td>'Others' become 'they'</td>
<td>Social category + outgroup</td>
<td>Technicians department and other op departments</td>
</tr>
</tbody>
</table>
### POST RE-ENGINEERING

<table>
<thead>
<tr>
<th>'I'</th>
<th>Social category + self</th>
<th>Integrated Tester</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Others' become 'we'</td>
<td>Social category + ingroup</td>
<td>Integrated Tester /Testing centre colleagues and management</td>
</tr>
<tr>
<td>'Others' become 'they'</td>
<td>Social category + outgroup</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 13. Group affiliations, Integrated Testers, Out patient testing centre

### Radiographer

#### PRE RE-ENGINEERING

<table>
<thead>
<tr>
<th>'I'</th>
<th>Social category + self</th>
<th>Radiographer</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Others' become 'we'</td>
<td>Social category + ingroup</td>
<td>Radiographer and radiography department</td>
</tr>
<tr>
<td>'Others' become 'they'</td>
<td>Social category + outgroup</td>
<td>Radiography department and other departments</td>
</tr>
</tbody>
</table>

#### POST RE-ENGINEERING

<table>
<thead>
<tr>
<th>'I'</th>
<th>Social category + self</th>
<th>Radiographer</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Others' become 'we'</td>
<td>Social category + ingroup</td>
<td>Radiographer and op testing centre colleagues</td>
</tr>
<tr>
<td>'Others' become 'they'</td>
<td>Social category + outgroup</td>
<td></td>
</tr>
</tbody>
</table>

Table 14. Group affiliations, Radiographer, Out patient testing centre
Table 15. Group affiliations, Pathologist, Out patient testing centre

THE REHABILITATION PROCESS
The third study took place within a further in patient setting. This time the process was based in the medical directorate as opposed to surgery, in order to provide a further dimension to the research. The difference between this setting and the musculoskeletal setting focused on the type of patient that the health professions were dealing with. Patients here were admitted for non surgical conditions such as strokes, chest infections and pneumonias. The patients involved were considered long stay patients as opposed to those in the acute surgical environment of the musculoskeletal process. Several factors contributed to the decision to consider a designated rehabilitation area within the directorate. The growing concern nationally concerning the availability and use of acute hospital beds had led the directorate to extensively research and evaluate their own bed status as part of the wider hospital re-engineering programme. It had been ascertained by the re-engineering team that within the medical directorate, at any one time, approximately
30 acute beds could be considered to be inappropriately used (Medical Directorate Briefing Paper 1995, Stanway 1995). In addition, the needs of an increasingly ageing population had led to health authorities requesting providers to plan ahead for the major impact on services that this particular group of patients would eventually have. Finally, it was acknowledged that in order to meet the health care needs of the future, resources and interventions had to be targeted at groups where they would have the greatest effect.

One of the wards within the rehabilitation process was to be restructured to become a designated stroke unit (see diagrams 5-8). Within this unit, the services and environment were to specifically focus and address the needs of patients with stroke, neurological disorders and disabilities arising from medical illness. Patients of all ages were eligible to be admitted to the unit. Once on the unit, they were encouraged to be as independent as possible and take an active part in co-ordinating their own rehabilitation programme. Members of the multidisciplinary team included professionals from all disciplines and included doctors, nurses, physiotherapists and occupational therapists (see Table 22, p213). The primary aim of the team was to provide a 24 hour, 7 day a week rehabilitation programme in order to maximise the individual’s recovery. Patients also had the opportunity to join in group activities on the ward which included yoga sessions and visits from the hair dresser.
Diagram 5: Rehabilitation process in patient admission trail; pre re-engineering

Diagram 6: Rehabilitation process inpatient admission trail; post re-engineering
Diagram 7: Rehabilitation process inpatient treatment trail; pre re-engineering

Diagram 8: Rehabilitation process inpatient treatment trail; post re-engineering
Again, the ward was in a newer part of the hospital and consisted of four, six bedded bays and a number of side rooms. Nurses and rehabilitation staff worked within multidisciplinary teams and were encouraged to make rehabilitation and discharge decisions. Overall responsibility for the unit belonged to the process manager, who was not ward based and whose role was not incorporated into the multi based teams. At ward level, a team leader took responsibility for the development of the unit and the nursing staff were organised into two nursing teams led by key workers. Having said this, nurse staffing levels were low due to a general shortage of nurses within the medical directorate. Attempts at recruitment to the new unit from both within the directorate on a voluntary basis, and through advertising in the nursing press had been unsuccessful. Ward teams included the new support worker role, which nursing and physiotherapy assistants had been encouraged by management to volunteer for. Members of the physiotherapy and occupational therapy staff continued to be department based, with the exception of one of the physiotherapy assistants who took on the new support worker role. Emphasis was placed on the training and development of staff in order to promote multidisciplinary working practice and the rehabilitation philosophy.

The introduction of a new multidisciplinary training programme which underpinned the new support worker role was an important new initiative by the Trust. The programme had a number of objectives. It was expected that by improving the support workers knowledge base the continuity of care, handling and rehabilitation of the patient would be enhanced. In addition, the blurring of professional boundaries through the newly trained Support workers enhanced skill mix on the unit through providing some therapy intervention at weekends and promoting rehabilitation outside of formal treatment sessions. To further the concept of a skill enhanced support worker, a competency based training package was
developed with the help of the Trust's training centre, which was based on the national NVQ system and centred on basic nursing, occupational therapy and physiotherapy skills. These skills included dressing practice, wound care, simple exercise regimes and walking re-education. This specifically designed package enabled the support worker to concentrate on specific skills related to rehabilitation and allowed them to obtain an in house award when completed. All of the support workers had gained or were working toward this in house award at the time of the research.

**General Attitudes to the Change Programme**

During the interviews, much was made of the change in work process in terms of the chaos and disruption for staff. Many of the staff nurses whose role had not been specifically redesigned as a result of the restructuring expressed feelings of disillusionment with the new working process. In discussing a move she had made voluntarily from one of the medical wards to the new unit one staff nurse commented, ‘I don’t feel as comfortable with my work – more disillusioned than anything. The workload goes up and up and I miss my old life a bit too much at the moment’. Again, it could be argued that staffing problems inherent in the health service alone have led to an increase in workload. Those whose jobs had been redesigned more readily accepted the changes in the working process. The support workers especially, whilst expressing concerns about losing core skills as assistants with the individual professions, appreciated the benefits of the changes not just to them but also to the patients. As one support worker said, ‘As a volunteer I am committed to seeing it through. It has a lot to offer in terms of myself as it has increased my skills and also for the patient as they will have more specialised care.'
My only concern is that I may lose out on some of my more basic nursing skills, which I enjoy.

Those nurses whose jobs had been redesigned accepted that problems in staffing levels and teething problems in the early stages tested their commitment, but most accepted the change around them. The key worker, whose new role now included extra responsibilities in terms of managing her ‘team of nurses’ commented, ‘I feel more part of everything in my new role and although things are difficult I think that as the problems are ironed out my commitment will grow. I think that means I am generally committed to the change...’. In discussing his managerial role within the unit, the team leader appreciated that change ‘wasn’t easy for everyone’, acknowledging that he felt his staff fell into two distinct categories - those who saw ‘changes as a challenge’ and those who saw ‘changes as a threat’, and that this was in part due to the perceived incentives, ‘There are always problems with change. The essential thing for me is to get the rest of the staff on board and behind the initiative. This isn’t always easy as people can feel threatened by change and that is happening here’.

This issue of change being seen as a threat was also touched upon by both the physiotherapists and the occupational therapists, particularly when questioned over the issue of multiskilling. ‘There is a dichotomy here because so much can be seen as a threat – particularly over things like multiskilling’, said one physiotherapist. And when discussing the impact of the new working environment within the occupational therapy department, one occupational therapist commenting on the issue of who should be considered eligible for assessing washing and dressing practice, commented, ‘new roles
and change can be threatening and that can test your acceptance to something new. Also, a new working environment can be frustrating which tests your commitment'.

As with the previous in patient setting, change had affected the doctors little. Again, the junior doctors were to move on and thought little of the changes. For them, the importance was in working for their consultant team. As one said, 'It's a good idea and must surely be improving the care of the stroke patient and increase the resources available for these patients but to me at the end of the day they are patients admitted under my consultants name and I would see them anywhere in the hospital'.

Attitudes to Changes in Workload, Delegation and Responsibility

Once more, the interviews suggest that those who were experiencing a positive increase in job variety, were those whose jobs had been redesigned. These included the team leader, the key workers and the support workers. Work in these areas appeared altogether more interesting and more challenging for those interviewed. In discussing the impact of his new role the team leader commented, 'I have more influence and control over what happens. My nursing skills are less and I have more managerial responsibility. This new role has given me more power to create new initiatives .... I was less influential in my old working practice ...'. Despite this apparently positive approach to his new role, there were reservations. These centred around the problem of staffing. The team leader said, 'Staffing levels are poor which causes pressure no matter what your role is. I'm having to give up my managerial role to 'lend a hand' which isn't the way it should be working. Managerial duties can get neglected. It's a 'leave it or stay late' situation – increasingly both'.
The staffing problem concerned many of those interviewed and was regarded as the main cause of role ambiguity for the key workers. This left the key workers with an increase in task variety, but with little sign of being fulfilled. Despite this, there was little evidence to say that the key workers saw their increase in task variety as merely ‘intensification of work’. As one explained, ‘I have problems identifying what my new role is. This is due to the staffing levels on the ward. As I’m having to take on more of a clinical role again to make sure the work gets done. I can’t develop my role within the team. I don’t feel as if I have enhanced myself professionally by taking on this role’. And another, ‘The deficiencies in staffing levels are pulling the system down and make our individual roles more difficult’.

Whilst the notion of empowerment was not outwardly expressed when discussing individual roles within the new working environment, there was evidence that the newly created roles of team leader and key worker, did have more influence in changing working practice. Both acknowledged that this was due to their managerial type responsibilities. For instance, when asked how they might influence change one key worker admitted ‘Because this is a new role working environment as a key worker I am listened to. I can mention something, and even if it is not always acted upon at least I can have my say and it be discussed’. The team leader expressed a similar viewpoint, ‘I see it as part of my role to influence change. In that respect I have far more power now than I did previously’. This expression of ‘being listened to’ and notion of power did not extend down the nursing ladder. The more junior nurses saw themselves as ‘mere workers’ coping with intensification of work.
In discussing the issue of changes in workload and responsibilities, the most interesting and most unexpected responses came from the support workers who were experiencing an increase in task variety through becoming multiskilled. Positive comments on their new role centred on the increase in task variety and learning of new skills. There was sense of achievement amongst this group – particularly in view of their new qualification. However, this positive approach did carry some apprehension, ‘I am enjoying my role, more skills, more to do. However, I'm not using my core skills as much which leaves you feeling vulnerable if the pilot doesn't work’. And another, ‘There are more opportunities to develop yourself when you are in this role. You can develop your skills and competencies. At first I was worried about the relearning process and also you do feel you're not using your basic skills as much’.

Surprisingly all of the support workers hoped to return to their old working ways. Whilst they were experiencing an increase in task variety and enhancement in role and scope of practice, lack of incentive (financial) was most notably cited for a return to the norm, particularly for those who had been nursing assistants. Those assistants from the physiotherapy and occupational therapy who had taken on the role of support worker, expressed the added problem of change in work circumstance. With the threat of being no longer department based if the scheme were deemed successful, they felt uneasy in transferring to a full time ward situation. One of the support workers said, ‘I would prefer not to be employed in a ward situation. If I had wanted to do that I would have applied to become a nursing assistant. The truth is that despite all the advantages of more scope and enhancement of role, I still prefer to be a physiotherapy assistant. I would hate to be ward based long term’.
Comments from the support workers gives an extra dimension to the restructuring of people’s roles from within an organisation. Clearly, there has to be a financial incentive for the worker who takes on new responsibilities. Whilst higher up the scale this could be in terms of added opportunities, career opportunities for ancillary staff are more limiting. There has to be an established incentive for these workers. Role enhancement through increases in task variety is not enough to win the ‘hearts and minds’ of this type of worker.

**Attitudes to Multiskilling**

Of all the professions interviewed, as in the musculoskeletal process, nurses were the most positive toward the issue of multiskilling. Emphasis was placed on the benefits to the patient in terms of being able to provide a more fully comprehensive service. As one key worker acknowledged, ‘You can look at the patient more holistically. It benefits them from the amount of input that they can get, which will consolidate what they have to achieve whilst they are an inpatient with us.’ An interesting comment on the future role and scope of nurses came from the team leader, ‘It’s a very important part of the rehab process and so has got to happen in some form. I think we need both type of worker – multiskilled assistants and qualified generic worker with specialist input when needed. I don’t think that the nurse title will exist as it is today in the future. It will give us more scope and more responsibility’. This far reaching comment may help to explain one major concern expressed by one of the key workers interviewed, ‘Here it is the assistants who are becoming multiskilled. I can see a problem arising for the rest of the nursing staff in terms of who is responsible for what, and really if your assistants are multiskilled so should you be as the nurse in charge of them’.

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This problem of multiskilling the nurse assistant, as opposed to the qualified nurse, is a direct contrast to the views of the therapy professions, who viewed the idea of increasing the role of their own assistants more favourably. Comments from the occupational therapists explained this, 'People don't feel recognised or supported on this issue. It's okay to expand and multiskill the assistants but they really should be our own assistants...'. And another, 'The idea of rehab assistants is a good one. I think the therapy professions would benefit from this'. This again seems to highlight the therapy professions' reluctance to pass on skills to those other than from their own profession. Generally, there was much criticism of the idea of multiskilling the workforce. Both physiotherapists and occupational therapists expressed fears over protection of role and boundary. One physiotherapist commented, 'Multiskilling concerns me from the point of my role within the team. It's a protection thing I suppose. A protection of that role within the team...'. And another, 'It's encroachment of role from the physiotherapist's point of view, even the assistants role is encroached...'.

The occupational therapists went further in suggesting that there should be very distinct professions, 'We have all got our own skills and they should be kept separated. Each professional approach is very different. A big worry is that you feel you are losing something that is yours and furthermore where are the boundaries of such an initiative'. However, though reluctant to lose their own role and identity within the team, the physiotherapists acknowledged that there had been a positive knock on effect in introducing the role of support worker to the ward team. Various comments from them highlight this point, 'One advantage here is that the nurses and support workers have more awareness of what we do and what we are trying to achieve' and, 'In some instances I can see our role being trivialised, but on the more positive side, it can be a great way to
back up what we do and also have what we do reinforced by others when we are not here'.

Another said, 'I don't think that there are advantages to us as a profession although there
are definite advantages to the patient. Others, by learning some of our basic skills can
learn to handle the patient better'.

It proved difficult at times during the interviews to ascertain whether interviewee
responses were really echoing the view from the professional associations. This was
evident from some of the physiotherapy responses where it was acknowledged that there
were difficulties in extrapolating personal feelings from the views of the professional
association, 'What's the point in having a person whose trained for three years to have
become a member of the Society and then to have watered down skills through what
happens locally'. And, 'We should be making use of our own assistants, rather than
training up others. It's a dichotomy of where the profession should go and what happens
at local level. No one knows the answer at this stage'. The general feelings amongst the
medical staff on the issue of multiskilling was positive. Again little tolerance was given to
the perceived negative side of multiskilling given by the some of the nurses and therapists.
One consultant summed it up saying, 'In an area as specialised as this it is imperative that
we have skilled workers who can treat the patient holistically. All this talk of losing
boundaries shouldn't really matter at the end of the day - not in an area like this. The
more intensive rehab the patients get the sooner they are able to leave hospital and be
returned to the community, which at the end of the day is what primary care is all about'.

Summary and analysis of the interviewee responses

These interviews specifically highlight the tensions surrounding the issue of professional
boundaries and demarcation when adopting a multidisciplined approach for the delivery of
patient care. The nurses welcomed the concept of multiskilling in the treatment of this type of patient. Physiotherapy and occupational therapy professionals expressed fear over encroachment of boundary, tending to reinforce their practice as uniquely theirs. The support worker role had not been entirely successful. Although perceived by all to be of benefit to the patient, there was little incentive for the role to succeed – either for the support workers themselves or for the professionals working alongside them. Their professional/occupational identity was placed firmly in the professional camp rather than within the organisation. Rather than attempting to forge some form of social identity within the team, allegiance was to their professional identity (see figure 8).

**Figure 8: Triangle Locating (a) Winners, (b) Losers, (c) Professional Tensions for Therapists**

In considering the interviewee responses with regard to Tajfel's work on self categorisation the following tables illustrate similar findings to those in the musculoskeletal process for both the key workers and the nursing team. The picture is more complex for the role of support worker and therapist. Rather than feeling integrated
with the ward multidisciplinary team, the support worker became alienated from her previous ‘in group’ – the physiotherapy department. Through the restructuring process they had become an out group to her new organisational role. With no perceived financial or career benefits the support worker role in this instance was serving to create feelings of loss of identity within the new work setting. Earlier in the chapter we saw how the therapists benefited in becoming part of the ‘in group’ with the development of an on site gymnasium. The therapists in this part of the study had not benefited from changes in the work structure in that their temporary situational factors had not altered and so they remained an ‘out group’. Again, the long term stable factors remained unchanged emphasising their position as an out group member.

**Key Workers**

<table>
<thead>
<tr>
<th>PRE RE-ENGINEERING</th>
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</tr>
</thead>
<tbody>
<tr>
<td>‘I’</td>
<td>Social category + self</td>
<td>Ward sister</td>
</tr>
<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup</td>
<td>Ward sister and nursing team</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup</td>
<td>Nursing team and management</td>
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</table>

<table>
<thead>
<tr>
<th>POST RE-ENGINEERING</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I’</td>
<td>Social category + self</td>
<td>Nurse</td>
</tr>
<tr>
<td>‘Others’ become ‘we’</td>
<td>Social category + ingroup</td>
<td>Nurse manager and management team</td>
</tr>
<tr>
<td>‘Others’ become ‘they’</td>
<td>Social category + outgroup</td>
<td>Management team and nursing team</td>
</tr>
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**Table 16. Group affiliations, Key Workers, Rehabilitation process**

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Nursing Team

<table>
<thead>
<tr>
<th>PRE RE-ENGINEERING</th>
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</thead>
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<td>'I' Social category + self</td>
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<td>'Others' become 'we' Social category + ingroup</td>
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<td>Nurse</td>
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Table 17. Group affiliations, nursing team, rehabilitation process

Support Workers (eg physiotherapy assistant)

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<td>'I' Social category + self</td>
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<tr>
<td>'Others' become 'we' Social category + ingroup</td>
<td>'Others' become 'we' Social category + ingroup</td>
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<td>'Others' become 'they' Social category + outgroup</td>
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<td>Physiotherapy assistant</td>
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<td>Physiotherapy assistant and other health workers</td>
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<td>Support worker and ward team</td>
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<td>Support worker and therapy department</td>
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Table 18. Group affiliations, Support Workers, rehabilitation process
Therapists

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</tr>
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<td>'Others' become 'they'</td>
<td>Therapist and other health care workers</td>
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**POST RE-ENGINEERING**

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<tbody>
<tr>
<td>'I'</td>
<td></td>
</tr>
<tr>
<td>'Others' become 'we'</td>
<td>Therapist and therapy department</td>
</tr>
<tr>
<td>'Others' become 'they'</td>
<td>Therapist and other health care workers</td>
</tr>
</tbody>
</table>

Table 19. Group affiliations, Therapists, rehabilitation process

**General Conclusions**

The Schofield Report (1996), advocates the need for the health care professions to support and facilitate a new breed of multiskilled healthcare worker. The three fieldwork sites highlight the advantages and potential limitations of the recommendations published in this report. The principles behind re-engineering programmes, facilitate the redesign of jobs to encompass the concepts of empowerment and multiskilling. Within health care the creation of this style of role is not without its problems.

From these interviews it can be seen that this particular re-engineering programme has created a winners and losers situation for the workers involved. Although this is nothing new further insights are given to this argument by analysing the responses of the interviewees using Tajfel's theory of self categorisation and Turner's work on social accessibility. The win/lose argument can be seen from both within and across the
individual field work sites used in this case study. Across the three sites four roles had been redesigned – that of team leader/key worker (the old traditional nursing sister) based in the musculoskeletal process and rehabilitation process, the integrated workers based in the Test Centre within the Out Patient department, and the support workers based in the Stroke Unit within the rehabilitation process. All spoke positively of their increase in task variety and their sense of enrichment in their new role. Whilst many acknowledged that there was intensification of work accompanying the new role, it was also appreciated that times were generally difficult within the health service in terms of staffing and resources, and that work intensification could not necessarily be attributed to the restructuring of their working environment. All of those interviewed in the new roles had been working at the Trust before applying for, and embarking their new roles. For the team leaders, key workers and the integrated workers there was no talk of ‘going back’ to the old way of working. It was accepted that their new roles would stay and that the restructuring would move forward. As incumbents of newly created roles their social identity and recognition within the organisation had been enhanced.

For these workers, the restructuring had created roles that were more fulfilling and potentially more rewarding. Thus, they appeared committed to the change process. Salary did not come into the conversation during the interviews and it would be wrong to suggest that financial incentive was never an issue with these workers, but it is clear is that they saw their individual new roles in a positive light. Certainly, the posts of team leader and key workers were a step on the managerial level and had potential for future career progress. Their occupational identity had shifted away from that of nurse carer. New roles and tasks had created a new reference point for them within the organisation and that had become involved with a new ‘in group’. The integrated testers were slightly different.
Expressing the same kind of fulfilment they were the epitome of fully committed, multiskilled and empowered workers. Almost plucked from obscurity in their original departments, they were part responsible for a centre that had been showered with accolades both nationally and internationally. However their success was a double edged sword. On talking to them, incentive to succeed came from a sense of going forward, with not a lot to lose if the testing centre had failed. They would merely have returned to their old role within the organisation. There were advantages for them in not being part of a hierarchical ward structure where professional identity and role boundaries play a significant role in the delivery of care. However, as a new occupation their skills are organisation specific and they do not hold any corporate professional identity with which they could, in time, develop their image and status in a wider context.

Whilst experiencing an increase in task variety and enjoyment in their new roles the support workers wished to return to their old working way. For them there was no clear career pathway, so financial incentive for their new way of working was the only possible reward. However, this new role had led to a new and different form of group identity which imposed new challenges on their work. They had taken on a new organisational role that had left them with more responsibility in terms of extended role, but with little incentive. Other losers included nursing groups who were experiencing an increase in task variety and change in role as a direct result what was happening higher up the ladder. This was especially obvious among the nurses within the musculoskeletal process. There was no talk of sense of job enrichment or empowerment when interviewed – only of an increase in task variety that was held responsible for intensification of their work.
The health service is unique in the number of professions working within it. All adhere to their individual codes and ethics. Although training is University based, accreditation is through the individual professional associations. Local change initiatives, such as this re-engineering programme need to take into account the distinctiveness of the professions working within the health service. The interviews highlighted the dichotomy for management and the professions over the issue of role boundary and professional/occupational identity. Multiskilling, whilst seen as beneficial for the patient, was largely seen as detrimental to the occupational identity of the professional employee. Nursing staff viewed the concept as a means of increasing workload even further. The physiotherapists and occupational therapists viewed the issue as deskilling or the erosion and dilution of skills. Local change therefore, was perceived as threatening the professional role and the occupational identity of these professions in particular. Strong in opposition to the issue of multiskilling, the physiotherapists and occupational therapists knew however, that they were fairly safe. Temporary situational changes at local level cannot directly affect the long term stable factors that determine role and scope of practice, without a national agenda and framework. However, what is apparent for these professional employees, is the tensions that change processes create between their corporate professional occupational identity and their commitment and standing within the organisation in which they work.

The interviews for this thesis have given an indication of how health professional employees working within teams, have adapted to changes in their work circumstance. New in groups and out groups are created –some are beneficial but are clearly lacking in scope when dealing with changing role and scope of practice. In short, temporary situational factors can only go so far in redirecting the delivery of health care. The
following chapter gives an account of four focus groups that were carried as part of the research for this thesis. The focus groups add a new dimension to the data collection as they allow the professions to be interviewed by professional grouping.
### Table 20: Interviews carried out within the Musculoskeletal Process

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL PROCESS</th>
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<tr>
<td>TEAM LEADER</td>
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</tr>
<tr>
<td>KEY WORKER</td>
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<td></td>
</tr>
<tr>
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<td>OCCUPATIONAL THERAPY</td>
</tr>
<tr>
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### Table 21: Interviews carried out within the Out Patient Process

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<tr>
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<tr>
<td>INTEGRATED TESTER</td>
</tr>
<tr>
<td>INTEGRATED TESTER</td>
</tr>
<tr>
<td>INTEGRATED TESTER</td>
</tr>
<tr>
<td>SENIOR PATHOLOGY TECHNICIAN</td>
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<tr>
<td>SENIOR RADIOGRAPHER</td>
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### Table 22: Interviews carried out within the Rehabilitation Process

<table>
<thead>
<tr>
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<th>PHYSIOTHERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM LEADER</td>
<td>SENIOR PHYSIOTHERAPIST</td>
</tr>
<tr>
<td>KEY WORKER</td>
<td>JUNIOR PHYSIOTHERAPIST</td>
</tr>
<tr>
<td>STAFF NURSE 'F' GRADE</td>
<td>SUPPORT WORKER (PHYSIOTHERAPIST)</td>
</tr>
<tr>
<td>STAFF NURSE 'E' GRADE</td>
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</tr>
<tr>
<td>SUPPORT WORKER (NURSING)</td>
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</tr>
<tr>
<td>SUPPORT WORKER (NURSING)</td>
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<td></td>
<td>OCCUPATIONAL ASSISTANT</td>
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</table>
CHAPTER 7

THE FOCUS GROUPS

‘The Trivial round, the common task,
Will furnish all we ought to ask’
(The Christian Year, John Keeble)

Introduction

The case study has so far focused on the effects of change on individual health care professionals as they function within a team. Teams were taken from three very different settings within the Trust hospital. Professionals working within these teams came from a number of health care professions. Particular emphasis was placed on doctors, nurses, physiotherapists and occupational therapists. Due to the diversity of professions involved, it became clear that a further dimension to the case study was needed. So far, the case study had sliced the organisation in terms of multidisciplinary teams in three different settings. Focus groups allowed the professionals to be interviewed by profession grouping (see Tables 23-26 p.244). Thus, by using focus groups, the case study sample could be sliced in a different way. The focus groups proved to be an important part of this particular case study, as it was an opportunity to hear the professional voice after the team based voice. Individuals invited to the focus group had not been part of the previous one to one interviews. However, those involved in the focus groups were directly involved and working with the change programme at the Trust hospital.

Although the same interview schedule was used as in the interviews, the line of discussions did not allow for interpretation of the data in the same way. Instead emerging themes focused on organisational change that impacted on professional issues. Four focus
groups were used - nurses, physiotherapists, occupational therapists and managers. Each group had eight members. Doctors were excluded on the basis that they would be an almost impossible group to get together for an interview. Furthermore, it had already become apparent in the one to one interviews that their particular group opinion and identity had been established. It was felt that managers should be included as a group since the case study was based on a management led change initiative. The managers focus group was not primarily about managerial identity. Its objective was to glimpse how the managers viewed and reacted to the dilemmas faced in orchestrating change in a complex environment that encompassed a variety of professional images and identities. Furthermore, this group would be able to give an 'outside view' of the other professions. The length of time taken for each focus group was in the region of one hour. All of them could have gone on for longer in terms of volume of discussion, but due to time restraints, this was not possible. Whilst the same interview schedule was used as in the one to one interviews, often certain issues stimulated more discussion and deliberation. In each case the same issues dominated the discussion. The focus groups were tape recorded and subsequently transcribed.

The Nurses

This focus group took place in a ward setting within the medical directorate. The nurses involved were all qualified registered nurses. The number of years qualified varied between one and fifteen years. This allowed for a good mix of nursing experience. Some had trained and worked within the old traditional nursing hierarchy. The more recently qualified had trained on the new diploma and degree courses, and though aware of the old nursing structure of ward sister and subordinates, had not actually worked with it. All the nurses were presently working within the medical directorate as opposed to an acute
surgical setting. Nursing sisters no longer existed and had been replaced by ward managers, though still form the nursing profession. Within this focus group, references are made to two types of ward based team – nursing teams, and multidisciplinary teams involving a number of professions. Furthermore, reference has also been made to two types of nursing team – that of the old traditional nursing team led by a nursing sister, and the newer style of nursing team encompassing a mix of qualified nurses and nursing assistants led by a nursing team leader. The title ‘ward manager’ speaks for itself, but is not part of the nursing team as such. Although the ward managers had helped to organise the focus group, non were present. Non of the nursing staff taking part in the focus group had been included in the one to one interviews earlier carried out in this particular research.

Early discussions centred on issues surrounding the problems of nurse staffing levels in ward situations. Most striking was the amount of loyalty the nurses showed toward each other. This loyalty also demonstrated a strong commitment to the work process, ‘In a situation when you are short staffed it’s not necessarily the loyalty to the hospital its more that you worry about your colleagues. If you know that they are stretched because they’ve been on all night and are still working on in the morning you want to help. I suppose you feel for them, as you know that you are in the same position. It’s hard to leave your colleagues on their own, so therefore you look to do more’. Effects of poor staffing on colleagues was a major concern and loyalty to colleagues demonstrated a strong commitment to the work process, rather than to those managing the process. As one nurse commented, ‘We have to be committed to each other and to our patient. Its less about being committed to management. I wouldn’t say my loyalty and commitment was to be to them’. Another qualified this statement, ‘The problem comes when that loyalty is taken for
granted. Sometimes you feel you are too loyal to a downfall. Management just say ‘oh they’re coping’. If anything happened to the loyal people there would be a real problem.

On a ward like this it’s the same people who do extra all the time. It’s these people that are taken for granted’. The issue of poor staffing was not directly associated with local change, but was acknowledged as a wider national problem and one that particularly faced nursing. Changes in the way that wards are run and managed were seen as a contributory factor for the perceived lack of commitment to management in general, ‘There’s not a lot of trust toward them and so its difficult to build commitment to the principles of management. The support that we as nurses now get at ward level is a lot less now than compared to a few years ago. That is down to all the change that goes on generally in health care. It’s not just about this change process, but I think generally things have changed for the nurse’.

The traditional nursing hierarchy system of one sister and her team of nurses, could now be seen to have had its benefits to nursing, particularly in terms of trust and support given to nurses. One staff nurse explained, ‘I can compare things over the last fourteen years. Some change is for the better, but then some times people can feel isolated sometimes and not supported. They have not really got people they can go to with problems now. Times have gone when the old nursing sister was there running the ward and she took on you problems for you. Now its much more you as part of a team to sort it out’. And another, ‘There is a big gap now between nurses and the ward managers. There isn’t a sister any more. Nurses are coming out as graduates at ‘e’ level. We now run the ward as senior members of staff and our role is the equivalent of the old nursing sister. Even 5 years ago it would be the ‘g’ grade who was a sister. I’m not sure that having one person to dictate
and make ward policy is healthy but then in another way you lose that continuity of care
and ward responsibility'.

The issue of team based nursing was seen as a positive change that had evolved over
recent years, particularly in role and scope of nursing practice on the wards. The
traditional ward sister and the hierarchical nursing structure that had prevailed, had
provided a support system built on trust and commitment amongst the nurses and nurse
management. Although this had now gone, team based nursing had brought with it
increases in responsibility in terms of scope and nursing practice, 'I think management
listen more in nursing to what you have to say in things like how the ward is run, more
than what they used to. If you want to change things you are more easily able to do that.
Our opinions are valued more and that has been a radical. The old traditional nursing
system of 'I'm in charge of this ward and you do it this way', has gone and that is for the
better. The team process has helped that'. And again, 'Also nurse training has radically
changed to incorporate this new style of nursing. You are not actually in fear of the old
sister and daren't say anything. Young nurses are much more open and questioning than
they ever were before. Team based nursing has brought a lot more democracy to the ward
and more bottom up decision making'. The team process was also of beneficial in terms of
recognition for other professionals working alongside nurses and of their own value and
worth in the work process, 'I think professions are more valued in their own right now
than they were ten years ago. Because things are team based, the physios and ots are,
despite being department based are more likely to be heard and valued on the ward. In a
way they are no longer visitors to the ward and it has helped their involvement of the way
that things are run. Also everybody appreciates and understand more what others do and
the part they play'.

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A discussion on the role and scope of practice highlighted a number of issues. Much was made of the holistic approach to nursing, which had extended its role and responsibility through team based nursing. However, increases in specialisation in nursing, had led to fragmentation in some areas of ward work. One nurse commented, 'I think we appreciate that we can't do our jobs without the help of others. I think years ago, we did far more and didn't involve others in the same way. Because of that the care has improved enormously. Nurses did everything and not very well. We are dealing more with other professions and other people and our job is more fragmented now. Sometimes you don't know where you are coming from'.

It would seem that increased specialisation in specific areas of nursing had changed the outlook and role of the ward based nurse considerably. Rather than having a holistic approach and general hands on experience, the ward nurse was slowly becoming seen more as a controller of patient care. One nurse gave an example of this when discussing what was meant by specialisation and fragmentation of work, 'Specialised nursing has changed our role on the ward. We as 'basic' ward nurses are forever referring on – to the respiratory nurse, the dietetic nurse, the cardiac nurse – that has also caused fragmentation of the basic nursing work. We lose out there as our skills are not used as they perhaps should be. Our nursing assistants do the basic nursing duties, the specialists come into the specifics and we do the admin and the liaison. They feed back to us and we refer back to the doctors. A staff nurse is more like a handler. Hands on is no longer there.

This change in skill base extended also to basic nursing skills which were increasingly being passed onto nursing assistants. Changes here were attributed to the influences of skill mix, which is part of the national health service agenda, 'We pass responsibility
down. Before there would be seven nurses on an early – only one would be an n/a, the rest would be qualified. Now there are seven on an early – only two are trained. That puts a lot of responsibility on the trained staff to watch over what everybody is doing – patients and doctors included and that is quite daunting at times. This means that basic nursing is done by the n/a whilst you do the sorting out and coordinating'. All agreed that it was the passing on of these skills that was the most demoralising for them as professionals. The passing down of these skills, rather than realising their potential in professional terms, detracted from the fulfilment of the more ‘caring’ role and vocational nature of their work. One nurse commented, ‘You are too busy coordinating now and I think most nursing staff on the ward would like to have the time to do basic nursing skills and we have been taken away from that. I have had a lovely morning because its been busy I have done so many basic nursing things and I have really enjoyed it this morning. I always enjoy my job despite the pressures but getting back to basics has been lovely. I don’t normally get my hands on patients’.

The issue of multiskilling proved as controversial as with either of the therapy groups, although the emphasis was different. Unlike the therapy professions it was less about professional identity and protecting what was uniquely theirs, but more about ‘dumping and intensification of work’. One nurse commented, ‘Extended roles can be a cost cutting exercise. After all you can teach monkeys to cannulate, monkeys to take blood. Oh here is something else a nurse can do. I’m not flattered that it may be expected of me to do these things. It is just another measure for palming off’. And another comment emphasising the same point, ‘Its not extended skills that makes me a better nurse. If you can keep a lot of things in your head and can coordinate that makes you a good nurse these days. If you
just keep an eye on how patients are on a day to day basis on a basic level. You need to get that right before you can do anything else'.

These general feelings against multiskilling were backed up by frustration about the way the other professions worked and the contribution that they as nurses had to make to ensure continuity of patient care. When discussing the role of the occupational therapist, this comment was made, ‘I must admit some of the OT’s skills that are done are done by the nurses over a period of time whilst the patient is on the ward – like washing and dressing practice and we probably get a better overall picture of how that patient copes than an OT does in a half hour session. Perhaps not kitchen. In any one admission we pick up an awful lot about the patients general care of themselves. There is a place for us to say this woman needs washing and dressing practice. This is our opinion.’ Examples were also given on how the role and scope of practice of others places restrictions on the holistic role and identity of the nurse, ‘It’s like the dietician. I wanted to give a patient some leaflets on diets but had to let the dietician come along which held up discharge for the day. I’m perfectly capable as a nurse to be able to give health promotion advice to a patient but I couldn’t do it. I have enough training to know about dietary advice and I could give that advice but had no literature to back it up and had to refer to the dietician. That’s a case of too much specialisation’.

Fixed working practices of others, such as five day working week, also had an affect on the nurse’s role. This became apparent in a discussion on multidisciplinary team based working when one nurse remarked, ‘Although we are a multidisciplinary team, there are boundaries in a multidisciplinary team I suppose. I think we have to get round them somehow. We are the only profession here seven days a week. The hospital is run by nurses at
the week end. There has to be overlap somewhere. Sometimes it's as if we can only use
our skills after five pm. For example we follow up what the physio does in a half hour
slot, at the weekend in say something like walking practice'. Another example was given
of the ward pharmacist, 'It's like the pharmacist she does a wonderful job explaining the
drugs Monday through to Friday and then at the weekend we have to do her job and
explain them. We have to keep up to date with this info ourselves so that we can do the job
when they are not around. It's easy to loose touch. If we rely totally on one professional,
things don't get done when they are not there at the detriment to the patient. You have a
personal commitment to keep yourself up to date'.

Interestingly, unlike the therapy groups, the role played by the professional associations in
determining role and scope of practice did not enter the discussion. When asked about the
role played by the Royal College of Nursing (RCN), little was expected of it, 'What does
the RCN do for us? – Well you get a nice badge and a diary. Absolutely nothing but I
expect they would be good as back up if needed in incidents.' All nurses in the group had
chosen to be members of the RCN rather than UNISON because they 'wanted to be
represented by members of their own profession'. It was acknowledged that nursing
assistants chose UNISON as the RCN did not allow membership of non qualified staff, 'A
lot of nursing assistants go with Unison as they can't join the RCN . I don't think nursing
assistants should be able to join as we need trained nurse representation. At the end of
the day they haven't be trained and have no qualifications. You have to be careful that you
don't dilute our profession too much. You wouldn't see doctors and lawyers let non
qualified staff in would you – it's a professional thing'.

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The nurses in this focus group acknowledged that despite the advent of team nursing and multidisciplinary team based nursing, nurses had a long way to go in securing a professional image as 'dynamic' as the doctors. All acknowledged that this was never likely to be so for a number of reasons. A great part of the problem centred on how they were portrayed in the media and seen in the eyes of the lay person, 'We are seen as hard working, underpaid, undervalued, as angels. But as the same time we should be able to do everything. Soon as we cross the border and perhaps get cross that's a different matter. Doctors are seen as gods, somewhere up there. Even then if they have a run in with a doctor they wouldn't complain. The doctors are respected by the patient on the ward. Most haven't got the medical knowledge so they don't question the doctor, but they do question us'.

When asked why they felt their identity hadn't changed, it was felt that the problem was one of long standing image, 'its because of the image, uniform, hats etc. Doctors with white coats and stethoscopes. It's definitely an image thing. Although we have tried hard to change that over the years it still prevails. Sometimes when people come in they get a shock because that image doesn't exist anymore in reality. They realise things are more technical. Nursing has radically changed over ten years. The public can't keep up with that unless they see it for themselves'. If it was accepted that the image and identity had not changed in the eyes of the public what had changed was the relationship between doctor and nurse at ward level. Referring specifically to the more junior doctor, all felt that the relationship had improved considerably in terms of respect for the nurse. It was commented that the junior doctor took much more direction from the nurse in charge of the ward than ever before. 'We can guide them, particularly the younger ones into doing something. Tactfully, but you can do it. You even get doctors saying now 'well what do
you think then' that never used to happen. We manage the care and then they come along and sort out the drugs, bloods and referrals'. A major reason given for this was the introduction of the diploma/degree based nurse that had led to more mutual respect between the two professions. Having noted this, it was also accepted that in some specialities this change in relationship was less noticeable, 'On the surgical wards there is still a power base thing. The surgical doctors are much more in control and are much more directive rather than asking what someone thinks. I suppose its because the work is much more acute.'

Summary

It is clear from the early discussion in the focus group that respect and loyalty to colleagues are the major factors that secure commitment of the nurse to the working process. The trust and loyalty experienced by the older nurses working in the traditional nurse setting of 'sister and her team' though missed, were accepted as part and parcel of the changes in nursing life generally. Commitment was less directed at management and more toward nursing colleagues. Changes in terms of increased responsibility were on the whole welcomed. However it was felt that the profession had paid a price for increasing specialism with a loss of their basic nursing skills and holistic approach to nursing care. This loss of skills was seen less as deskilling, but more as a change in role and scope of practice. Despite their role and working relationship with other professional employees having changed dramatically over the years, their image in the eyes of their professional colleagues and the public had changed little. The image of carer remains firmly fixed.
The physiotherapy focus group took place within the Physiotherapy department over a lunch hour. There was a good mix of seniority from within the department, ranging from physiotherapy assistant to a senior clinical specialist (Senior 1 grade). The members of the group were working in a variety of settings from around the Trust. One of the major concerns and hence one of the major talking points during the focus group discussion, centred around the issue of multiskilling. It became clear from the discussion, that this particular issue overrode issues of commitment toward the Trust. As one of the senior physiotherapists said, 'It's difficult to discuss commitment to what is happening around you when there is a lot of contention between roles and who should be seen to do what. Working environment can be improved when there is collaboration between professions not conflict over role'.

The physiotherapists were quick to point out, that this was less about any one particular Trust and more about what was happening within the health service generally. It was felt that the issues surrounding the concept of multiskilling not only posed a threat to the status of the profession but also, at local level, increased competition between the professions, 'If you have to prove yourself all the time and prove what your skills are worth against other professions, competition creeps in. Professionals become wary of each other which then poses a threat to that collaboration'. This apparent threat of seeing others in competition reflects the apprehension at local level change management, particularly in areas where boundaries and professional role become blurred. Furthermore, the acknowledgement that there are overlapping of skills with some professions, in particular the occupational therapists, appeared to exacerbate this problem; 'There is a lot of overlap in our work especially in certain areas. Aspects of our work needs looking at and redefining, so that
we know where we are in terms of skill base. You can't deny that our roles are similar'.

This similarity in role and overlap in skill covers a multitude of practices, from walking re-education and balance activities through to wheelchair assessment and assessment for home discharge.

From the discussions it became apparent that there was some professional antagonism between physiotherapists and occupational therapists. This was exacerbated by local change, 'I think at times there is professional jealousy between the two professions and that mars collaboration between the professions at local level. Certainly we appear to have a higher profile and their role doesn't seem to be expanding'. Multiskilling was seen as a direct threat to their own professional identity. The notion of deskilling came into discussion much more forcibly than multiskilling. A typical comment that received consensus, 'If you take away our lesser skills then you deskill us in favour of someone else - it's a form of professional thinning'. Again the idea of the transference of skills to their own assistants was the solution most readily given. This idea of keeping skills 'within the family' served to protect professional identity. The physiotherapy assistant saw this as a positive move forward and all favoured keeping their own assistants rather than sharing a generic support worker role within the multidisciplinary team. No consideration was given to sharing skills with occupational therapists. On discussing the role of generic workers in the form of support workers, the physiotherapy assistant explained, 'It's fine if you have adequate staffing, but as soon as you don't, it's the basic nursing duties that are done first, leaving little time for rehab practice. At least if it's separated out, the patient would benefit from rehab as well, rather than it waiting for another day'. Whilst acknowledging that professions such as physiotherapy and occupational therapy should work together in order to define role, there were strong feelings that rather than sharing of skills, they
should be more adequately defined for individual professions. In addition, the part that the professional associations played in protecting scope of practice was deemed to be important, 'There are grey areas that affects the boundaries in practice, but the associations should tackle this one. They are the ones who need to be seen to tackling these areas – to define role and to defend it as part of their national agenda.'

The importance placed on the professional associations in terms of defending of role and scope of professional practice extended to the promotion of the 'right' professional image. Promotion of the profession was unanimously seen as an important remit of the association. It was admitted that as a relatively small profession, particularly at local level where the profession was seen as nothing more than one department, profile and image were important factors in promoting identity. On quoting a particular article promoting complementary therapies in a woman's magazine, one physiotherapist commented, 'If they (the CSP) don't get it right we will not do ourselves any favours – either nationally or locally...'. Despite the apathy toward multiskilling in terms of giving away their own skills, a very different viewpoint came over when discussing restrictions in practice. It was apparent that enhancement and furthering of skills in certain instances would benefit practice. Skill enhancement was seen as a way forward for maintaining and protecting professional status, 'It would be great to do more. As a profession we are well qualified in anatomy to be able to do things like inject joints, order and read x-rays I know it's unlikely to happen realistically, but it would be nice to think we could move forward in that way'. A more flexible working pattern was also viewed as a positive means by which identity could be enhanced. The introduction of seven day working was seen as an important initiative for the profession in order to 'prove its worth'. As one physiotherapist commented, 'I think it is an important issue that we have to consider. We can't honestly
prove ourselves when we say patients don't need us over weekends and bank holidays. We need to address this very carefully. I think it has probably contributed to all this talk of shared skills.’ And another comment, ‘We should be promoting ourselves and therefore should be able to be here seven days a week. Anything we can do to promote ourselves as specialists in certain areas and we should be seen to be doing it’. This means of justifying their own role also had wider implications for how the physiotherapists viewed themselves generally within the organisation. An example was given of a new member of the department’s induction day, when physiotherapy had not been mentioned in hospital statistics, ‘As a large department within our own right we account for 10% of the hospital’s out patient stats and we weren’t even mentioned’. All agreed that this point highlighted their need to further their own standing within the organisation and that they were probably not unique in this.

Summary

This focus group highlighted a number of dilemmas and challenges facing the physiotherapists. Concepts such as multiskilling were seen as a direct threat to the occupational identity and image of the profession. Being small in number and departmentalised, the physiotherapists acknowledged that working with management on change issues strengthened their ability to limit unwanted change. In acknowledging too that they were closely allied to other health professions, such as the occupational therapists they emphasised the importance to their professional occupational identity of protecting their role and scope of practice.
The Occupational Therapists

The occupational therapy focus group took place within the occupational therapy department. The group represented a mix of seniority, including a student occupational therapist and an assistant. All were clinical grades either working on the wards or based within the occupational therapy outpatient department. None had taken part in the one to one interviews for this research.

The occupational therapists held similar views to the physiotherapists in terms of commitment towards maintaining their occupational identity. Much was made of the prime importance and commitment they should have as a profession, in defending skills and scope of practice, 'It is difficult to accept that we can share skills that others either want or feel they are capable of achieving....' Much was made of the deskilling of their profession with similar arguments to those of the physiotherapists. The passing of lesser skills to others was potentially threatening in terms of how the profession was viewed in terms of status and identity. However, an added dimension was the view that there was a potential threat not just to deskilling of the profession, but also to devalue the skills that would be given away. An explanation of this was given by one occupational therapist, 'The handing over of skills could well fall back on ourselves as it has the potential to make our skills of less value than they are. Washing and dressing practice may look simple to give away, but if we give these away to a novice expert, those skills become diminished.'

All agreed that giving skills away to those deemed less qualified would lessen the importance of their own role within the system. All accepted that the role and scope of practice of an occupational therapist, seen in the context of a multidisciplinary setting, looked easy. All supported the view expressed by one, that occupational therapy was good for hiding what it does, 'When you look at simple tasks that we do on the wards, they look
simple and uncomplicated. It may not come over as difficult but the implications for adequate evaluation and assessment of a patient is huge'.

Whilst acknowledging the perceived benefits to the patient of a more generic style role of hospital worker, problems were identified in terms of training, accreditation and accountability. In a discussion on the role of generic workers, one occupational therapist commented, 'If we take four years to train how can we train someone in a matter of weeks. It would be far better to allow us to accredit our own assistants who work along side us on a day to day basis'. Whilst accepting that this could be seen as an attempt to secure their own skills, all felt that this was the most appropriate way forward.

Within the focus group, the occupational therapists demonstrated a real fear of how their own identity might survive an organisational change process. Fears over their size and other peoples' awareness of their knowledge and skill base were identified as the main precursors, 'You get a feeling of it's a case of survival and accommodation of the turmoil around you. I suspect that we are not alone on that although no-one would question the role of the nurse or doctor'. Commenting on the local changes happening around them, 'In the beginning we were railroaded but the pace has slowed down so we can respond better. Also, as time goes by and new staff arrive, they seem more able to accept the issues surrounding what's been happening over the last few years': This notion of accommodating change was put into perspective by a comment made by an occupational therapy student working within the department, 'As a student, you're not always in touch with reality. You are taught the theory and not the real issues. When you get out into the real world you realise that life isn't always black and white'. By this, the student was referring to the issues that were openly being discussed within this focus group. She
recognised the potential for conflict within the workplace over the issue of skill mix and that these issues could well be exacerbated by low working morale, staff shortages and intensive workloads. All these issues aren't either readily apparent or readily highlighted in the confines of a School of Occupational Therapy. There was little doubt that one of the key reasons for other professionals viewing their skills in lesser terms, was the poor image that occupational therapists had generally within the health service. Whilst the physiotherapists expressed similar concerns over profile, the Occupational Therapists accepted that theirs was a much bigger problem, 'We have to work harder than we do to get the right image across. We have fallen behind other professions. Most people on the street don't know what we do, in fact some of the health professions don't know what we do'. This comment highlights one of the major differences between themselves and the physiotherapists. Whilst the latter would prefer to move away from either the glamorous image of running on a sports pitch with a wet sponge, or being seen as a curer of backs and necks, they do have an image of sorts with the general public. Certainly, the role of the occupational therapy is a lot less noticeable.

This difficulty in establishing what occupational therapists actually do, was seen as a contributory factor in the difficulties they faced in how their role was perceived by other health care workers. When discussing their role within the team, one commented, 'Our role as facilitator in aiming towards achieving a patient's quality of life isn't always appreciated within the team. So often it's about quantity rather than quality'. The occupational therapists were less hopeful than the physiotherapists that they could count on the work of their own professional association in building up a better image. When probed further on this issue most saw their professional association more as an accreditation body than an association that had any real influence on the national arena.
Similar thoughts were expressed about how they might influence change at local level, from within their own departments. The smallness in their number rendered them with little real power, ‘As one of the smaller professions we don’t come across as often as perhaps we should. I think it is a problem we have at both national and local level. Because we are small, we just don’t have the power and I don’t see how that can change in the future’.

When asked how this might change, there was agreement that working as part of a multidisciplinary team, through time, helped to increase awareness of what they did. This awareness of their skill base was seen as an important way forward if they were going to be able to contribute to the change process. One of the profession’s greatest drawbacks was their lack of evidenced based practice. This lack of research base was seen as an obstacle in proving their worth and standing. When discussing flexible working practice in terms of a seven day a week profession, one occupational therapist summed this up, ‘I think if the staffing was right we should be 7 days but that isn’t easy in practice. We might have to agree with it if we want to keep our skills. My own personal feeling is patients need a break from us. As yet there is no evidence to prove that patients either get better or go home quicker. The trouble is we are not an evidence based profession, which is a big drawback when you are trying to stem the tide of change’.

Summary

The occupational therapists face similar difficulties to the physiotherapists in that they are small in number and departmentalised within a large hospital setting. On the evidence from this focus group, the professional employees appeared ready to work with change in order to secure and enhance their own status within the organisation. They recognise the
need to control what happens in order to protect their own skill base and professional identity. A major dilemma facing the occupational therapists was their perceived role within the organisation. That so much of this role was deemed by others to be transferable emphasises the lack of perception as to the extent of their knowledge base. In attempt to counteract this misconception the occupational therapists looked to protect their role and scope of practice in order to secure the value placed on their contribution to patient care. These dilemmas appeared to be compounded by the lack of direction from their professional association and the lack of identification with specific skills in the eyes of the public.

The Managers

This particular focus group involved managers from a wide spectrum from within the organisation. Representatives from both senior and middle management were present. Many were members of health professions and had progressed to management through their respective clinical ranks. Some had been members of the re-engineering team from the early stages. Others had benefited from the post re-engineering organisational management structure, through being promoted to the new process manager roles. They were chosen after recommendation by a senior member of the Trust's re-engineering team. They were recommended for two reasons. Firstly, they provided a diverse range of managers from around the hospital. Secondly, they were known for being able to speak out in a group situation.

It became clear early on in the focus group that, in their view, the nurses, through the nature of their profession, were more able to accept and adapt to change. One process manager commented: 'there are certain professions more readily acceptable to change,
nursing is one of them. This is because they are more practical about things and more aware of change than perhaps other professions'. Many of the managers agreed with this putting forward a number of reasons why this should be so, 'Perhaps this is because they are more practical but also because their process has been more evolutionary and have had to struggle more for their recognition'. And another, 'It's true nurses are more holistic than any other profession. They are the only profession that can honestly say they are with the patient 365 days of the year'. The following discussion on the role of the nurse added to the acknowledgement by managers that nurse were more readily accepting of change than other professions. 'Do you think nurses are more readily acceptable because they are extending their boundary as opposed to be seen to be losing them? 'They are extending their skills but they are also giving some away to untrained staff. So they are having the same professional worries, but they are more ready to accept a job and do it'. And the director of nursing added, 'That's right. They don't see something and say right that's not my job. It's anything that affects the patient'.

The points made above highlights not only the expanding role of the nurse through the years, but also the adaptive nature of the profession as a whole. Members of the group who were also members of professions other than nursing, suggested increased specialisation within the professions as a major contributory factor for those who were less likely to be committed to changes in their role. The change leader commented, 'Do you think it has anything to do with professional specialisation. I'm thinking again of radiography. We qualify, then specialise further down then when you ask people to share again its very difficult for them to do so because they consider their extra training and experience as paramount to their own recognition and worth'. Increasing specialisation led to an interesting debate on professionalisation strategies. If skills are lost in favour of
specialisation there is a risk of skills becoming diluted, having a knock on effect on the professions’ identity. Conversely, if skills are too narrow, the respectability and kudos of the profession is threatened. For the health professions there is a further dilemma. Increased specialisation brought about through advances in technology has led to fragmentation in certain specialties. Areas such as general surgery and general medicine are no longer ‘general’. However, in other professions, such as nursing and physiotherapy, increased specialisation has afforded the individual more autonomy in day-to-day working practice. As the pathology business manager pointed out, ‘Specialisation is one of the big problems in pathology. The notion of multiskilling is seen as deskilling because of the degree of specialisation within the profession. You can’t train everybody to my level so therefore you’re downgrading my role within the organisational change process. If you look back, most of the professions were multiskilled before they specialised into whatever role they took’.

Professional accreditation and regulation reinforces the individual’s professional need to protect their own skills at local level and one such comment from the pathology business manager highlights this, ‘People hold onto skills and guard them jealously, almost as their own right of passage and that is reinforced by the professions. They have vested interests in terms of prestige’. More senior managers within the group saw the issue of multiskilling more in terms of the sharing of skills. The director of human resource management suggested, ‘The starting point is the particular patient group and asking yourself some very sensible questions that if I’m going to extend the range of that person’s skills is that person going to be competent enough to do it to the standard that I need. So the starting point is the needs of the patient group. The next bit is to say okay these are the needs of that group be it nursing, therapy or whatever, is it sensible in the terms of the contribution
that that person makes, is it sensible to ask that person to take on a broader role for their satisfaction without jeopardising the standard of patient care and that’s critical too. Multiskilling, which is not a term I like – shared skills is far better - is only on the basis that that person is properly trained to so’. The director of nursing added, ‘...it’s not about taking away skills and giving them to another its about sharing of skills, not removing them’. Whilst these may be the views of senior level management, local hospital level changes have implications for the professions nationally. It was acknowledged that some skills at least ‘looked easy enough to be shared’. As the business manager for pathology explained, ‘technology is making the possibility of multiskilling much more viable particularly in areas such as pathology. It is making the work simpler for others less qualified to do’.

One process manager went on to explain how managers themselves faced difficulties in identifying which skills could be shared, ‘As a process manager when you start reorganising the work, you think we need this but do we really need this. In a way you are attempting to direct organisational learning. At the same time as a manager your actions come into question by others. Managers who don’t have a health background in changing health roles may not know what they have made redundant – you don’t or may not realise what you have got until it is gone’. This last comment highlights the somewhat symbolic boundaries of the professions that have built up over time. The symbolic nature of the health professions is well recognised. The doctor with his white coat and stethoscope or the nurses uniform and cap, are very much linked with the cure and care status of the two professions.
A discussion on the issue of professional boundaries, highlighted the problems that both health professionals and their managers face in the change process. One of the big dilemmas was the role that the professional associations played in determining the role of their members. As the director of nursing commented, 'I think the real issue here is how we sell it and what we mean by it and that's the real issue for the nurses and that's what the RCN have difficulties with. If you talk about generics and all that that entails then we are running into problems. I think that what we need to develop is finding the right people with the right skills to deliver care most appropriately whether be it nurse, P/T or whatever. There are areas that you can't wander into without the additional skills and knowledge base. So it's where we define the boundaries.' This comment reaffirms the problems faced on where and how to define professional boundaries at local level, in a national health service, with nationally recognised professions. The director of human resources reinforced this issue with the following, 'so many of the professional associations, be it nursing, physiotherapy or whoever, have an in built scepticism and concern about the uniqueness of their own particular grouping. I don't want to threaten this uniqueness that each makes, but the particular contribution made shouldn't have to be within the confines of professional boundaries, and I wish that there was an easy way of overcoming these concerns that each individual and professional association has. To my mind it's a very lengthy process. I think the way to do it is that the particular groups of staff doing the care come to the conclusion that this is the best way to do this'.

Members of some of the smaller professions (Pathology and Radiography) commented on the intrinsic role that the professional associations play in the education and accreditation of their members with one of the business managers suggesting that this added to the dilemma, 'the training reinforces the boundary, the professional associations create the
boundaries so although people see the benefits of what you're trying to achieve their pressure is from the national institutions'. The change leader, who was a radiographer added, 'I'm a diagnostic radiographer. I taught radiography for 12 years and you realise that in the education process itself you are reinforcing this boundary and therefore, the hardest thing to think of is the patient process and what happens along it in terms of shared skills and the education process reinforces the professional boundary. Not only that, working in departments also does that. The scary bit comes in when you realise that perhaps you have got skills that overlap'. This problem of department bound professions, reinforces the boundary issue. Department-led professions compound and compartmentalises role and boundary. One further comment from the change leader confirms this, 'It's a personal thing as well. I stood up at a conference recently and suggested that someone else could take an x ray, but you feel an absolute traitor to your profession. You have a professional identity and a professional responsibility, and there is that pressure on you to be the first to suggest that things may be different or that you would like it to be different. It's an accountability thing and can be very daunting to promote change within your profession. It's difficult to achieve mutual support from your own when you are suggesting radical change'.

This comment highlights further the dilemma for individual professionals in determining where their own commitment should lie. There was a view among the managers that what had been achieved in this particular organisation was little different to what had evolved naturally in health care over the years. The director of nursing commented, 'Can I be contentious here and suggest that are we doing anything different here than before. If you look at what medicine did and what it does now and nursing and what it does now, that without any dialogue of what skills we need what we share, we are where we are through
a process of evolution. The sharing of skills and changing of roles are changing through evolution. What is happening now is that because it has to happen now, it is producing the professional dilemma that we have today'.

Much was made of the power of the professional associations, not only in terms of professional role but also in terms of their own political agendas. As one process manager said, 'that is certainly true in nursing terms. The vested interest in the RCN to maintain prestige is very important to them and the message that comes out is of deskilling and the creation of generic roles and so we are devaluing nursing. It's so political out there. They work to their own agendas on the political front and what their response is embedded in their political agenda. It's a power thing'. When asked how this is approached in terms of the local agenda all agreed that it was a difficult situation to deal with. As the director of human resources commented, 'You can put all the logic into the discussion at local level, but you still have the problems with the professional associations in terms of accreditation, accountability and responsibility.' Managers kept referring back to the problems faced in attempting radical change at local level against a national backdrop. This led the head of re-engineering to explain, 'I think there are some interesting issues and relationships here. We are looking at national agendas and local arenas. What we know as top/down change and bottom/up change. What we have had in the health service is traditional top down change. An alternative way of looking at that is the bottom up approach where you get teams to look at what they do, look at their own roles and redesign it themselves. Bottom up is a lot more effective and we have proved it to be successful and lasts and is sustainable. I think that needs to happen at national level in national discussions to allow it to happen at local level. In a sense you have to have both, you have to have the strategy from top and the work from the body of members'. This
optimistic approach was echoed by many of the managers. The manager responsible for Research and Development suggested something radical was needed to change the tide, "I think in terms of getting something driven nationally if what we are doing here was seen to be going the right way forward whether it be to do with delivering patient care, patient satisfaction or staff satisfaction, or being able to recruit, if there was a ground swell you have a chance to create a different mood at national level and perhaps a common core of health studies. That is the type of radical change we need". This last comment reflects the radical change process that this particular case study had recently undergone. In reality, because of the complexities of health care in terms of number of professions involved, the idea of a common core health studies programme is unlikely to happen.

Summary

So far, this case study has referred to the dilemmas faced by the health professions in accepting change processes happening around them. What this focus group has done, is to emphasise the particular problems faced by health care managers when attempting to introduce new working practices. A major dilemma centres on how to introduce and orchestrate local change in the face of existing national professional cultures and identities. This struggle between professional identity and where an organisation would like to be is highlighted throughout.

Conclusions

These four focus groups highlight a number of key dilemmas and challenges faced by the health professions when implementing local change initiatives. There is clear emphasis placed on the importance of how change affects occupational identity when new working practices are adopted. Much of the discussion hinged on how to adapt change around the
awareness of the individuality and uniqueness of the professions involved. There were clearly defined and deep rooted boundaries which hindered the dynamics of the change process. There was acknowledgement too that presently much of the work done through the professional associations reaffirms boundaries rather than crosses them. The issues surrounding changing roles and practice were not always clear cut. For the managers, the theme was one of sharing skills and competencies that a particular client group might require, and then adapting the skills of the professionals involved in order to meet the requirement. The holistic role of the nurse made the nursing profession more adaptable to change and the move away from the traditional role of nursing sister exemplified this.

The concept of multiskilling was seen as a very real threat to the two therapy professions. Being small in number and departmentalised, the two professions acknowledged that their image and occupational identity were key factors in presenting themselves and expendable members of the multidisciplinary team. In addition there was recognition of the importance of working with change at local level, in order to secure their own base and status within the change process. By working with management they could control their own skill base and so too their occupational identity fostered outside of the work place. In doing this they had the added benefit of enhancing their social identity through their working relationships with other professional employees.

In his work on expertise Scarborough (1995) talks of a paradox whereby expertise can be both instigator and resister to change. The position of professionals as both obstacles and resources to change is demonstrated through the dialogue of the four focus groups. Control over accreditation and regulation is in the hands of the person Watson (1976, 2001) refers to as the 'occupational spokesperson', that is the professional associations. In
acknowledging the importance of forging new forms of work, the political agendas of the professional associations are aligned to what Reed refers to as his 'continuity thesis' - a framework for producing a modified status quo vision for the future of the professions. The argument follows that existing health professions are well equipped to absorb and adapt to change. Within the managers and nursing focus group, dialogue suggests that the nursing profession, being holistic in nature, does reflect this argument.

The therapy professions at grass roots level are less likely to be able to adapt to change due to the gatekeeper nature of their professional associations. These professions face a number of dilemmas and challenges. In recognising that their occupational identity rests on their professional role and scope of practice they rely heavily on their knowledge base in order to secure a monopoly over their expertise. Chapter two of this thesis emphasised the importance of both Larson's professionalisation project and of Foucault' translation of knowledge into power and the extent to which humans are subjected to and are reliant on superior knowledge. Ultimately, it is this expertise that is proving to be an obstacle to change. Discussions in therapy focus groups acknowledged that there is indeed overlap of skills. To share these skills is seen as detrimental to their distinctive identity as it is seen to devalue their role within the health team. This dilemma is further exacerbated by the fact that that they are small in number and department based. Being small in number they have a smaller voice and smaller profile within a large organisation. Being department based they are a good example of what Parker refers to in chapter 2 as spatial/functional organisational divisions. Links can be made here also with Turners theory of social accessibility - who is an in group member, who is a minority out group member. Change programmes such as BPR and PFC that encourage cross functional working should be able
to assist these smaller departmentalised professions in becoming more integrated within the organisation, and provide opportunities for a stronger identity.

The final chapter draws some broader theoretical conclusions from this research.
### Table 21: The Physiotherapy focus group

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### Table 22: The Occupational Therapy focus group

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### Table 23: The Managers focus group

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<td>DIRECTOR RE-ENGINEERING</td>
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<td>CHANGE LEADER</td>
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<td>PATHOLOGY BUSINESS MANAGER</td>
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<td>PHARMACY BUSINESS MANAGER</td>
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<td>PROCESS MANAGER (REHABILITATION)</td>
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### Table 24: The Nursing focus group

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CHAPTER 8

CONCLUSIONS AND POLICY IMPLICATIONS

'Flexible change of the sort that takes aim today at bureaucratic routine, seeks to reinvent institutions decisively and irrevocably, so that the present becomes discontinuous from the past' 

In one of its reports, The NHS Plan: A plan for reform, A plan for investment (2000) the current government has expressed its desire to break down professional boundaries. In strongly articulating the need to create opportunities for staff to work beyond their traditional roles we are in the midst of redefining professionalism in health care. This thesis contributes to this debate. The major argument is that changes in the role and scope of practice introduced through initiatives such as BPR or PFC directly impact on professional/occupational identities. If this is the case, it is therefore critical to open up this 'black box' in order to create a motivated, flexible work force for the future. The empirical work in this thesis demonstrates how the effects of change in working practice creates a situation whereby there are clearly defined winners and losers. The idea that there are both winners and losers in a change process is not new. But this thesis links such a recognition with the pluralist nature of health care, the multiplicity of interest, emphasis and values and the complexities of professional/occupational identities within the NHS. It contributes to exiting knowledge of the health service change process by taking the winners and losers theme and relating it to Tajfel’s (1982) concept of self categorisation and Turner’s (1982) concept of social accessibility in organisations. These are used to give new insights in to the winners/losers argument and the complexity of occupational identities within health care. An added dimension is the extent to which the nature of disciplinary knowledge creates these professional roles and occupational identities. If
health care professionalism is to be redefined there is a requirement for an agenda for change in how discipline and expertise are acquired.

The last two decades have certainly seen great changes in the way in which health care is delivered. Although a process of radical thinking on how the NHS is run has underpinned the nature of this change, there have been calls for stability and consolidation by those working within it. There is evidence to suggest that changes in the way health services have been delivered since the mid 1980s, have been short term and responsible for creating a ‘culture of panic’ within health care (Pettigrew 1992:275-276). The driving force behind this culture has been political intervention on behalf of the tax-payer and the ‘customer’. For the professional associations, this intervention has been a double-edged sword. On the one hand, political intervention has demanded increased accountability and responsibility from the professions. This has challenged the tendency of professional groups to cherish and protect autonomy. On the other hand, political intervention has provoked the professions into examining and re-evaluating what they traditionally always assumed to be theirs, through an apparently natural evolution of their role and scope of practice.

Making the workforce work harder is one way in which productivity can be increased. The other is to make the workforce work more efficiently or ‘smarter’. Either way, involvement of the professional associations and unions is imperative in the planning of today’s health service, not least because of the effects of change on the role of the health professional. Whilst the knowledge base available through a professional association is useful in developing and diffusing new levels of expertise, Swan (1996:146) suggests that the role of professional associations in the innovation process depends on the boundary and occupational status of its members. Moreover, since professional associations are not
politically neutral, they may serve to constrain the development of new ideas, especially if this expertise crosses professional boundaries.

A conclusion of this thesis is that the professions can be seen as both obstacles and resources to change and this determines the limits on the character of effective change. However, change should not be seen to weaken the Health Service's core human resources. As key components of the health service labour process, there are a number of benefits to viewing the professions as a resource. They provide a recognised, well established system for training, providing the health service with an educated labour force which has a pool of skills that are clearly defined. It is this very distinctiveness of the health professions that drives the delivery of care, which in turn makes them an indispensable asset. The dilemma is how to allow the professions freedom to develop their expertise and knowledge and judgement, whilst acknowledging the need for them to be aligned with both the political and local health care agendas (Leverment et al 1998). This dilemma is posed most acutely by the changes enacted from below, as in this Trust hospital's BPR programme. The emphasis on professional/occupational identity, however, suggests that the dilemma can only be resolved by NHS-wide initiatives by management and the professional associations.

The empirical work in this thesis indicates that there is a complexity of identities within the NHS. Firstly, there is a control from above by the professional organisations over knowledge and techniques. This control forges a professional role and occupational identity for the professional employee that is fostered outside of the workplace. However, this identity is rarely completely exclusive. Not all workers, all the time, agree with the corporate professional viewpoint. Against this backdrop is the wider social identity of the
professional employee. One part of this identity, not explored in this thesis, is nurtured in roles outside of the work environment – as a mother, a father or a sibling. Within work, identity is advanced through working relationships, team working, being a member of a department or speciality, or even ‘on the other side’ as a patient or relative. When change is orchestrated through local management initiatives, employees have to constantly mediate between their professional identity, their organisational identity and their immediate relationship with colleagues. ‘Professional identity’ is the ‘black box’, or in the case of this thesis, the ‘professional triangle’, of the NHS change process. It explores what is distinctive and yet little explored about the health care labour process.

The NHS is a large complex organisation, based on a series of interlocking systems and groups. Because of this it appears fragmented and incoherent. The skill in managing change centres on managing a series of dilemmas and dualities. Paradoxically, whilst NHS change in the 1980s and 1990s was politically driven, change has been managerially executed and based on Unitarist general management organisational assumptions (Fox 1974). BPR is but one instance of this. The dilemma is how to orchestrate and sustain pressure from top down, whilst leaving the freedom for individual organisations to build locally acceptable change. Certainly, there is a need for the health professions to be regarded in a more complex, multidimensional way than most of the ‘popular’ change management literature suggests. The notion of the ‘charismatic leaders’ pushing down change through the ranks, sits uncomfortably with the deeply entrenched nature of the health professions. There is a crucial tension between managerial unitarism and the entrenched occupational pluralism found within the health care arena. The differences between, and within, the individual professions, not only define the uniqueness of the individual professions but also that of the health service itself. Self regulation and self
accreditation afford the professions the prerogative of defining what is uniquely theirs and this limits how far the change process can go. This thesis shows that the distinctiveness of the organisational context of the health service limits how far general management concepts can be simply translated into the NHS. A different approach is required.

The impact of political change on the health professions was considered in Chapter One. This established the Conservative governments' policy in attempting to introduce general management principles into the NHS. The chapter highlighted the tensions between the managerialist and unitarist approach to change management and the pluralistic nature of the health service. The 1984 Griffiths Report is associated with the introduction of general management principles, which attempted to shift the power and control over how health services are run, away from the health professions. The growth of general management, together with the enforced introduction of clinical auditing in the White paper of 1989, directly challenged the autonomy of the health professions. It was thought that, by making the professions more accountable and responsible for how they delivered health care, the quality of health care would improve. ‘New Management’ viewed the process as an example of responsible autonomy. However, many professions – in particular medicine, who, due to their hitherto unquestioned position in the health care hierarchy, had the most to lose – viewed the process as a form of direct control (Friedman 1977, Leverment et al 1997). By the time of the political reforms of 1990, despite Griffiths, it was clear that the power of medicine remained intact for two reasons. Firstly, their historical power base and the hierarchical nature of the profession both at micro and macro level had changed little. Secondly, they had used initiatives such as clinical audit to legitimise existing practice rather examine it. For the other professions, the political reforms of the 80s and 90s had left them a greater need to work with organisational change. There was a growing
awareness of the need to examine practice. But this was interpreted in terms of being able to reinforce professional role, scope and practice that was deemed rightfully theirs in order to protect their professional/occupational identities. Management and professional associations both faced problematic choices in this new era of heath care. ‘New management’ was driving through the introduction of new initiatives to a service that had hitherto adopted a pluralist, collectivist approach to the delivery of health care. Professional associations were actively protecting their professional/occupational identities, while coming to terms with new customer focused working practices. Both were struggling to square the circle of organisational change and professional/occupational identity.

These new management/employer driven initiatives had many of the hallmarks of the ‘human resource management’ model that had evolved in the eighties (Guest 1989, Storey 1992). The initiatives encouraged individualistic rather than collectivist approaches to the employment relationship, and brought with them new tensions within the health arena. There was emphasis placed on market and consumer needs and attempts to marginalise trade unions and professional associations. Alongside this, came the call to move away from conformity, toward a new level of commitment to changes by the health professions. There is a tension here, between individualism and collectivism, which Storey and Bacon (1994) describe as an ‘irony’. Previously, Fordist patterns of work had involved strict divisions of labour, rigid hierarchies and role demarcations, that had operated in a collectivist manner. New forms of work design encourage post Fordist, flexible specialisation, in the form of team working, quality and flexibility - all accentuating the need for collective behaviour. Paradoxically, they are encouraged through the management notion of individualism. The implication here for the health service is, in implementing new forms of work design, there is a need for a recognition of some kind of
balance between individualism and collectivism. Much of the health service continues to be run in the Fordist style pattern of work, with the professional associations responsible for the strict division of labour and role demarcation. This thesis demonstrates the tensions between multiskilling and job identification, and raises the problem of reconciling the individual and the collective, the unitarist and the pluralist, professional identity and the changes of scope and practice of contemporary health work.

Through examining the literature on the professions, Chapter Two begins by identifying the distinguishing characteristics of a profession. The chapter abandons the old functionalist and trait discourse that takes for granted that professions actually exist. Instead, through the work of Larson (1977), it favours the notion that it is occupations that are of prime importance and that professional identity is something that certain occupations strive to acquire through a carefully constructed professionalisation process. Larson's work together with Foucault's (1980) translation of knowledge and discipline into power and human subjection is used to illustrate why the health professions place a high emphasis on controlling professional role and scope of practice. Their knowledge and expertise is demonstrated through their role and scope of practice in the delivery of healthcare. This specific knowledge base and expertise significantly influences their professional/occupational identity. This begs the question, who is it that actually pushes the professional identity line – occupational members, occupational spokesperson or a mixture of both? In welcoming a shift towards a more 'general concern with occupational restructuring and the processes of mobilisation around expert knowledge', Watson (2001) argues that members of almost any occupation are likely to be attracted to the 'professional label', justifying the right to resistance to employer control, high social status and material reward. Added together, this all leads the way to a level of inertia and
status quo within health care similar to what Reed (2000) refers to as his continuity framework. In turning to the social identity literature, the chapter differentiates between corporate professional identity fostered by professions outside of the workplace and the identity of professional employees within the workplace. In acknowledging that individual professional employees have more than one source of identity, we begin to see how professional employees may show a mixed response to organisational changes within the workplace. A professional employee may be pulled to respond in line with their professional organisation. But their professional and individual relationships within the organisation may necessitate a response that is more in line within their own working environment. Here, there is a tension between the professional/occupational identity acquired from outside of the organisation and a commitment to working with change within. The concept of the ‘professional triangle’ is used to underpin this argument. In short, there is a need to know where employees are located within the triangle, in order to ascertain the response of professional employees to organisational change, and to gauge the effects of change within the workplace. The complexity of identities within the health service either from the designs of management or the views of the professional association, suggests that it is impossible to merely ‘read off’ the responses of employees. This necessitates research that assesses the responses of professionals at grass roots level.

Chapter Three sets out to identify and explore the uniqueness of the health professions within the NHS organisational context. In doing so, it portrays the health service as a distinctive and unique organisation. One central reality is the pluralistic nature of health care delivery. This chapter highlights the unique nature and identity of each health profession and, in doing, so recognises the importance and complexity of professional identity within health care. By tracing the evolution of the four professions involved in the
research for this thesis, we can see how the inception of the NHS was a major turning point in each of the professions' histories. The chapter illustrates how the development of knowledge and discipline secured a distinctive occupational identity for each of the professions. Medicine, as a male dominated profession founded on sound scientific knowledge, emerged as a powerful, immovable force within the health arena. Although dominated by this medical hegemony, the formation of the NHS allowed and helped to create the other professions' legitimacy. At the same time, the professions became the health service's most powerful resource, as they provided and secured a well trained, self motivated professional labour force. This is an important point to take into consideration. The role that knowledge and discipline play in the shaping of occupational identities also serves to create a sophisticated and highly specialised workforce that can be used as a valuable resource. It is evident that throughout their development the professions worked tirelessly to carve out their own identity and uniqueness. The drive from within the other professions to move away from medical control over their work, reinforced the emergence of the smaller professions as identities in their own right. As this identity is based on a well established role and scope of practice, they are unlikely to adapt to change in role easily.

Having played a part in shaping the other health professions after the inception of the NHS, the medical profession ensures that it remains the power base within health care. Though in general terms, there is a public display of disappointment, dismay and disrespect for medicine as a whole at the present time (see Guardian 1998), medicine continues to sit at the top of the health hierarchy. Abbott (1988) argues that it is not possible to examine the notion of professionalism in present and future terms, without referring to the past. What this chapter identified is, how over time, the different health
professions have gained territory by means of legal legitimacy, self-regulation and in some cases, a degree of mystification. Today, professions generally are open to forces that threaten the division and deskilling of some members. Firstly, organisational needs for commercial awareness require new forms of work organisation that provide a flexible competitive workforce, and this is central to the focus of this thesis. Secondly, political requirements demand accountability and transparency that threaten the exclusivity of regulation. Thirdly, the societal growth of individualism and consumerism has led to a loss of deference by the customer. Finally, advances in technology has led to the systematisation of knowledge.

The thinking behind BPR both as a general management philosophy and in an NHS context was explored in chapter four. One of the arguments in this thesis is that as the major organisational resource within the health service, the health professions, are often able to turn these threats to their own professional advantage in order to minimise division and deskilling. Reed (2000) postulates that the professions are well equipped to absorb change and maintain the status quo. Certainly this has been the case in health care. The NHS, as an organisation, is dependent on the health professions. Through a number of guises, the health professions can continue to add value to themselves and enhance their own uniqueness and identity. Firstly, they can use advances in new technology, in order to increase specialisation thus having the potential for increasing their mystification. The more specialised they become, the less they are prone to systematisation through technology. In addition, through continuing to control their role and scope of practice through the professional associations, they can continue to evaluate and enhance what they do in order to protect their uniqueness and identity. One of the key arguments by advocates of BPR is that the potential for success is dependent on a 'clean slate' approach.
In this respect, with its unitarist assumptions, BPR is in tune with other management led organisational cultural change programmes of the 1980s and 1990s. This style of leading from above and reinventing the workplace, sits uncomfortably with the pluralistic professional structure of the health service. The pluralist nature of the NHS makes its application far more complex than even critics of BPR have so far suggested. If a clean slate approach is to be adopted, BPR has to *destroy* tradition. This thesis argues that NHS change needs to *involve* tradition through the role and scope of the professions, their unique identities and their distinctive contribution to the delivery of care. A major conclusion of this thesis is the need for change policy within health care to ‘work with the grain’ of NHS pluralism and allow for the heritage and traditions of the individual professions (Fox 1985). This is not to say however, that any change policy should surrender to them. Although there are attempts to move away from professional bureaucracy to a more customer focused orientation, professional bureaucracy is adapted, not abandoned. Indeed, research carried out by Buchanan (1997:70) within a hospital setting, concludes ‘In the absence of compelling arguments and evidence, the deeply entrenched positions of the various occupational groups involved are likely to render movement beyond simple and routine modifications to minor elements of the patient trail problematic’. Health professional employees have a central role to play in determining disciplinary boundaries and in determining the extent of cross boundary working within their own organisation. Firmly located in the Mode 1 form of knowledge production, addressing professional identities is an essential prerequisite for creating new forms of working that are more akin to Mode 2. Scarborough’s (1995) work on Mode 1 and 2 forms of knowledge production has important connotations for professional groups. The current reality of work within health care remains predominantly within the Mode 1 model of knowledge production. However, the introduction of multidisciplinary team based
working and change management programmes such as BPR, do encourage a strong Mode 2 element. Concepts such as multiskilling have strong links with Mode 2 but its introduction presently undermines Mode 1. An alternative professional future, and possible way forward for health care, is to encompass a hybrid of the two - an element of traditional professional structures but with scope for more open boundaries. This research shows BPR not to be some amorphous change programme, but a blend of hard and soft approaches to organisational change that has considerable and direct impact on the jobs and responsibilities of the workforce. A key argument in this thesis is that these changes will remain limited and possibly short-lived until such a time as professional/occupational identity becomes part of the change equation.

Chapter Six of this thesis shows the complexity of the change process at grass roots level in a large NHS hospital. The research was carried out in an NHS Trust carrying through a BPR change programme. The research interviews involved multidisciplinary teams of professional employees, working within three very different working environments within the Trust. Evidence from the interviews, suggests that one of the biggest dilemmas facing health care professionals is the tension between their commitment to the patient and their working environment and their commitment to their own corporate professional identity. Dawson (1986) suggests that the degree of conflict that arises between professional and bureaucratic system is rarely extreme. This is due to the adaptive nature of humans which permeates into the group and organisational setting. Greening and Hining's (1996) argument in chapter 2 of this thesis suggested that the NHS reflected highly resilient forms of organisation, in which there is a tendency towards inertia, exactly because the health professions occupy specific and strategically powerful enclaves – encapsulated mini organisations in their own right. The empirical work in this thesis suggests that some of
the professions, notably the therapists, are on the periphery of dynamic change. In considering Turner's six shaping factors, discussed in chapter 2, it can be seen why this is so. Any change in temporary situational factors can only go so far as they are restricted by the long term stable factors that determine the legitimacy, role and identity of the professional. Radical change programmes, such as BPR, confront the professional identities of those working with it. Whilst radical change may instil fear in the early stages through fear of the unknown, this research suggests that the vocational nature of the health professions and commitment to their patient outweighs that fear. This commitment to the delivery of quality care demonstrates the bond between the NHS and the health professions and reiterates the point that changes which can be demonstrated to improve quality of care are welcomed by them. Yet, if professional identity is not replenished as a resource, it may quickly reassert itself as an obstacle.

As mentioned in the introduction, this research demonstrates how the effects of change in working practice creates a situation whereby there are clearly defined winners and losers. This indicates that job redesign affects more than just those whose jobs have been formally redesigned. The restructuring of work affords the organisation the opportunity to place people into newly created posts that are committed to, and work with, the change process. In his book, Sennett (1998:52) writes of 'the willingness to let the shifting demands of the outside world determine the inside structure of institutions'. He argues that the ability 'to let go' is connected to a second character trait of flexibility – to be able to tolerate fragmentation as part of the energy of irreversible change by those who thrive on it. At the same time he contends that these traits become more self destructive the lower down the ladder in the flexible regime. The positive feelings toward the restructuring and the willingness for restructuring to succeed, lay primarily in those whose jobs had been
redesigned, that is, those at the ‘top of the ladder’. This was particularly evident amongst
the more senior nurses, where there was acceptance that the advantages to their new
managerial role, as Team Leaders and Key Workers, may have been temporary had the
restructuring failed. There was evidence of ‘losers’ amongst more junior nurses whose
work had intensified as a result of the new nursing structure. There were clear differences
in viewpoint between those who were carrying out more challenging newly created roles,
and those who were left to experience intensification of work. This was particularly
evident in the changing role of the nurse. Here, recognition and value in the work carried
out was an important motivator to commitment to change in working practice.

Referring back to the concept of the professional triangle, professional employees, in
particular the nursing groups, whose values edged towards those of management
philosophy were more likely to view themselves as ‘winners’. Those who affiliated
themselves more within their own working group, were more likely to perceive
themselves as the losers within the change process. Those professions who held a strong
defensive sense of professional identity, in particularly the smaller professions, recognised
the need to forge new relationships with both the newly designed work groups and
management, in order to secure professional advantage in the working environment.
Using Tajfel’s (1982) theory of self categorisation gave new insights into the winners and
losers argument. Winners, such as the team leaders and key workers in both the
musculoskeletal and rehabilitation processes, through their new role, formed new ‘in
groups’ with management. The nursing teams in both processes and the support workers
in the rehabilitation process found their allegiance was to their original ‘in group’. The
therapists in the musculoskeletal process became an ‘in group’ member rather than an ‘out
group’ minority member. On the surface this was positive, but new working practices also
brought new tensions. Changes in temporary situational factors had gone part way to improving there local circumstances. Long term stable factors on the one hand could be used as a safety net, but on the other, restricted progress.

New modes of working within the Trust had led to the creation of a ‘new’ occupation – that of Integrated Tester. This new breed of worker had been selected for interview as a ‘control’ against which the response of the other professional employees could be compared. Working within their own small department, they enjoyed a strong sense of job enrichment and autonomy in their own unique brand of knowledge, skill and expertise. These workers were considered to be unique in the field of health care. When interviewed, they were the epitome of the fully committed, empowered worker that Hammer and Champey had depicted in their rendition of the re-engineered organisation. They were evidence that new roles can be successfully developed, on ‘greenfield sites’, where the old professional traditions don’t exist as a barrier. On the one hand, they successfully demonstrate one of the key concepts of BPR - that starting with a blank sheet can work in practice. On the other, this new occupation dramatised the difficulties posed by the more traditional health professions, when challenged to examine their working practice and adapt to change. This group had acted as more than just a control. Having proved successful within their own work situation, they now looked for some form of identity outside of the organisation. Working in isolation and being unique within the confines of their own organisation, meant that recognition from outside was more problematic. Occupational identity was restricted to the boundary of their own organisation and the relationship with health professionals working with them. In order to gain credibility on a wider scale, they would need to acquire some form of professional identity in the future. At the time of the interviews no mechanism was in place to be able to achieve this.
Change had a minimal effect on the working practices of doctors whatever level they were working at. This substantiated the notion that curer/carer continues to have an important influence in the delivery of health care. Earlier chapters in this thesis, showed medicine to be the archetypal instance of a profession. Other health professions have depended on medicine for their own credibility as professions in their own right, and in doing so have allowed medicine to exert considerable influence over them. This concept of medical dominance has been readily questioned through the work of Friedson (1970), though until recent times the picture has been one of unlimited trust by patients. Whilst events of the last year or so, have dented the image of the profession and the public trust placed upon them, medicine collectively is as powerful as ever. The image of medicine may be changing from the outside, but their role as curer, together with the norms and structures that have been built within the profession, remain intact.

The smaller professions were experiencing new dilemmas. These primarily centred on how to work with management to ensure that change was unlikely to damage their own autonomy and identity, whilst at the same time promoting their image and professional standing within the new working environment. In addition, the potential for erosion of professional/occupational boundaries through concepts such as multiskilling posed real threats to these professions in terms of their identity. An emerging theme here, at local level at least, is the importance placed by the professions in affecting negotiated change. Unitarism assumes shared values and assumptions, and therefore top-down management led change. Buchanan and Storey (1995) argue that in order to have maximum effect change should be pluralistic in nature. In an NHS context this is doubly true, since 'external' professional associations continue to have a major say in the success of any
change programme. The evidence here, from professionals at grass roots level, suggests that change which directly effects role and scope of practice needs to be agreed with the professional associations nationally. In short, the NHS requires a national level resolution to the professional/occupational identity dilemma. But there are deeper issues about knowledge and identity. In this way, change should not be about weakening or by-passing the professional. Rather, change should be about directing this very specific knowledge base and expertise in more fruitful directions to the benefit of both the professional employee and the organisation. A further debate surrounds the issue of political power wielded by the various stakeholders within organisations and this is particularly pertinent in the pluralist nature of healthcare delivery where there is a multiplicity of interest. In advocating the need for recognition of the political dimensions of organisations in change management, Buchanan and Badham (1998) refer to the 'neglect of', and 'superficial manner' in which the significance, recognition and support of influential individuals and groups, is treated in the organisational change literature. This thesis demonstrates the problems faced in change management within health care precisely because such politics exist. On the other hand, it also demonstrates that local change masters accept that support is needed by the various national stakeholders in order to orchestrate effective change. At the same time, professional associations need the confidence and trust to move beyond the defence of 'frozen' professional/occupational boundaries, to grasp new opportunities for their members. Earlier in this chapter it was suggested that future professional models in health care could be a hybrid of mode 1 and mode 2. In chapter 2 Foucault’s 'le regard medical' was used to gain understanding on why the professions see identity as important aspect of their make up. By acquiring a knowledge skill base and expertise that is specific to themselves that can use these subject humans to their discipline. Others therefore, look up to and rely upon superior knowledge base. Within health care, as with any other
profession, as a general public we need to have confidence in the treatment given to us. This confidence is drawn from the assurance that the practice is competent and legitimate. Confidence stems from our emphasis on disciplinary knowledge that underpins expertise. New forms of work should be produced in the context of application but should build on disciplinary knowledge and the factors that make such knowledge stable.

Chapter Seven develops the debates and arguments of the major theme of this thesis – the impact of change on professional roles and occupational identities in the workplace. The managers’ focus group emphasised the problems faced by managers when introducing changes in working practice. A major dilemma centred on how to introduce and orchestrate local change in the face of existing national professional cultures and identities. So far, managed localism has been the strategy for change – a cross between de facto working practices and de jure professional boundaries. This has seen some successes, but has now reached the limit et by the continued national agendas of the professional associations. This dilemma emphasises the struggle between existing professional identities and how organisational change at local level is orchestrated. Change that attempts to bypass the professions is either extremely limiting or damaging to service provision. For the smaller therapy professions the challenge of maintaining or enhancing identity at local level is deepened further by the inflexibility of the profession since the protection of skills and identities is a national agenda. In the heart of the Conservative years, Storey and Sisson (1989:180) talked of the ‘fascination in some circles with the alternative and previously unthinkable option...of not only by-passing the Unions but at some point completely ignoring them’. Whilst this may have been at the centre of Conservative policy, this has never been a viable option within the health service as we need to use this specific knowledge expertise as a vehicle for change. Altogether
this calls for a new approach to health service change management which transcends the pluralist model of the 1970s and the unitarist approach of the past two decades.

**Policy Implications**

In reflecting on the importance of change within public services, Pollitt (1990) draws on the work of Pettigrew (1985) who argues that a proper understanding of organisational change is only achieved when intraorganisational politics and extraorganisational factors are combined. That is, the content and type of change needs to be understood within the environmental context of the organisation and the political processes within and between the organisations concerned with that change. This thesis addresses this through the ‘black triangle’ of professional identity. It presents an organisation that is pluralist in nature, and has a number of professions historically embedded within it, who are subject to a crisis of identity in the face of change through issues, such as, multiskilling and change in work design. What is apparent from this study is the need to orchestrate local change within a national framework agreement as suggested by New Labour’s partnership agenda (Ackers and Payne 1998).

This research shows that this partnership is needed at a number of levels. Local change that involves the redesigning of role and scope of practice needs to be free of the shackles of professional politics, but also needs to be free of the neo-Taylorist mood of the eighties and nineties. The question to consider is not now far can the blurring of professional boundaries go, but how far should they go. If the professions themselves are seen as the key resource of the health service, their sense of identity needs to be protected in some form. However, the potential limitations need also to be dealt with. Change shouldn’t be viewed by the professions as process of diluting skills, more a process of upskilling. The
debate should not centre on deskilling and proletarianisation of the health professions, but on how these professions and their knowledge can be adapted to meet the needs of the changing world of work. The partnership agenda should be about national, multi-level integration in order to create a professional workforce which continually appraises and develops the service that it delivers. Organisational change within health care can be seen as an opportunity for professionals to develop skills beyond their traditional role. A more hybrid model of expertise would afford the professions and the health service an alternative future with increasingly porous and blurred boundaries. This may be a daunting prospect for some but one where new challenges could create a health workforce that is trans disciplinary yet still socially accountable and reflexive at the point of application.

The Allied Health Professions Forum sets out an agenda for change in Meeting the Challenge: A Strategy for the Allied Health Professions (2000). Acknowledging that these professions have too often been 'undervalued or neglected' (p5) Meeting the Challenge sets out the Government's plans for developing and supporting professional roles in the NHS. It states that 'to do this effectively the professions need to be open to change - change in the way in they work, in the roles they play and in the care they give (p7). They are encouraging this by committing themselves to expanding the PAM's workforce, investing in training, taking action to improve recruitment and retention and modernising education. In turn they look to the professional bodies to support new arrangements for professional regulation and to support the development of support workers in order to ensure best use of professional skills. There is also acknowledgement of the need for employers to promote the PAM's as a career and to ensure diversity in the workforce for these professions. The introduction of extended scope practitioners (ESP's) by some professions - notably physiotherapy and occupational therapy - has begun to change the
face of health care delivery. These practitioners are clinical specialists within their own field who see patients referred for assessment, clinical diagnosis and management. Extended scope implies working beyond and redefining the recognised scope of practice. Examples include requesting or undertaking investigations such as x rays, scans, bronchoscopies, assisting diagnosis and referral to other health specialists as necessary. Firstly, this new role is thought to improve patient management (Langridge and Moran 1984, Hattam and Smeatham 1999) thereby improving the quality of service to the patient. Secondly, it is said to encourage the deployment of staff, allowing staff to be used more productively (Hourigan and Weatherly 1995, Durrell 1996). Furthermore, research evidence suggests that cost savings can be made (Daker-White et al 1999) and patient satisfaction is increased (Byles and Ling 1989, Daker-white et al 1999). For the professions themselves, it could be argued that these new roles might go some way in addressing the problems of staff retention within the NHS. The EnRIP Report (Kings Fund 1999) studied a number of professionals including nursing and physiotherapy who were undertaking new innovative roles within health care. Although one of the more negative findings was expressions of concern over a sense of loss of professional identity, the report suggests that practitioners in new roles are experiencing job satisfaction. This was seen in this particular study in the roles of team leaders and key workers. Factors seen to enhance this include independent working, the enhancement of skills and knowledge, opportunities to develop, change and expand service provision, stimulation of working roles in offering variety and recognition and respect from other staff.

This research suggests that professional identities within health care are very deeply entrenched in the organisational soul of the NHS. Professional identities are an asset and as such should not be simply eroded or fragmented. Whilst there is an argument for
continuity and stability within health care, the onus is on the professions to be responsible in moving away from defending what they do, to being proactive in creating a newly designed workforce that acknowledges the potential for blurring of professional boundaries. What is needed is a flexible, highly trained workforce that is capable of responding to changes in workload and technology. At the present time, professional structures within the health service have a limiting effect in achieving this stance. A reprofiling of the workforce, in order to reflect workload, is an important future challenge of the health service policy makers and the professional associations. These challenges are further reinforced by the need for employers locally to have a degree of autonomy in the designing of new roles. In interviewing those workers employed as Integrated Testers, this thesis has shown how newly designed roles, without the professional 'baggage', can be successful in building non hierarchical, multiskilled teams with the opportunity for role enhancement and cross boundary training. There is potential for research into the development of the 'specialist role' who is supported by a 'generic worker', within both the multidisciplinary team and within a particular service area. Beyond the scope of this thesis, we are already seeing influences of new initiatives such as NHS Direct, where the role of nurse consultant has begun to change the face of primary care. As the search continues for a high efficiency service, that is equitable to all, initiatives that encourage reprofiling and redesigning of role and scope of practice will continue to be introduced into our health care system. This study indicates a new policy agenda around the theme of changing skill base and the shifting roles and identities between professions.

The Future of Professions in the Changing NHS

Swan (1996) highlights two significant factors in managing expertise. Firstly, that the proliferation of specialist knowledge poses new demands on how management 'manage'
expertise and specialism. Secondly, that it is the professional networks that, on the one hand, supply the needs of management, but, on the other, promote their own brand of expertise. Furthermore, it is these associations that are the major structural influences on the construction of knowledge within organisations. As a result, they are capable of reinforcing professional boundaries and creating interdisciplinary conflict. As we have seen, professional boundaries have the potential to hamper and undermine changes in work processes and job redesign. Concerned with innovation within organisations, Swan considers the ways which professional associations construct and constrain knowledge and expertise. Her research, though carried out within industry, highlights a number of issues that are also pertinent to the role of the health professions themselves, as specialists, and their professional associations within the health service. As Swan points out, increased complexities of knowledge require organisations to be adaptable and innovative. This, in turn, necessitates that people within organisations have the expertise and knowledge to provide solutions to new ways of working. The NHS has specialism and expertise in abundance. Paradoxically, whilst adopting new forms of working practices to improve the processes within the delivery of health care, this same specialism and expertise can place limitations on how far the change process can go. Swan utilises the term 'boundary spanners' for specialists who act as potential 'gatekeepers', arguing that specialists involved with professional associations have the ability and opportunity to monitor, translate and disperse their own specific body of knowledge within organisations. This was apparent in this study. In Chapter four, the early days of the health service saw medicine, through its superior knowledge base and established professional networks, as the 'gatekeeper'. The profession controlled the knowledge base of the other professions. In turn, to secure their own identity and status, the other health professions embraced the medical model for their own development. As the professions have grown in stature, they
themselves have become their own gatekeepers within the health arena, determining both the extent and limits of their own boundaries.

Evidence from this case study shows the professions are reluctant to disperse their core skills, and role and scope of practice. So clearly there is a policy implication to consider here. The professional associations will want to continue to act at national level as boundary spanners, determining their long term stable factors (see Turner chapter 2), with the policy makers at government level. In addition, the professions are likely to want their membership to continue to act as boundary spanners, at the interface between association and organisation at local level. In both the interviews and the focus groups it was clear that core skills could be identified 'across the board'. If we are looking for a more flexible workforce, that at the same time maintains its level of expertise, specialism and individual identities, there needs to be an agenda for change in how the health workforce acquires its skills in the first place. Why not move toward a core skill qualification which then allows individuals the opportunity to extend their skills and adopt specific expertise and specialism through the professional associations? New Labour are calling for new collaboration and partnerships to be adopted in these areas. Changes in the skill base of the health labour process can only be achieved through collaboration in how health professionals are trained. Yet, in doing this it is important to take into account the disciplinary roots of the individual professions.

Swan (1995:133) writes that 'institutional value systems for professionalism are highly developed in Britain and are embedded in the national systems of education and work organisation'. On the positive side, the entrenched nature of the health professions has contributed to the establishment of a labour process within health care that promotes
knowledge and expertise. More negatively, this has created boundaries that are responsible for the delivery of health care that is fragmented and departmentalised. This thesis has shown how these boundaries are problematic when adopting a more innovative approach to health care delivery. However, this research has also highlighted that new roles and occupations can be successfully developed in areas where there is less professional ‘cultural baggage’ and less in the way of traditional knowledge domains. Local attempts at changes in role have faced national professional agendas and the hierarchical nature of the health professions. Indeed, at the present time New Labour are considering ways in which professions - in particular medicine - can be made more accountable for what they do. It is expected that when plans are announced on how the health service is to be modernised, the government, in terms of their self-regulation and accountability (The Independent 23/5/00) will harness the power of medicine. It is also expected that the government is to announce new forms of working for doctors, such as 24 hour operating, by a new grade assistant consultant, which the profession is already committed to oppose. This is of course, in part, a response to the general public and opposition parties’ criticisms of Labour’s handling of the NHS since coming into office. However, the medical profession have done little in addressing the flaws of their own internal mechanisms, for protecting patients (Sunday Times 4/6/00).

Swan and Clark (1992:133) researched organisations adopting new technological systems. They suggest that ‘specialists from different functional areas cognitively construct and represent knowledge in different ways’. The hierarchical, fragmented systems that have existed within health care, can prove detrimental to new forms of work design such as team based working, precisely because professions do represent knowledge in different ways. Through taking account of some of the smaller health professions, this thesis
highlights that those who lack power through being small in number and departmentalised, feel a stronger need to project a corporate image and protect identity within the change process. Further on, they acknowledge that ‘some areas of expertise were more strongly represented in the decision making area, leading to problems when making choices about innovation design,’ adding that those who lacked power in the decision making process fared less well. In addition, organisations that failed to see this often had problems in the implementation phase of the new innovation. This latter point emphasises the importance of user involvement on the decision making process. It also suggests that new innovations in the work process can construct a ‘winner/looser’ style environment, especially where differences in level of power are a factor. One argument in this thesis is that it is too simplistic to argue that re-engineering is either ‘all good’ or ‘all bad’. It can affect workers in different ways. Nursing can be seen to be a prime example in this case study, where within the new nursing team structures those higher up the ladder had benefited in terms of work enhancement, recognition and new opportunities. Structurally too, starting from a clean slate approach can disorganise the spatial territory of the professionals. In chapter 2 Parker’s (2000) typology of organisational divisions was considered in the context of health care. Spatial/functional divisions that have evolved in the health service leading to a delivery of service that is fragmented. A positive outcome of programmes such as BPR is to dissipate this fragmentation by taking a processual, cross-functional approach.

Having acknowledged the importance of the role played by the professional associations in providing an educated labour force for the health service, it must also be stressed that professional associations can constrain new developments. The structural-functional perspective given by Drazin (1990) assumes that all professional groups collectively share
values and motivations towards contributing to the development of knowledge in any
given field. As their shared values would be expected to promote innovation within the
organisation, it would be assumed that organisations with more professional employees
would be more innovative. This thesis argues that the health service is unique in the
number of professions working within it, but has also identified the uniqueness and
individualism of each of the professions. This divergence of interest and pluralistic setting
does not sit comfortably with the structural – functional perspective. Swan and Clark
(1992) argue that it is too simplistic to place all professional groups into this perspective
and uses Drazin’s radical-functional perspective in determining whether the role of
professionals in the innovation process is more useful. Here, the pluralistic nature of the
professional groups as described by Abbott (1988) is acknowledged, where there is
orientation to maintaining power status and control over knowledge. Swan and Clark
(1992) argue that the link between innovation and status – that is when innovation
threatens status - is not positive and members of the profession may be encouraged to keep
the status quo. Although there was, at times, a strong feeling in the interviews, particularly
among members of the smaller professions, that the skill base should not be dispersed,
there was also a sense that they needed to ‘work with change’. An argument of this thesis
is that, though innovation in health care is problematic not least because of the divergence
of interest and complexity of identity, there is scope to develop the expertise and
uniqueness of its labour force, not just to maintain the status quo.

Kelly and Glover (1996:31) argue that behind organisational change in the NHS lies a
modernist assumption – the belief that an answer does exist to organisational problems.
Yet, their own conception of change in health care is contrary to this view. For they argue
that, from the inception of the NHS to the reforms of the nineties, reorganisation has been
rhetorical and ideological. They argue against the view that each reorganisation is different and better than its predecessor, by suggesting that each change has done nothing more than continue with the past in re-enforcing both a centralised and localised bureaucratic system. In addition, the best that can be achieved, they argue, is to strive toward minimising inefficiency, rather than finding an 'ultimate answer to the efficiency problem'. Furthermore, and somewhat pessimistically, they suggest that given the complexity of the task, health service reform can only ever be a form of narrative.

Whilst this thesis acknowledges the complexities of health care in terms of its diversity, number of professional groups and variety of functions, it is more upbeat in suggesting that this complexity is better understood in terms of what is unique and distinctive about the health care process. This uniqueness, in turn, can be viewed both as an obstacle and as a resource or potential in considering new forms of work design. More positively, in demonstrating the uniqueness of health care and the human resources to be found in the health labour process, it can be argued that these resources should be able to be 'tapped' in order to design new ways of delivery of care. Kelly and Glover refer to the 'administrative-professional approach' (29), as a major influence in the way the health service is run. This thesis illustrates that the bureaucracy to be found in the wider context of health care specialism provides a daunting challenge to the change masters. However, new forms of management, introduced in recent reorganisations have forced professions, locally at least, to work with change, and this can be viewed positively. The inertia that Kelly and Glover point to is not as profound as they suggest, certainly at local level. The hybrid role of the clinician/manager, that has arisen as a direct result of the reorganisations of the last twenty years, has afforded new understanding in how work and roles can be redesigned.
McNulty et al (1996) offer a novel approach for understanding the effects of market forces on health professionals in choosing to refer to the concept of *practice* rather than *profession*. Although this thesis is not about the effects of the internal market on health care, McNulty et al's approach is relevant. Their argument is as follows. They first point out that medicine is a *practice* and as such, in using Macintyre's (1990:81) definition, can be seen 'as an activity, guided by collectively established standards of excellence, which those individuals engaged with a practice endeavour to adhere to and enhance'. This acknowledges Abbott's (1988) own argument that a major weakness of the professions literature is that discussion concentrates on how professions are organised rather than what they do. This has diverted the attention away from individual level of analysis to one of occupational level. They justify their choice of the concept of practice, because it allows the focus to be on work activity rather than occupation, organisation or status. Furthermore, they argue that the concept can be used at both individual and group level. They state that the two defining features of a practice are firstly, 'internal goods' and secondly, collectively established 'standards of excellence'.

In terms of health, a skill which results in any form of patient care, is a source of internal goods. They are internal because they can only be described and recognised by the activity and their participation in it. For example, a doctor or nurse inserting an intravenous drip, a nurse caring for a wound, a physiotherapist instructing a patient on exercise. To enter a practice is to accept the authority of existing standards. These standards are dynamic, because what is involved, is 'a process of critical reflection' on existing goals and standards (81). These standards of excellence correspond closely to the other dimensions of entry control, education and codes of conduct that are associated with much of the professions literature. This particular way of considering activity at work level, is a
refreshing alternative to existing trends in health care. To almost start with a clean slate, define the activity, the various skills needed to achieve the activity and the competencies necessary would be to break away from tradition. In short, the concept allows more scope for analysis and change. It is an approach that needs to be adopted when redefining role and scope of practice and in considering new and alternative methods of health care delivery. A far reaching consequence of this approach would be to ultimately break down the professional boundaries that exist in today's health care system.

In examining the shift of power between medicine and management, Ashburner (1996) warns against seeing professionalism and bureaucracy as opposing forces. Indeed, evidence from her own research into the role of clinicians, mainly medical, suggests that the two can work together. She raises the importance of questioning whether the new bases of power can be accounted for within the traditional concept of a profession, or whether a new concept does in fact need to be developed. She suggests that the key to understanding the professions lies in seeing them in terms of relationships from within them, with other groups, within organisational settings and within work itself. She suggests that a profession's susceptibility is dependent on its ability to recognise the significance of change and be willing to adapt, and argues that willingness to adapt on their own terms would appear more protective of their position in the long term; a case of 'doing', before 'being done to'. This thesis, in highlighting the crisis of identity for professions on the one hand emphatically demonstrates the fear that health professions demonstrate to the threat of diminished identity and autonomy. But, on the other hand, it also identifies that there is an awareness arising out there of Ashburner's argument. Furthermore, this research consolidates the argument that accommodation is possible between management and profession at local level. This is particularly so in relation to the
redesigning of role and scope of practice, as both sides are well aware of the limitations present in the process. It could be argued that this works to the professions' advantage.

What then, is the way forward for the professions? At local level professions need to be seen to working with management in the change process, in order to preserve their identity and autonomy. Rather than being defensive and reactive, a more proactive approach needs to be adopted that will nevertheless still take into account the present professional role and occupational boundaries that presently exist in the workplace. The knowledge and discipline base of the professions needs to be redefined. The new hybrid roles of clinician/manager that are evolving certainly have the potential to have an important bearing on the future for management of health services. In addition, much more work needs to be done at national level in securing an agenda that will redirect the process of change within health care. Whilst this thesis rejects the criticism of Kelly and Glover (1996) who suggest that reorganisations have resulted in inertia, there is clearly a need to move away from the fragmented delivery that presently exists. The solutions rest not only on partnership. They also rest on far reaching changes nationally about how professions can, on the one hand, continue to preserve their individuality, but on the other work towards a more generic/specialist approach. This may well mean starting with a clean slate, examining work activity and the processes of how health care is delivered, and developing practice that will deliver the preferred outcome, rather than be restricted by clear demarcation of professional role and boundary.

The issue of role/boundary is particularly pertinent to the therapy professions. Rather than approaching this problem through enforcing stricter control over boundaries the professions need to 'look from within'. New forms of working can enhance these
professions and their identity in a number of ways. Inter-professional training, through a common health professions learning programme, would encourage flexibility across boundaries and could be used as an opportunity to break down professional barriers in the fledgling years of professional careers. New forms of undergraduate education such as this would also serve to break down the symbolic boundaries that have built up in health care over time. The enhancement of education, training and accreditation for the support worker/assistant role would afford the opportunity for qualified members of the professions to be deployed more beneficially and productively. In addition, this would encourage the development of extended practitioner roles, ultimately leading to the role of Consultant Therapist. The development of either of these roles would help in the retention of highly trained and skilled professionals. Being department based has historically compartmentalised and compounded role and boundary demarcation for these professions. Adopting innovative approaches to education, training and professional development will afford these professions new opportunities whilst preserving their tradition and identity.
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APPENDICES

Section A

General attitudes to the Change Process

1. Describe your old working practice.

2. Since the introduction of the changes in your own working environment, how has your working practice changed?

3. What are the main advantages of your new role?

4. Do these advantages differ at all from your old working practice?

5. Are there any disadvantages in your new role?

6. Do these advantages differ from your old working practice?

7. What reservations/concerns do you have about working in a changed working environment?
8. How would you define your professional role in terms of 
   
a) the patient

   b) the team

   c) training and education within the team

   d) research

Section B

Attitudes to Changes in Workload, Delegation and Responsibility

9. In view of the changes are you happy with your job content? If not, why not?

10. Are there any restrictions in your working practice that you would like to see changed?

11. How do you think you may be able to influence this change?

12. What factors may prevent you from influencing this change?

13. In your working practice do you come into contact with any other health care professionals? If so, who and in what capacity?
14. How would you best describe your working practice with each of the above mentioned?

15. How do you communicate with other members of the team?

16. Do you feel these methods of communication are adequate?

17. Given the opportunity, how might you wish to change the structure of the team?

Section C

Attitudes to the Issue of Multiskilling

18. On the issue of multiskilling, what do you see as the main advantages to your own working practice?

19. Are there any disadvantages?

20. What do you see as the main advantages/disadvantages to your own profession?
21. How does this personal view compare with the stance of your professional body?

22. On the issue of flexible working hours, what do you see as the main advantages to your own working practice?

23. Are there any disadvantages?

24. What do you see as the main advantages/disadvantages to your profession?

25. How does this personal view compare with the stance of your professional body?

26. Is there anything else you would like to add?